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Please find attached the response of the Association of CHPs.

The Association welcomes the direction of the proposals set out in the consultation paper. We fully support the integration of adult health and social care services and budgets, and although we understand that partnerships are at different stages of development, we do think that the fully integrated model that a number of CHCPs have developed is ultimately what we should be aiming for nationally. To separate children and adult services will lead to problems in the coherence of social work services for vulnerable families and add complexity to the relationship with primary care. To create separate bodies to manage services currently managed within CHPs could further add to transactional and management costs and should be discouraged.

Whilst we understand that a number of organisations are seeking a degree of local choice and variability of models, we are only too aware of the criticism that Audit Scotland had of the variability of the CHP model across the country. Based on the premise that the delivery of good outcomes for individuals is critical, we nonetheless believe that there needs to be an element of consistency in the models adopted.

We are very supportive of the need for a single accountable officer at senior level, reporting directly to Council and NHS Board Chief Executives. We believe the role of

the Chief Executives in supporting the partnership and the single accountable officer to achieve the agreed outcomes needs to be strengthened, as does the role of the Partnership Committee in setting priorities and direction of travel.

We are comfortable with the notion of localities, but do think they need to be defined locally. We are thoughtful that the current arrangements where GPs have patients who are not resident in the locality may cut across these proposals.

Finally, one of the key successes of CHPs has been in the area of health improvement and reducing health inequalities and we would be keen to see these responsibilities vested in the new partnerships.

Yours sincerely

Julie Murray
Chair ACHP

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 Yes, given the pressures and priorities associated with demographic change. However, there are significant advantages in including the totality of community health and social care within partnerships given the risks associated with fracturing currently integrated social care services. There would also be complexities for primary care services which currently provide health services from cradle to grave. We therefore believe that the process of integration could be phased where services are not already fully integrated; starting with older people through to adult and children's services at a pace which suits local circumstances.

Setting the direction of travel early will be crucial to establishing a structure in the partnership that will ultimately be able to deliver fully integrated services. Having a development plan setting out the longer term objectives may help the structures as they develop over time and clarify relationships with services initially out with the partnership such as children's services and other acute services.

Consideration should be given to the organisational development capacity that would be required to ensure new partnerships develop in a truly integrated way.

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 As above, we believe there are significant advantages in including all

community health and social care services for a defined geography. The function in support of primary care contractor services is not explicitly mentioned in the consultation but we believe this function should sit within the health and social care partnership.

The role of the partnership as a health improvement organisation and what that means in terms of delivery and commissioning needs to be addressed, it is not referred to in the consultation document and has been a significant strength of CHPs. There are real opportunities for partnerships to lead work with Council departments and community planning partners to improve health locally and to tackle inequalities.

National outcomes for adult health and social care

Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

Yes No

Comments Yes, we are supportive of the nationally agreed outcomes and agree that statutory partners should be jointly accountable. We are concerned however to ensure that a proper review of HEAT targets takes place in light of these outcomes, given the unintended consequences that some HEAT targets have had on outcomes i.e. the increase in admissions following the introduction of the 4 hour A&E target. It is important that the statutory organisations, and in particular the Chief Executives of Councils and NHS Boards are accountable for making these new arrangements work and supporting the single accountable officer and the partnership committee.

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

Yes No

Comments Yes, this is crucial to a strategic sign up to joint working across the public sector as well as operational delivery. Many of the issues will need to be tackled across the whole partnership, not just adult health and social care. As highlighted in our response to Question 3, it is very important that HEAT targets are also reviewed to avoid duplicate reporting and the unintended consequences of targets that are not outcome focused.

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 We think the arrangements described in the consultation document are too complex and potentially unworkable given the different roles of the Council Leader and Health Board Chair. In some of the existing integrated arrangements the single accountable officer is directly accountable to the Council and NHS Chief Executives, and to the partnership committee. The Council CE is then held to account by the Council and the NHS CE by the Health Board Chair and the Cabinet Secretary. These arrangements generally work well and emphasise the crucial role of the Council and NHS Chief Executives in supporting the partnership to succeed. The issue of the accountability of the jointly accountable officer as differentiated from the partnership committee needs further clarification

Again, it is important that partnerships have one set of performance measures and a single performance framework, and the role of the committee in monitoring this locally needs to be strengthened within the proposals.

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

Yes No

Comments *This would need to be determined to be the best solution locally.*

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

Yes No

Comments *CHPs have experience of having large committees with representation from a variety of professional groups and interests and this has often proved to be unworkable. Therefore the committees should be kept as tight as possible with inclusion of a wider set of partner groups and professions being included through other means of Governance/partnership working, perhaps at a more local level.*

The partnership should have equal representation from the main partners with agreement on voting rights etc. Consideration will need to be given to the different roles of Councillors from non executive Board members. The accountability of the Chair of the partnership committee should be clearly set out.

If the committee becomes too big, there could be a danger of the partnership appearing to become an entirely separate and even competing entity to the Board or Council. It is important that the NHS Board and Council are seen as equal partners regardless of any anomalies in the size of the two organisations.

Public Partnership Fora have been a major success of current Partnerships and their members will regret the loss of voting rights. It will therefore be important that the new Partnerships are encouraged to ensure these perspectives remain strong and that services are planned and delivered in the spirit of co-production. There are some similarities but many differences in the guidance for local authorities and the NHS on public involvement, engagement and consultation. This has to be addressed at a national level.

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 Council scrutiny and health board performance arrangements for the framework need to be set in a single collective framework and proportionate to the range of services delivered through the partnership. We are not sure whether the proposals to have a triumvirate of Cabinet Secretary, Council Leader and Health Board chair is workable given the different role of health board Chair and Council Leader.

Councillors advocate for their constituents and can take forward issues raised in their surgeries. How will this match with the NHS complaints procedure in which there is no role for the individual Board members, which procedure would be followed?

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

Yes. We should assume all functions are in, unless there is a clear reason and criteria for exclusion. We need the least disruption of structures; otherwise there may be more complexity and more transactions across the system preventing us from focussing on improved delivery. If NHS Boards and Councils create new and separate entities to manage services excluded from partnerships this will run counter to the spirit of the proposals to streamline and improve efficiency.

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 It will be important to ensure that the statutory partners commit financial allocations that fully reflect at least existing expenditure. There should be a read across between the financial planning arrangements used by Councils, into the NHS to ensure a continuity of investment in the delivery of service strategies.

Financial arrangements need to be established which hold Partnerships to account but enable full delegation to the Committee and thereafter relevant delegated authority to the Single Accountable Officer so that redesign and service change can be delivered. Essential to improved service delivery will be the streamlining of complex financial arrangements. Decision making and budget management need to be simple and flexible. We believe that it is appropriate that resources allocated to the Partnerships lose their NHS or Social Work identity, as this will give flexibility to direct resources to local priorities. It does, however, raise complex issues about the governance of the statutory responsibilities of the two parent bodies. There are some existing arrangements which work well that could be built on. A sound commissioning framework will help strategically in establishing a clear service framework and pathways of care across the whole system. We are not clear of the meaning of ‘body corporate’ as set out in the consultation, as this suggests a separate body rather than a partnership, and it would be useful if this could be expanded on for clarity.

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 Consideration should be given to the existing CHCP arrangements and other formal partnerships such as ADPs etc. The lessons learned from the IRF work and how that would play into the financial arrangements needs to be explicit. Lessons will also have been learned from the change fund and from joint arrangements such as joint equipment stores.

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 Only if the minimum categories include much greater clarity about the acute resources that the Partnership will be accountable for/influence. If that is not clear, there is the potential for huge variance across Scotland. Partnerships will need to have real influence over acute services in order to facilitate better pathways of care; this is a significant opportunity to make a difference across the whole system and to shift the balance of care.

Jointly Accountable Officer

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

Yes No

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

Given the importance of these new roles and requirement to straddle two very different legal and statutory arrangements, consideration should be given to a development programme for the first new appointees.

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

Yes No

Comments Yes, must be accountable to the Chief Executives, at a lower level it would be an impossible role to have. Clarity and simplicity of structures are essential.

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

Comments It would be appropriate for the Scottish Government to outline what the features of the locality planning landscape should be and the outcomes clear. How it works locally should be determined by the Council and NHS and described in the partnership agreement.

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 Yes

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 Capacity, time and finance are sometimes barriers in the engagement of clinicians, specifically independent contractors This is the crux of much criticism of CHPs as they stand and it needs to be addressed as a whole system rather than seeing it as an issue for each partnership to resolve.

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

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

Yes No

Comments This should not be prescribed. Let the local partnerships agree the best configuration, but it will be essential to emphasise the central role of GPs in helping to deliver the intended outcomes. One complexity in this proposition is the difference between resident and registered populations. GP practices with significant numbers of patients out-with the locality can present huge challenges to the concept of 'team around the patient'.

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

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

Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

Yes No

Comments This should not be prescribed. Let the local partnerships decide how their locality model should work.

Do you have any further comments regarding the consultation proposals?

Comments

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