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Date 11 September 2012

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Your Ref
Our Ref JGB/SM

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Dear Sirs

Integration of Adult Health and Social Care in Scotland – Consultation Response from NHS Ayrshire and Arran

I attach the Board's response to the consultation proposals which was approved at a meeting held on 6 September 2012.

In addition, I have been asked by the Board to highlight its particular concern about how its statutory responsibilities in relation to clinical and staff governance will be discharged in the new partnership arrangements. It is felt that this will have to be made explicit in the legislation.

You will note that in the Board's response, we have made reference to combined views of our three Community Health Partnerships (CHPs) and included as appendices the responses made by the individual CHPs. We felt it important that all these views should be included whilst acknowledging that they are not always consistent with the Board's view in every regard.

I trust that this response is a helpful contribution to the Scottish Government's further considerations and would be very happy to provide any further detail which may be necessary.

Yours sincerely

Mr John G Burns
Chief Executive

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

In general, the Board endorses the case for change and supports the

proposition that the legislation can build on progress made to date with closer integration of services and provide the necessary framework of support to improve outcomes. On balance, an initial focus on older people is supported given the work which has been done to date on outcomes and reshaping care for older people. It will be necessary however to construct a narrative which gives a clearer vision of the outcomes for adult services. In addition, there is a need to ensure those services which may be outwith the scope of the legislation, in particular, services for children and Social Work Criminal Justice Services, are not disadvantaged as a consequence and are underpinned by a strategic integration narrative. Moving on from legislation, it is recognised that staged implementation will create practical challenges. Detailed guidance will require to be developed in partnership to underpin this approach and avoid the possibility of creating artificial barriers to integrated service planning and delivery.

Combined CHP comments:

Of all the questions in the consultation document, this one produced the most diverse range of options from CHPs with no clear YES or NO consensus.

CHPs highlighted the need to focus on care needs and outcomes across all age bands, with concern that artificial age categories may not lead to effective care, since most services were not age defined at present and many were already integrated on basis of care needs – addictions, learning disability, mental health etc. There was also concern about care at points of transition from adult to older person, about potential negative impact on other groups not included – eg childrens services. Children’s OLGs highlighted that successful outcomes for adults start with children. However CHPs also recognised benefits of starting integration process with focus on improving outcomes for older people due to demographics, provided the integration focus quickly extended to adults thereafter.

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

Overall the framework is fit for purpose and provides a solid basis for moving forward. It strikes a reasonable balance between the need

for national supporting mechanisms and the need to avoid imposing inappropriate or unnecessary regulatory duties. Again, however, implementation will have to be carefully planned and executed in partnership.

Combined CHP comments:

Broad agreement on 'Yes' with particular welcome for the link with locality planning.

Concern about lack of focus on children's services and limited mention of health improvement and tackling 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 No

The Board welcomes the ongoing emphasis on outcomes and believes that this must be sustained over the long term if our ambitions for Scotland are to be achieved. The proposed measure is viewed as proportionate. Beyond the legislation, strong leadership will be required to ensure joint and equal accountability is delivered in practice and a supportive culture is created.

Combined CHP comments:

Broad consensus on YES.
See individual CHP comments for additional points highlighted.

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

There is strong support for nationally agreed outcomes to be included in Single Outcome Agreements. This will provide an opportunity for national consistency in outcomes and flexibility locally on how they are delivered. This will build effectively on our current approach in Ayrshire where our Community Health Partnerships are directly linked to SOAs through delivery of the health components.

Combined CHP comments:

Broad consensus on YES.
See individual CHP comments for additional points highlighted.

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

From a health perspective it is viewed as appropriate for the joint accountability to be carried through to ministerial level and this builds effectively on existing NHS Board Governance arrangements. Clearly, the outcome of the forthcoming evaluation of directly elected NHS Boards will require to be kept in view and any implications for joint accountability taken into account. From a Local Authority perspective, it is likely that the accountability arrangements concerning Council Leaders will require detailed consideration.

Combined CHP comments:

CHPs 'Not Sure' with CHPs highlighting complexities of new arrangements particularly for HSCPs covering more than one area.
See individual CHP comments for additional points highlighted

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

Yes No

The Board feels that it is essential for provision to be made in the legislation for Partnerships to cover more than one Local Authority. In particular, this will allow flexibility where there is more than one Local Authority in a Health Board area.

Combined CHP comments:

Consensus on YES – there should be scope

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

Yes No

The Board supports the proposed Committee arrangements and supports the concept of parity in membership. As a Board with three Councils, we feel three members is realistic but accept that this may raise challenges for Councils. The proposals made no reference to the NHS responsibility to work in partnership with Trade Unions and staff and to deliver against the Staff Governance Standards. There will be a need to develop appropriate partnership structures in the new arrangements. Similarly, there is no reference to the Board's statutory responsibility for clinical governance and again, appropriate structures will require to be put in place in the new arrangements. As a minimum, the Chairs of the Area Partnership and Area Clinical Forums should be specified as non-voting members of the Health and Social Care Partnership Committee. It is noted that the Chief Social Work Officer is designated as a non-voting member. Further detailed consideration should be given to ensure equitable practitioner arrangements for health services.

Combined CHP comments:

Broad consensus on YES but concern that proposals do not reflect wide range of groups already engaged in current Ayrshire CHPs – professional groups, staff and PPF partners, third and independent sector, with role of Forum particularly highlighted.

See individual CHP comments for additional points highlighted.

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

Whilst there is a need to establish how the arrangements will work in practice, the principle of “earned autonomy” is welcomed by the Board. It is accepted that if national outcomes are to be established to support consistent delivery across the country, there must be a mechanism for supportive intervention where assistance is required. This approach should be supported by practical tools to assist local partnerships in delivery, for example, the sharing of best practice across the country.

Combined CHP comments:

Broad CHP consensus on NO – not robust enough, with CHPs highlighting range of concerns about local accountability; lack of service user engagement; no voting rights for third sector; difficulty of measuring and reporting long term outcomes; accountability not robust enough to withstand challenge; need for consistency across Ayrshire.
Performance management needs to be underpinned by robust public engagement.
See individual CHP comments for additional points highlighted

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

The Board feels that it is essential for Health Boards and Local Authorities to have the freedom to include budgets for services beyond the “national minimum”. Further, such freedom should not be restricted to budgets associated with current CHP functions.

Combined CHP comments:

Broad consensus on YES.
See individual CHP comments for additional points highlighted.

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

Yes, however, the concept of creating health and social care partnerships as a body corporate is considered to cut across the accountability arrangements through the Chief Executives of Councils and Health Boards and neither would it fit with them being committees of the two organisations. NHS Ayrshire and Arran also consider that there would be a disproportionate effort to transfer staff from two organisations to a third legal entity.

Care will be required to ensure the Integrated Resource pot is not diminished by unintended consequences such as VAT treatment. The implications of funding losing its identify will have to be carefully thought through and the human resources, accounting and legal costs associated with the model identified. In addition the proposals for self directed support in social care may blur policy differences in areas such as means testing and charging for services.

Combined CHP comments:

Mixed views expressed, with no YES or NO consensus: risk of creating new barriers between community and acute services with proposals not addressing fundamental challenge of reducing acute admissions; how to provide corporate support to partnerships; model too service focused, with little mention of prevention – population based outcomes take time to achieve; how to integrate approaches with housing and leisure. See individual CHP comments for additional points highlighted.

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

The Board and its partners have extensive experience of making flexible use of resources across health and social care and was one of the pilots for the national Integrated Resource Framework. Our experience is that the IRF approach can effectively support locality planning. What works best is

clear delegated authority given to credible local clinical leaders supported by management to engage with service users and providers in reshaping services. Knowledge of actual resource utilisation is empowering for all stakeholders and can help underpin a co-productive approach. The Board would encourage Scottish Government to give detailed consideration to the recommendations made in the recent evaluation of the IRF Test Sites.

Combined CHP comments:

Consensus on YES: there are opportunities for simpler arrangements, however we should be build on successes - eg jointly funded posts, colocation, IRF learning.

See individual CHP comments for additional points highlighted.

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

Yes, although in some ways it is difficult to respond to this question as it depends on the definition of “minimum categories of spend.” In particular the consultation document is vague in its references to “acute” spend and it is important that this is worked through. The Board feels that there is a risk that debates about “fixed costs” are restricted to hospital services only when they apply equally to many aspects of social care and this must be kept in view as the categories of spend are worked through. The Health and Social Care Partnership will be mainly community focused and will have an important role to minimise emergency admissions to hospital, however there is a synergy in the management of services within district general hospitals (DGHs) and the optimal patient flows. As noted above, there should be maximum flexibility for partnerships to include budgets beyond the legislative minimum.

Combined CHP comments:

Variety of views, with no clear consensus on YES or NO depending on minimum categories of spend (not defined). However broad agreement that as much as possible should be determined locally. It would help to have more national guidance on what acute elements to include, to avoid huge differences developing across Scotland.

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

It is agreed that this post will be critical to the success of the new Partnerships. Although the financial authority seems to be appropriate in principle, there needs to be further detail, given, for example, on the extent to which it may be overridden in specific circumstances. It is important that the post is not seen as a stand alone arrangement. It will require to be supported by comprehensive integrated management arrangements. In addition, the post's responsibilities in relation to clinical, staff and information governance will require to be developed.

Combined CHP comments:

Broad agreement on NO – depends on model. However, unclear how these proposals will shift resources from acute to community.
See individual CHP comments for additional points highlighted.

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

Yes No

As noted above, this does require to be a senior level post and is essential if the Partnerships are to function effectively. The detail of its responsibilities will have to be developed but its core function should be ensuring delivery of the Partnership's objectives. It will have to be supported by a fully integrated management team.

Combined CHP comments:

Broad consensus on Yes but depends on wider partnership models.
See individual CHP comments for additional points highlighted.

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

In general terms, the section of the consultation document covering locality planning has generated the broadest range of views within NHS Ayrshire and Arran. This is most encouraging as effective locality planning is seen by the Board as a critical success factor for the new Partnerships. On the specific issue of whether locality planning should be directed by Scottish Government, our view is that it would be helpful for guidance to be issued by SG highlighting the characteristics of successful locality planning. It would also be helpful for guidance to be issued on what can be planned effectively at each level from locality through to national and beyond. Thereafter locality planning should be taken forward at a local level within the context of the guidance.

Combined CHP comments:

Broad CHP support for YES to ensure consistency of approach particularly regarding involvement of independent contractors, but implementation to be determined locally .

See individual CHP comments for additional points highlighted.

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

Given the pivotal importance of locality planning, the duty should go beyond consultation to include involvement and engagement.

Combined CHP comments:

Mixed views expressed but more responses said NO – need to strengthen wording and to have fuller engagement and involvement of all partners - not just consulting.

See individual CHP comments for additional points highlighted

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?

The main practical steps which can be taken to enable closer involvement are firstly creating the capacity for clinicians to be involved, secondly ensuring effective delegation to locality level and thirdly providing clarity of what should be planned at each level from locality through to partnerships and beyond. These steps will help ensure ownership of the process.

Combined CHP comments:

See individual CHP comments for points highlighted.

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

Our response to question 16 above implies there should not be a single prescriptive approach to locality planning. This has to be developed locally, informed by the characteristics of successful locality planning.

Combined CHP comments:

Variety of views expressed, but most said No - planning should be focused around needs of population and individuals, not teams and structures. Local GPs and some groups have highlighted their support for organising services round GP clusters, others have suggested electoral wards, community council areas, natural geographical communities. This needs to be determined locally.

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

There is strong support for real responsibility and decision making to be devolved to locality planning groups. To ensure consistency, this should be backed up by a formal Scheme of Delegation to be developed locally. With such delegation, however, will go the responsibility for delivery of the nationally agreed outcomes, otherwise there will be unacceptable inconsistencies in quality. In addition, a core purpose of the delegation should be to enable service change and redesign.

Combined CHP comments:

See individual CHP comments for points highlighted

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

Again, our response to question 16 above implies there should not be a single prescriptive approach to locality planning. This has to be developed locally, informed by the characteristics of successful locality planning.

Combined CHP comments:

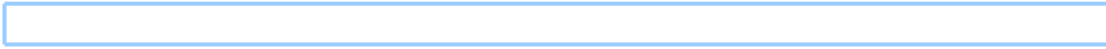
Broad agreement on NO - depends on agreed model – eg island of 5000 is natural locality/size.

Do you have any further comments regarding the consultation proposals?

The Board considers that the consultation document does not give due weight to public health, health improvement and tackling health inequalities. Partnerships must grasp opportunities for advancement in those areas which closer integration may present.

It is also the case that there is a raft of proposed legislation in other key policy areas such as social care self directed support, children and young people and community empowerment and renewal. It is critical for policy to be developed on a consistent basis across the various aspects of legislation.

This will be a huge change for health and social care, and requires care in moving the agenda forward. All stakeholders will need to be kept well informed and there will be a process of “winning hearts and minds”. The changes will require to be supported by organisational and staff development programmes.



Combined CHP comments:

CHPs raised the following general comments at the integration event on 21st August and in other discussions:

- The CHPs support the proposals in principle but consider there is insufficient detail to allow full consideration of all the implications.
- Children's services are not considered in sufficient detail and, in particular, there is concern about what will replace Children's CHP OLGs when CHPs are removed from the statute books.
- There is insufficient mention of health improvement and addressing health inequalities and concern that this key objective of CHPs may be lost in the more service focused H&SC partnership model.
- There is little mention of service user engagement in the proposals.
- The focus of the proposals on health and social care may impact on NHSA&A's whole system service approach across acute and community services for mental health, older people, long term conditions, children's services, acute/ community hospital links etc.
- There is a need to articulate more assumptions about what will be included in the integrated model – not just in relation to acute but also mental health, primary care etc.
- Concern about very different patterns of health and social care emerging across Scotland if there is too much scope for local freedoms to determine local models – how then to ensure consistent outcomes reporting?

- Need to learn from Ayrshire's unique CHP Forum model to build partner engagement and involvement:
- NHSA&A's Public Partnership Forums must retain their crucial role in future partnerships
- Lack of mention of workforce issues represents a huge gap; practical issues like staff terms and conditions are hugely important, particularly when delivering truly integrated services; learn from Rapid Response successes and challenges.
- There is a huge opportunity, and requirement, to engage with local GPs, with agreed arrangements to be linked to the GP contact.
- Much progress has been made through the change fund in taking forward integrated services at local level. There is concern that focus on structural change could divert local partners from core task of delivering integrated services.
- For service and affordability reasons, it is important to retain the best of pan Ayrshire arrangements while delivering integrated care at locality level.

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

The Board trusts that the development of the full EQIA will be carried out openly, transparently and inclusively.

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

The Board trusts that the development of the full BRIA will be carried out openly, transparently and inclusively.

INTEGRATION OF ADULT HEALTH AND SOCIAL CARE RESPONSE FROM EAST AYRSHIRE CHP

The Case for Change

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 Efficiency savings all areas of adult health and social care, practical and helpful?

There was support for service integration from the partnership. Partners agreed that at a ground level there is existing good practice. This has been evidenced through the recent work with Reshaping Care for Older People/Change Fund. Partners believed this should be a whole population approach. Emphasis should be on an integrated approach with Learning Disability Services, Addictions and Mental Health, and a staged approach may in fact marginalise vulnerable groups. Partners were keen to see that transition points between services and between adult and children's services were not hindered by the agenda and similarly support for anticipatory care. Individuals must be at the centre of future service delivery not vice versa, and the overall approach to improve outcomes for individuals.

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?

Partners felt that the framework required to consider the processes that are put in place to support the integration of health improvement/public health, and also the relationship with housing, and leisure services. There was concern on the impact on services not included, for example children's services since these will be directly impacted by new arrangements replacing CHPs.

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?

Partners agreed that this was sufficiently strong and welcomed the principle of joint and equal accountability for nationally agreed outcomes. Partners believe it will be beneficial to have early agreement of a small set of nationally agreed outcome, which are integrated within the community plan and related SOA.

4. Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Within East Ayrshire the CHP provides the improving health thematic group of the Community Plan, and as such is directly integrated within the SOA, and community planning partnership. Outcomes should also be integrated within GMS and other independent contractor contracts, to demonstrate responsibility and accountability.

Governance and Accountability

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?

Partners agreed that the current proposals would provide joint accountability, but reflected that there would be issues of individual local elected members, democratic accountability and the role in a Health and Social Care partnership.

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

Partners agreed that there should be scope to consider the establishment of health and social care partnership that covers more than one local authority area but agreed that this may be difficult in practice.

Partnership working is strong in East Ayrshire and partners agreed that the agreed delivery model should support and enhance the opportunities for locality planning and service delivery, and supported further discussion on the establishment of the best HSCP model for East Ayrshire's needs.

Discussions also reflected the opportunities for an individual partner providing/hosting corporate functions for Ayrshire and Arran.

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

Partners considered the proposed arrangements satisfactory, but advised clarity around the specific governance or legislative requirements regarding adult support and protection, child protection, mental health etc. There will require to be further partnership consideration given to the development of appropriate partnership structures in the new arrangements.

- 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?**

Partners agreed that this required further consideration. Issues required to be addressed in relation to joint accountability, the role of parent bodies, meaningful service user engagement, non voting rights for the third sector, and the need for consistency within NHS Board areas.

- 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?**

Partners agreed that this should be case, and were concerned that services may not otherwise address local need and priorities to deliver outcomes. Partners recognised that this may cause a level of disparity across Scotland with different models beginning to emerge, however, this will reflect the desire to respond to local need.

Integrated budgets and resourcing

- 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?**

Partners agreed the final model should focus on outcomes and reduce bureaucracy.

- 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?**

East Ayrshire has very positive experiences, particularly in the area of integrated resource framework, joint funded posts and co-location.

- 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?**

Partners were keen to see clarity of resources for inclusion, particularly around the area of acute care. Integrated budgets require to build on the experience of the Change Fund, and integrated resource framework.

There requires to be a focus on prevention, with a need for flexibility and local determination.

Jointly Accountable Officer

- 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?**

Partners suggest the role of the Joint Accountable Officer requires clarification in respect of:

Financial Accountability
Accountability to the Committee

The extent of acute services included within the scope of the post will be a key determinant in shifting the balance of care.

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

Partners agreed yes, whilst recognising the role would depend on the partnership models developed.

Professionally led locality planning and commissioning of services

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

Partners agreed that it was important to reflect consistency of approach both nationally and locally, but in terms of implementation – this should be determined locally.

- 16. It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GP's, 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?**

Partners agreed that the model in Ayrshire provided by the CHP Forums provide good opportunities – to be built on. There was general support that there required to be a process of engagement and not merely consulting with relevant partners and stakeholders particularly at a local level.

- 17. What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?**

Partners agreed that there required to be a mechanism to provide capacity for clinicians and other professionals to be involved

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

Partners agreed that this should be through local determination. There are some natural communities which do fit around GP practices but there are other groups of communities which may suit a different model. Models should be developed around populations and individuals, not teams and structures, and be determined locally.

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

Partners agreed that decision making should be made as close to communities as practical.

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?

Strong agreement that there should be no single fit. Partners agreed that this should be determined at locality level.

East Ayrshire CHP

10th September 2012

DRAFT

***North CHP – Comments received from OLG, CHP Forum, PPF public event and CHP Committee
Integration of Health and Social Care Consultation***

<i>Section</i>	<i>Question</i>	<i>Y/N</i>	<i>Comments</i>
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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? <hr/>	Yes	<p>An outcomes focussed approach is helpful, however, the risk of focussing on older people in the initial phase and the expected demographic growth may result in the adult agenda not being given the same level of planning support and support in the short term. It may mean that the integration agenda focus remains on older people in the longer term which would be unhelpful.</p> <p>It would be helpful for a full set of outcomes to be available for Adults and Children agenda's prior to the implementation of the Health and Social Care integration legislation to aid local discussions about what locally determined services should be included in the new arrangement.</p> <p>The key focus of CHPs was the reducing of health inequalities & Health improvement and this is not reflected in the outcomes approach highlighted to date.</p> <p>Structural change does not in itself deliver better outcomes.</p>
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<p>Outline of proposed reforms</p>	<p>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?</p>	<p>Yes</p>	<p>The legislative framework is comprehensive in terms of legislative focus and it is positive to see a role for the Third Sector and Independent Sectors building on the Reshaping Care for Older Peoples agenda. However there is very little detail about how the health and social care partnership will be delivered and concerns that a major structural change will divert time and resources away from service delivery.</p> <p>The complexity of independent providers' status for General Practitioners, pharmacy, optometry and dental services within the new arrangement was not highlighted enough or solutions offered.</p> <p>The role of the independent sector within locality planning and their accountability given national contracts also requires further clarity.</p> <p>Locality planning is a positive development and sits well with North Ayrshire Plans for Neighbourhood approaches, however, this approach needs to sit within the financial governance arrangements of the HSCP and cannot act independently.</p> <p>There needs to be greater clarity around Community Planning Partnership accountabilities.</p> <p>The current framework creates a vacuum for children's services, housing and criminal justice which is unhelpful.</p> <p>There also needs to be greater detail around union roles, workforce planning, organisational development, procurement and commissioning of services.</p> <p>The current CHP legalisation also requires Public Partnership Forum (PPF) involvement and this duty requires to be continued.</p>
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<p>National outcomes for adult health and social care</p>	<p>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 <u>required?</u></p>	<p>Yes</p>	<p>The consultation document is high level and outlines principles. Legislation is helpful, however this may not be enough to bring about change across the whole system. This joint performance approach is helpful, however there is a need to recognise the prevention and early intervention agenda in children and adults services which play a key role in older people’s outcomes over the longer term. Should HSCP choose not to include children’s services then this may limit its influence on the children’s work required to ensure prevention success and this may negatively impact on outcomes for adults and older people in the longer term.</p>
	<p>Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?</p>	<p>Yes</p>	<p>Ayrshire’s SOAs currently reflect National Outcomes but there is also a need to reflect local needs & priorities.</p>
<p>Governance and joint accountability</p>	<p>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?</p>	<p>Not Sure</p>	<p>The role needs to be balanced with partner organisations agreeing common behaviours and levels of responsibilities. The JAO is a key role and will be challenging to deliver. This role is complex if a HSCP covers more than one local authority area which North Ayrshire would prefer. In the event that different political party leaderships are in place across different Local Authorities, how will an agreed approach be taken forward? There is also a challenge around organisations requiring reporting and accountability at different levels. The Local Authority leader and Chief Executives are also accountable to their Local Authorities and these dynamics need examined further. The annual review meetings should be held in public to ensure accountability to local communities.</p>

	<p>Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?</p> <hr/>	Yes	<p>The majority of North Ayrshire Public partnership Forum (PPF), Forum and Committee expressed support for a single Pan Ayrshire HSCP covering the three Ayrshire authorities.</p> <p>There are currently Health Boards which cover more than one Local Authority area due to rurality or regionalised specialist service models and this approach may bring efficiencies.</p> <p>This approach also supports the Arbutnott Regional Commissioning models. There are some issues e.g. GP contracting for which it makes little sense to split this function down to small HSCP areas as it may not be cost effective. If there are good, effective and supported locality planning arrangements, the overarching partnership model should be less important.</p>
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	<p>Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?</p>	<p>Yes</p>	<p>The Committee arrangements build on current Ayrshire CHP governance processes however the proposed arrangements do not currently reflect the wide range of professional groups engaged in CHPs e.g. nursing, AHPs, dental, optometry pharmacy and social work.</p> <p>There is also no reflection of the statutory roles currently played by trade unions in NHS partnership arrangements In the event of a Health Board having more than 1 HSCP there may not be enough NHS Non Executive members to field different ones on Executive Committee.</p> <p>If more than one Local Authority per HSCP there are not enough elected members identified to be representatives on the committee to ensure a political balance.</p> <p>There is also the key role played by CHP Public Partnership Form (PPF) members in NHS and this needs to play a full part in new arrangements. Need to recognise that NHS and LAs have very different mechanisms for public engagement.</p> <p>The Ayrshire CHP Forums allow all professional, Third Sector, Independent Sector and Carers leads to play an active role in service change and this approach adds value and should be included.</p> <p>Voluntary reps will have advisory role and won't have voting rights on Committee so how democratic is it really?</p> <p>The public also need to be included and the differing approaches to public involvement and role of elected members in providing this conduit needs resolved.</p> <p>Concerns expressed about the democratic engagement of other nominees present e.g. Third Sector.</p>
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	<p>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?</p> <hr/>	No	<p>Outcome models currently rely on appropriate inputs and contribution analysis.</p> <p>If a service within an integrated structure fails how does the partnership determine which bit has had the negative impact?</p> <p>This is highly complex and requires significant performance, financial, public health and economic support. All of these functions are not seen as front end and it may not be cost effective to deliver the capacity required to support reporting.</p>
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	<p>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</p>	Yes	<p>It will be important to articulate assumptions about what NHS services will be included in any baseline integrated service – eg mental health and primary care?</p> <p>Local choice is a key democratic issue. However the fracturing of NHS and social care budgets and functions is a considerable risk to both organisations. However, if all budgets are included then the HSCP becomes larger than the parent organisations to which they report and account. There is a risk that organisations re-badge existing Adult and Older People Health and Social Care expenditure, so it is not included in new arrangements to safeguard current power base.</p> <p>There is also a challenge to the Scottish landscape of different services having different accountability routes across Scotland e.g. GPs if different arrangements are adopted and this may highlight ‘postcode’ lottery challenges.</p> <p>There is concern about preserving the ethos of free NHS services for all – this may be more difficult in pooled arrangements associated with private providers charging clients for services.</p>
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<p>Integrated budgets and resourcing</p>	<p>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?</p> <hr/>	<p>Yes</p>	<p>In theory this model can deliver, but the important thing is to focus on standards – quality outcomes, efficiency. The model can be successful if the service user is put at the core of delivery models and a personalised approach also helps in this area.</p> <p>However, given the current financial efficiency pressures and regional commissioning drivers there is a risk monies flow to meet public pressure/areas rather than population based outcomes which take a longer time to achieve. The NHS has not been as involved in local political planning structures as Councils and has been more focussed on evidence based outcomes. This new approach will bring new challenges.</p> <p>There are also concerns that large scale structural change to enact the legislation may have a negative impact on front line resources and take our attention from curent good progress in local integrated service delivery</p>
	<p>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?</p> <hr/>	<p>Yes</p>	<p>Current arrangements are not easy and huge opportunities for improvement. Teams have been involved in aligned budgets where SFIs were different, efficiency saving levels different and where money had been transferred from the parent organisation & these processes remained in place and the receiving organisations were then fully audited by NHS teams (money moved 10 years + ago). Existing governance challenges with Change Fund monies still exist around SLAs for third sector organisations and invoicing from councils, which is bureaucratic and unhelpful. The billing of public sectors for building space and rentals is also unhelpful but Scottish government guidance directs this approach – central government agencies need to consider implications of integration on their current practices.</p>

	<p>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?</p> <hr/>	Yes	<p>This is a critical area as organisations may re-badge expenditure to remain out with HSCP control. There will be considerable challenges in disaggregating NHS acute spend. A minimum list of service budgets to be included would be helpful and further legislation to change financial SFIs may also be required. The is also a challenge to the Scottish landscape of different services having different accountability routes across Scotland e.g. GPs if different arrangements are adopted and this may highlight 'postcode' lottery challenges.</p>
<p>Jointly Accountable Officer</p>	<p>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?</p> <hr/>	No	<p>The inclusion of all acute and primary care services will require to be in place to allow a shift in the balance of care to the levels expected. The inclusion of traditional older people beds and community based services will not solve the shifting the balance of care issue as the monies are tied up in acute specialisms. This is the key and challenging issue.</p>
	<p>Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?</p> <hr/>	Yes	<p>This remains ambiguous. The Officer requires to be a member of the Health Board and at Council Director level. The existing Health Board scheme of establishment requires to be changed to reflect HSCP role on Board. The officer must be able to operate without interference from parent organisations on a day to day basis if reporting and governance arrangements in place. Need to clarify role with CPP Boards. Consideration to a deputy Council Chief Executive role may be more helpful as influence required across all Council services to influence outcomes.</p>

<p>Professionally led locality planning and commissioning of services</p>	<p>Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?</p> <hr/>	<p>Yes</p>	<p>National Guidance would be helpful to ensure a consistency of approach based on outcomes and to ensure independent contractor roles resolved. Implementation of the locality approach should be locally determined with key local stakeholders and the public.</p>
	<p>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?</p> <hr/>	<p>Yes</p>	<p>The locality arrangements must ensure all primary care professionals e.g. nursing, AHPs, pharmacy, optometry, dental, trade unions and social work with Third and Independent Sectors are involved as well as acute clinicians and have an equal voice at planning group. The PPF requires to be included. The role of personalisation and direct payments mean that carers and service users also play a key role in determining what local plans for health and social care look like. The role of the CPP partners in this arrangement e.g. housing and leisure also needs to be considered.</p>
	<p>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?</p> <hr/>		<p>There is a need to ensure buy in from all partners and agencies. Due to independent contractor status it may be helpful if national contracts are modified to reflect the new role. The existing role of the PPF and CHP Ayrshire Forums need to link to locality planning. GPs need time and resources to engage in locality planning.</p>

	<p>Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?</p> <hr/>	<p>No</p>	<p>Locality planning could occur at around GP clusters if the neighbourhood was recognisable however, budget allocation/service charges would require to be governed by HSCP as it is the accountable agency.</p> <p>There is a possible mismatch between locality planning for small natural communities and regional commissioning to deliver financial effectiveness and efficiencies. This may mean that natural communities do not always cluster around GP surgeries. GP contracting arrangements sometimes refer to GP clusters and contracts could be a mechanism to embed new locality working.</p>
	<p>Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?</p> <hr/>		<p>Locality planning groups need to be empowered to make decisions for local people regarding their care and support needs.</p> <p>Decision making around strategic service changes requires to be informed by locality planning groups but the final decision should remain within HSCP. There may be issues, which the locality planning groups may be too small to be able to lever e.g. whole system District nursing re-design. There is also a need to ensure the public voice within locality planning as Personalisation may have a greater impact on local services models than statutory charges in the longer term.</p>
	<p>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?</p> <hr/>		<p>Depends on local needs Support natural communities, which populations recognise – this could be One to five thousand for a small rural area to 100,000 for a population of high urban density.</p>

	<p>Do you have any further comments regarding the consultation proposals?</p>		<p>North Ayrshire welcomes the integration agenda and supports the overall direction to improve local outcomes through public sector redesign. North Ayrshire has a strong history of effective and joint partnership working at the frontline and legislative change will ensure this approach becomes system wide. The role of the public, service users and patients requires to be strengthened. The consultation questions have for some moved the focus away from the positive benefits of partnership and integrated joint working to the challenges of implementation before the details are available. The guidance which follows must re-invigorate the benefits for our population and ensure “hearts and minds” buy-in from across the public sector. Key work around workforce, trade union roles across all the structures, organisational development, terms and conditions require resolved before legislation or the “hearts and minds” may be lost. The key issue remains how we release resources from acute specialist services in a large scale way to deliver resilient and healthy communities and the risk remains that re-aligning community health and social care services will not produce a strong enough lever to deliver this outcome.</p>
	<p>Do you have any comments regarding the partial EQIA? (see Annex D)</p>		<p>None to add.</p>
	<p>Do you have any comments regarding the partial BRIA? (see Annex E)</p>		<p>None to add.</p>

Integration of Health and Social Care Consultation

Collated view from South Ayrshire Community Health Partnership

Section	Question	
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<p>The case for change</p>	<p>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?</p>	<p>There was general support for the proposed movement although concerns raised included the risk of fracturing existing pathways the risk of destabilising existing transitions of services from children to adult.</p> <p>It was thought that whilst a pragmatic approach was probably wise there could be a risk of unwitting de-prioritisation because of initial focus on one population group.</p> <p>In general it was felt that much more thought needs to be applied to the case for integration of children’s services</p>
<p>Outline of proposed reforms</p>	<p>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?</p>	<p>A key limitation identified was that whilst the consultation paper refers to two ‘disconnects’ the integration paper focuses much more on the disconnect within Community health and social care services rather than between acute and Community Health/Care Services. This is arguably of even more significance than the first.</p> <p>It was felt that much more detail would be required in terms of level of devolution of resources (particularly relevant in relation to independent contractors)</p> <p>There is not enough reference paid to the important context of Community Planning Partnerships and Community Planning within the integration agenda.</p> <p>In relation to children’s services, it was not clear what thinking had been applied to potential arrangements.</p> <p>Concern that a range of other successful joint approaches could be at risk with the new arrangements (such as links with housing, community transport, leisure and adult learning, social enterprise development, etc)</p> <p>It was also felt that there was insufficient focus on how co-production and self-directed support fits in with integration proposals.</p>

<p>National outcomes for adult health and social care</p>	<p>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?</p>	<p>There was generally a positive view that a set of national outcomes (that should feature in SOAs) is desirable although there was felt to be a need to include more downstream, preventative outcomes rather than simply outcomes for older people (for example, Long Term Conditions work before the 65+ age group)</p> <p>The overall sets of outcomes worked towards need to be coherent and on occasions, there has been central reporting demand that is not congruent with this approach</p> <p>Use of term ‘outcomes’ needs to be better defined – for example, bringing together personal outcomes approach together with population based outcomes (eg 75+ bed days)and there were some concerns that not all the proposed ‘outcomes’ were actual outcomes!</p> <p>There was significant fear from children’s services providers that concentration on older people may de-prioritise outcomes for children and the linked resources</p> <p>It was felt that the Christie ‘pillars’ were not sufficiently embedded within the draft paper</p>
	<p>Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?</p>	<p>This was generally supported</p>

<p>Governance and joint accountability</p>	<p>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?</p>	<p>There were some fears expressed that local democratic accountability may be diluted or compromised by the increased role of the Cabinet Secretary.</p> <p>There were concerns that the Joint Accountable Officer will have to report via non-elected NHS directors (appointees) who are not democratically accountable</p> <p>There was a general view that the committee should be accountable to both Council and Health Board and not simply to the Leader of the Council and the Health Board chair</p> <p>It was recognised that the ‘languages’ utilised within NHS and council contexts are distinct and effort would be needed to ensure coherence.(eg Clinical Effectiveness, Best Value)</p> <p>One specific potential flaw in proposed governance was raised in relation to having a rotating chair with a casting vote .This could be very relevant particularly when major conflict might emerge (eg bed closures)</p> <p>In terms of other representation there were clear views that the place of and responsibilities for third sector and independent sector should be much more explicit. This also extended to lack of content on other representation, for example, service users and public/patient representatives, together with trade unions.</p> <p>It was felt that there was a risk of performance management arrangements becoming too complex and not sufficiently transparent, open and understandable for all stakeholders</p> <p>There was also concern regarding arrangements for the sanctions that might be imposed should partnerships not deliver.</p> <p>There was general agreement that new partnerships should have the freedom to include other budgets</p> <p>There was a strong view expressed that it would be helpful to have full evaluation of proposed models before them presented as legitimate options for future structures (for example, the Highland model)</p>
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	<p>Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?</p>	<p>There was support that the legislation should provide scope for this although there were very mixed views in relation to this approach being taken in Ayrshire.</p>
	<p>Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?</p>	<p>This was generally agreed, although details regarding level of Committee accountability would need to be carefully worked through to ensure compatibility with both NHS and Council procedures.</p>
	<p>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?</p>	<p>The performance management arrangements were generally supported although it was not completely clear how these might provide public confidence.</p>
	<p>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</p>	<p>This was generally supported</p>

<p>Integrated budgets and resourcing</p>	<p>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?</p>	<p>There were still major concerns expressed re the disconnect between acute and community services and budgets and the need to re-profile spend in line with, for example, Reshaping Care.</p> <p>There was a specific questions raised on how ‘overspend’ might be dealt with in new partnerships (eg prescribing) – ie who assumes the risk</p> <p>The need for consideration of corporate/backroom support was raised although it was recognised this could take place locally.</p> <p>It was felt that it was not entirely clear exactly what functions a ‘body corporate’ may legally carry out and questions on its exact legal status</p> <p>Often the integration of good practice happens with good local leadership, flexible and respectful approaches, and, it was felt that this was at least partially in place locally. Whatever structural reform that takes place should not undermine the good examples of current integrated practice exist in both adults and children’s services.</p> <p>It was agreed that whilst integrated grassroots working has been effective, higher integrated approaches (such as developing solutions re IRF for children with complex care packages, has been much more challenging)</p>
	<p>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?</p>	<p>South Ayrshire has a number of examples of flexible use of resources including jointly funded posts, development of integrated falls pathway and use of change fund monies to roll out enablement across the area.</p>

	<p>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?</p>	<p>It was felt that the NHS spend implicated in the new arrangements needs to be made much more specific since this is where the real shifting of resources is likely to take place</p>
<p>Jointly Accountable Officer</p>	<p>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?</p>	<p>Whilst the importance of the JAO was highlighted, it was felt that the post did not sit in isolation but would require an integrated support team to make the position practicable (eg finance, HR, OD) There was a strong concern that the JAO may run the risk of being the 'servant of two masters'. Related to this were questions on who line manages the post?</p>
	<p>Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?</p>	<p>It was felt that the level of seniority for a JAO needed to be articulated more clearly</p>

<p>Professionally led locality planning and commissioning of services</p>	<p>Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?</p>	<p>The following relate to the set of locality planning questions (15-20)</p> <p>Whilst it was felt locality constructs and structures should be left to local determination there was concern about potential issues arising from of different models emerging across Ayrshire. It was agreed that there needed to be a clear rationale (based on good evidence) in relation to size of locality structures (eg population)</p> <p>It was generally felt that locality planning should happen within local geographic areas and established communities 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.</p> <p>There were questions raised regarding the duties on GPs to become involved in the new structures? It was felt that devolved resources, of significant size, might provide a clear incentive for GP involvement</p> <p>There were tensions articulated about the differences between clinical leadership versus management approaches (for example, whether a non-nurse could manage a nurse as opposed to provide clinical leadership)</p> <p>There was a need for acute sector to more involved in locality planning (this was a major point sited within Audit Scotland CHP review)</p> <p>There was a strong view that there was a need to look beyond ‘services’ to asset based and co-production approaches (in respect of Christie Report recommendations)</p> <p>There was a strong view expressed that there was a need to ensure any proposed locality structure was in tune with existing children’s services locality areas</p> <p>A highly significant point raised that there was much a need for change of culture as a change of structure.</p>
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	<p>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. <u>Is this duty strong enough?</u></p>	<p>See answer to 15. Role of GPs will be vital to success of integrated partnerships. Duty to consult does not seem strong enough and should be extended to duty to engage and become involved.</p>
	<p>Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive <u>planning at local level?</u></p>	<p>See answer to 15</p>
	<p>Question 18: Should locality planning be organised around clusters of GP practices? If not, <u>how do you think this could be better organised?</u></p>	<p>See answer to 15</p>

	<p>Do you have any further comments regarding the consultation proposals?</p>	<p>It was felt that there was almost complete absence of thought of public health/health improvement approaches which were highly visible and integrated within the previous CHP statute and guidance.</p> <p>The lack of mention and thought in relation to both service users/patient and more general public engagement and involvement was highlighted</p> <p>The fear of significant disruption to good integrated practice through the structural change was articulated.</p> <p>There was perceived to be very little thought of how specialist services may be deployed in the new arrangements.</p> <p>There was felt to be limited consideration of how housing links might be protected and strengthened (and if children were considered, those with school and education)</p> <p>It was felt that issues and challenges of regional working were not specifically addressed.</p>
	<p>Do you have any comments regarding the partial EQIA? (see Annex D)</p>	
	<p>Do you have any comments regarding the partial BRIA? (see Annex E)</p>	

