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 ☐

Most services are provided for all adults, to provide integrated care, all aspects must be addressed. As it is young chronic sick and those under 65 are already continuously under represented in all sectors and to ignore their needs will only compound the matter further. Most development in all areas already focuses on the over-65s with everyone else being ignored.

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 ☐

There is no discussion of what the proposals mean outside of the financial management level. Staff do not get integrated training to provide an integrated care service, especially those in the private sector who often get nothing beyond mandatory moving and handling training (occasionally food hygiene or fire safety too). Obviously staff will be asked to do more with less staff and less money under these proposals and at the moment there is already significant duplication in some areas and lack of knowledge in others. People often receive several visits from various professionals, requiring the same information but giving different aspects of information. In some areas (such as NHS Ayrshire and Arran's CAMHS) multi-disciplinary professionals are able to conduct all aspects of initial referrals and assessment before more specific referrals are made – will professionals in adult health and social care partnerships be trained to do the same without the need for multiple visits, and where will the money for such training come from – if it is optional, undoubtedly it will never happen.

In addition, there is no indication of how the 3rd sector will be involved – will they

have representatives on the partnership 'board' and will they have recognised, regulated functions – or will they be contracted in and remain filled with undertrained, overworked staff with poor pay and conditions and little incentive to improve skills as a result. After years working in the private sector, most care workers have to pay for any training out of their minimum wage and have no protected time in which to do training, which makes it unlikely they will undertake any. The only training regularly carried out are SVQs which are not worth anything, given assessors tell people what and how to write so they will pass and are based on mainly on basic physical tasks, without reference to the multiple needs of most people requiring care.

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 ☐

Providing legislation also specifies that integration is achieved at ground level involving training and coordination – so far it appears people will be doing the same jobs with yet another quango in charge holding the money.

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

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

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

Yes ☐ No ☐

NHS Ayrshire and Arran covers 3 local authorities, so the options would be to have 3 partnerships resulting in 7 overall bodies (including the councils and the health board). Most Ayrshire and Arran services comprise 3 teams within each service which have links to local councils. Utilising the integrated health provision and team working already available may aid integration with other services if these were all transferred to one body as well as bringing together professionals with expertise of the diverse demographic across Ayrshire. It is likely that other, such as Glasgow and Clyde would also benefit from shared working as well as providing the additional benefit of a centralised budget and less need for duplicated management layers which would free up cash for actual services.

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

Yes ☐ No ☐

As usual doctors are mentioned as the relevant professionals but doctors have minimal contact with patients and rarely have any idea of their health and social care needs, beyond their prescription. District nurses, social workers and professionals from voluntary and private organisations are far better placed to understand the needs of their clients than doctors.

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 ☐

There is no indication of who will regulate the services, NHS, Care Commission or others, how will it be decided that the money is not being spent 'properly'.

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 ☐

While that would depend on the nature of the services provided and the areas which provide them, in some areas other aspects are closely interlinked, with professionals carrying diverse caseloads across services and it would make sense in these areas to centralise the budgets to reduce the amount spent on managers and duplications in bureaucracy.

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 ☐

A single budget is essential, the time wasted by arranging for things like joint funded equipment is ridiculous. However, it also needs to be supported by integrated training to provide integrated support otherwise it is just another tick box exercise.

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 ☐

In addition to applications for joint funded equipment mentioned above, multiple visits to patients who are required to provide info repeatedly to get support for things like benefits, health care, home care, equipment etc, and the frustration of trying to get access to information which is held on completely different computer systems that professionals do not have access to.

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 ☐

That will depend entirely on the categories set out. National outcomes should make it clear what is required to be addressed and spending should be outcome led. Not all areas will require the same priorities in all areas.

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 ☐

This consultation focuses only on money – put money does not provide care, it only makes it possible for the care to be provided. Health boards and local authorities should work together, if one has overall control then the focus and concerns of that body are the ones which will be addressed first – this is not integration.

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

Yes ☐ No ☐

Comments

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 ☐

The government as it is exists has already shown how little it cares about Scots outside the areas where most of its voters are found. Planning should take place at local level where there is understanding and competence.

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 ☐

As already specified, GPs have minimal knowledge about their patients care needs. Other professionals should be prioritised since they have the knowledge required.

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?

Appointing senior professionals from all disciplines to the management board of partnerships rather than business/money people. Anyone not directly involved in that area has no place being in charge of it.

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 ☐

GPs are private contracters, not NHS or local council employees. They have virtually no knowledge or experience of most health and social care needs beyond medical conditions. Most health and social care teams exist across areas of similar social demographics and geographic locality and it would make more sense to associate with these existing teams than appointing arbitrary ones.

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

Groups should have responsibility for giving evidence about locality need to the partnerships.

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 ☐

This would depend on the demographics and locality of the population, in some areas this would be one town, in others it might cover a vast area of tiny villages. The focus should be on existing team structures to reduce cost of reorganising and increase available funds for training and services.

Do you have any further comments regarding the consultation proposals?

This is obviously the English CCG plan on an initial smaller scale and downplayed to avoid association and bad publicity. If it is to be feasible and work it should show real integration, nationally as well as locally and be based on patient outcomes only.

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