

Here is my input to the Consultation on Integration of Adult Health and Social Care.

I have set out my responses in terms of the questions laid out in the consultation, though my answers may stray beyond the specifics of the questions themselves.

Q.1. No. Elderly care in general is more complex and extensive than that for younger adults, so younger adults moving to more integration first may allow an easier initial transition during which issues can be addressed before more complicated cases move to the new approach.

Q.2. Yes.

Q.3. Yes.

Q.4. Yes.

Q.5. Yes.

Q.6. No. In Dumfries & Galloway, there would be no sense in extending a Health & Social Care Partnership beyond the Local Authority boundary. The Health Board boundary is the same and the area is large with mostly areas of sparse population at the peripheries.

Q.7. No/maybe not? Some local authorities and health boards give no indication of prioritising governance, so it is difficult to know if the proposed arrangements are adequate. It is likely they will not be adequate in some cases, but the review system could be established in such a way as to enable more comprehensive governance being imposed where found to be necessary.

Q.8. Yes/probably. But how confident the public will be is difficult to estimate. It may depend on targets/outcomes as they change with time. It may depend on how robustly additional governance requirements are imposed where needed. Public confidence, I would argue, has to be earned by demonstration of robust systems in action, rather than by thinking a system looks like it might be good enough. And in any case, most of the public will not be bothered until they have need to interact with the health and care system. Sadly.

Q.9. No. Initially I think time will needed to develop systems and get integration working, so limiting it to a stepwise process makes sense. No area in Scotland is so small as to enable the whole of the care system to be integrated in one sweep. Also, other elements of services could be brought into joint working at the delivery level by good systems of communication and so on, without needing to be managed within the same care partnership.

Q.10. No. In principle, this is appealing but in practice, joint working can only work well with the right people, understanding, attitude and commitment from key senior staff; and the type of system cannot of itself be any guarantee that money is truly used to best effect.

Q.11. Yes. In Dumfries & Galloway, there are frequent difficulties agreeing priorities for service between local authority and health board areas of responsibility, and this is more of a challenge in austere times. In Inverclyde (where I worked previously), fully integrated mental health services worked very well, mainly because senior locality management from local authority and health board had a clear and complementary view of need, service priority and management of systems, and the personnel involved in setting up and managing the systems were committed to integrated working, with appropriate developed responsibility for operational management, and a culture was

therefore fostered of true joint working and respect.

Q.12. Don't know.

Q.13. Yes, maybe. But the choice of candidate to be Jointly Accountable Officer is obviously key, and to work, it has to be someone with practical knowledge of both health and social care, and the post needs adequate resourcing (to attract suitable candidates) and level of responsibility.

Q.14. Yes.

Q.15. Leaving to local determination makes most sense, but some scrutiny or central approval may be wise; or an option to call in decisions for review if concerns are raised perhaps would be a suitable compromise.

Q.16. Yes. But again, central approval of the proposed process should be required, with opportunity for clinician/practitioners to contribute to the assessment of the proposed process also. Health Boards generally have a poor record on meaningful consultation and engagement.

Q.17. Employ sensible people! Communicate and consult meaningfully, at a time that impact of such communication and consultation can be seen to make a difference. Commitment of time and money to underpin systems.

Q.18. No. Arrangements need to depend on geography and community. In Dumfries & Galloway there are already divisions of the local authority area which make useful zones/localities. Basing sub-regions around GP practices may make sense, but it could as easily not do so. Flexibility on how to divide areas should be down to local proposals, but as above this should be subject to some form of central scrutiny or approval.

Q.19. This has to depend on other decisions and the specifics of arrangements.

Q.20. No. This is arbitrary and could not sensibly be applied across the country.

Comment. The proposals in the consultation are good in principle, but past experience suggests that the practice may not be so easy.

Comments on EQIA / BRIA. None.

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