

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: We are the Mental Health Services Public Reference Group covering the area of NHS Ayrshire and Arran. Our membership comprises c30 service users and carers, and we meet regularly with the management of NHS Ayrshire & Arran to contribute to the ongoing development of mental health services in both the acute and community settings. Because of this, our comments are naturally made from the perspective of our membership. Nevertheless, we are firmly of the opinion that people's health has to be treated holistically – that mental and physical health both form part of an individual's characteristics and both influence the individual's needs for health and social care. We believe that this gives credibility to our views on the whole spectrum of health and social care.

Our group was established after a major two year review of mental health services in Ayrshire and Arran, during which the view continually and strongly put forward was that major service improvements could be achieved if health and social services worked more effectively together. It was also considered that this was only likely to come about given some Government impetus, as history has shown that without this, progress towards integration has been painfully slow. Because of this background, we warmly welcome the current proposals for closer integration, and our comments on specific elements are given in the ensuing sections of this response, as follows.

We agree that the *initial* focus should be on older people. However, we consider that the definition of "older people" should be clearly identified, and not based solely on age. In our view the definition should be:

- based on clinical and lifestyle criteria of each individual;
- sufficiently flexible to allow a person's physical and mental health

characteristics, together with his/her living environment, to be the determinants of the individual's categorisation as "adult" or "elderly";

- consistent with developments in other areas of legislation, e.g. movements in state pension age etc.

We have italicised "*initial*" above as we consider it important that the timescale for extending the focus to all adults should be as brief as possible, to avoid the creation of even greater fragmentation of services than at present. Indeed, the legislation should include a timescale so that it can be implemented consistently across the country.

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: By and large the parameters of the framework proposed seem adequate. Nevertheless, we have some concerns that this section of the consultation document, whilst recognised as simply an introductory chapter, either doesn't mention, or skates very briefly over some important issues which we will return to in our more detailed comments on later questions. Among these issues are:

- The role of the third and independent sector, given that many community based services are delivered by this sector;
- The role of the public, given that the Cabinet Secretary for Health and Wellbeing has frequently stated her desire to see "mutual" or "co-owned" public services;
- The independence and level of authority of the proposed Jointly Accountable Officer;
- The dependence of the proposed framework on the highest quality of local leadership, and balancing this with an element of nationally imposed requirements; and
- Only a very brief and general hint is given that local communities will be directed to focus a greater proportion of resources than hitherto on community provision rather than institutional 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

Comments: There is insufficient detail in this chapter to be able to agree that the approach by itself will provide a sufficiently strong mechanism to achieve the changes required. The reforms concentrate on the statutory providers, their relationship with each other and with central government.

In our view, the framework will also have to include measures to regulate the third and independent sectors and make their rewards clearly dependent on achieving the appropriate national outcomes. This is considered necessary because to date it has become abundantly clear on many well publicised occasions, that the statutory local bodies have been unable to monitor service delivery by these

sectors sufficiently to achieve agreed performance standards.

Additionally, we would like to see a recognition of the importance of the public on local communities. This chapter refers to the accountability of health and social care providers to the Scottish Parliament. However, we believe that there must be measures to ensure that the statutory bodies are also able to be held directly accountable to the local communities that they serve, and not just through the mechanism of bodies such as the proposed Health and Social Care Partnerships, which will inevitably be largely populated by “professionals” of one kind or another.

Again, we will comment in more detail in later sections of this consultation. At this point, however, we consider that the approach is built on the right foundations, but requires much more explanation and clarification than that provided so far.

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: Single Outcome Agreements were a great step forwards in moving away from the previous ring fencing of elements of local authority funding. They have also gone some way towards defining joint outcomes between local government and health boards.

If we are to move to true integration of health and social care outcomes it will certainly be necessary for all nationally agreed outcomes to be included within SOAs. However, this will require SOAs to be refined and extended to reflect the legislative requirements of the proposed framework. It will also be necessary to ensure that SOAs and HEAT targets are consistent.

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: This question appears to be inconsistent with the text of the consultation document. Section 3.4 of the document refers to accountability for nationally agreed outcomes being “transparent and accountable locally and to the Scottish Parliament via Ministers:”, whilst section 4.9 states “The Cabinet Secretary....., the Local Authority Leader and the Health Board Chair will together hold the Chair and Vice Chair of the HSCP, and the Health Board Chief Executive and Local Authority Chief Executive, to account...”. Neither of these seems consistent with the question, which ignores the role of the Health Board Chair.

It is our belief that joint accountability has to be ultimately to the Scottish Parliament via the Cabinet Secretary for Health, Wellbeing and Cities Strategy. This means the accountability of all bodies involved in the proposed new Health and Social Care Partnerships, both statutory and others. It is also our belief that in order to achieve the “community of governance” referred to in section 4.11 of the consultation document text, some element of enforceable national guidelines will be necessary, as experience over the past decade or so has shown that when left to local leaders without some form of legislative backing, the development of true joint partnerships has been extremely slow to evolve.

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

Yes No

Comments: The consultation document suggests in section 4.27 that there could be, at most, 32 health and Social Care Partnerships, based on local authority areas. We believe that such a structure would perpetuate some of the problems that have arisen since 2004 with the present CHPs. If the primary desire is

to improve services for the public, and to implement many nationally agreed outcomes to achieve a truly integrated approach, there appears little validity for utilising local authority areas.

One of the problems this has thrown up over the past eight years is illustrated in our own area of Ayrshire and Arran. With one health board covering three local authority areas, the difficulties of achieving some consistency in three CHPs has been constant. It seems to us that basing HSCPs on, for example, health board areas would immediately halve their number, and thus halve the difficulties associated with achieving consistency. All this would mean in terms of representation would be that the HSCP committee might contain two or three local authority chief executives. However, this shouldn't matter if we are pursuing the stated aim of forgetting the originating providers in favour of a truly integrated, seamless delivery of services.

If this approach is adopted, it would also be essential in our opinion for the other functions of existing CHPs to be transferred to HSCPs, as otherwise we would be left with a duplicated and fragmented structure for these other important functions.

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

Yes No

Comments: Having considered the proposed composition of the Health and Social care Partnerships, we are concerned that voting membership is to be restricted to health boards and local authority representatives. In our view, this immediately opens the door to potential limitation of progress towards true integration. We consider that, at the very least, the patient/service user representatives should be full voting members. We also consider that the number of such representatives should equal the representation from the statutory bodies, i.e. a minimum of three.

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: Whilst we accept the basis of the performance management measures outlined, we would make the proviso that the proposed sanctions should be imposed for any significant shortcomings in achievement, and not kept as a very, very last resort. We would be given more confidence in the proposed measures if more detail is outlined in the text of the consultation, and if more assurance is available on the independence and level of authority of the Jointly Accountable Officer.

We do not intend these comments to be interpreted as unduly negative. Rather, we see the proposed legislation as an opportunity for very clear and explicit drafting in order to avoid leaving issues such as this open to later, and possibly variable, interpretation.

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: As we have indicated for question 6 above, we consider that it will be essential for the other functions of the present CHPs to be managed by the HSCPs. Leaving this to local choice could, and probably would, lead to these functions being dealt with differently in different areas. Whilst it might appear that local discretion is an advantage, it would, in our view, be an advantage only for the convenience of the financial management processes of the statutory providers. Conversely, it could lead to inconsistencies and unacceptable variations in the quality of the services provided to recipients.

We accept that, even if this view prevails, the accountability proposals in the consultation will apply only to the nationally agreed outcomes for the functions covered by the legislation.

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 is difficult to form opinions about using money to best effect when this chapter lacks any indication of the level of resources likely to be made available, whether in absolute terms or relative to the current provision. We are, however, encouraged by the statement that these proposals are not about saving money, but about using it more effectively in clinical and practical terms (practical for who?)

Looking at the two alternative options outlined for integrating budgets, we consider that the first of these – establishing the HSCP as a body corporate – would probably facilitate the progress towards true integration of services more than the delegation model.

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: Although we do not have the outlined experience in a direct management context, it became clear during the strategic review of mental health services referred to above that failure to agree flexible use of resources, and reluctance to forego sovereignty over resource decisions, was one of the major obstacles to improving the effectiveness of partnership working between statutory agencies. Indeed, it also became clear that the delivery of seamless “joined up” services was subservient to resource considerations. This is an area where clear and unambiguous guidelines from central government could help to overcome the

continuation of these attitudes.

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: As we have indicated earlier, we believe that a measure of direction and national control will be necessary to ensure that local bodies achieve the required outcomes. The balance of ministerial direction outlined in this chapter should be appropriate, given the statement in paragraph 5.16 that an integrated budget will be a duty of health boards and local authorities.

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 consider that there needs to be greater detail spelled out in order to be confident of the effectiveness of these proposals, and this really applies both to this and the following question (14).

It appears that the Jointly Accountable Officer will have responsibilities laid down in legislation, and yet will be reporting to the Chief Officers of the two statutory bodies who may have differing perceptions of his/her role. In paragraphs 6.2 and 6.6 it is stated that the JAO will report to the Chief Executives. However, paragraph 6.9 states that the JAO will be accountable to these Chief Executives,

who are subsequently accountable to the Government. More and clearer detail would be welcomed.

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

Yes No

Comments: See the response to question 13 above. We do not consider that we are competent to agree or disagree on the level of seniority proposed based on the very summarised outline in paragraphs 6.2 and 6.3. However, we do consider that the level of seniority and the route of accountability must be sufficiently clear for the JAO to carry out the functions of the post with confidence and without fear of intimidation.

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: The balance outlined in the proposals is considered to be about right. The duties proposed for the legislation should set the parameters of a framework capable of achieving effective locality planning. Subject to the requirements indicated, locality planning should be best carried out at a local level. The proposals recognise that it is not necessarily appropriate to base localities on the area of an HSCP, and this is addressed below.

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: The text of the document, unlike the question, does not make specific reference to the ongoing implementation, review and maintenance of service provision. Provided these functions are specifically included, we consider that the duty outlined should be effective.

We welcome the inclusion of carers and patients as full participants in the locality planning process.

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: We are not competent to give a view on this topic, which requires knowledge of professionals' current job specifications.

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: G P clusters would give a closer approximation to actual localities and their communities, rather than defining an arbitrary population number. We consider this to be an important point, as the effectiveness of locality planning is directly linked to the community identity of the locality.

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

Comments: Devolution of responsibility from HSCPs to locality planning groups should be related to operational and delivery issues, with planning and strategic matters reserved to the HSCP. This will ensure a measure of consistency, whilst recognising particular local circumstances associated with individual communities.

We have already welcomed the inclusion of patients and carers on locality planning groups, and we trust that they will be included in the management of any devolved activities.

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: As indicated in the comments on question 18, we do not favour using local population groups to determine localities. Localities are very variable in nature, and differences between, for example, heavily populated inner city areas and more sparsely populated rural communities would not produce locality groups associated with identifiable communities.

Do you have any further comments regarding the consultation proposals?

Comments: Please see the background included in the introduction to our comments on question 1 of the consultation.

Regarding Annex A, we acknowledge the organisational diagram relating to the draft national outcomes for adult health and social care, and the accompanying text. It is our view that the potential for achieving these desired outcomes will depend upon the quality of staff training and supervision, together with the quality of management and flexibility of working practices.

Looking at Annex B, we wonder about the adequacy of the consultation carried out by the Chief Social Work Adviser. 200 people is not a large number to cover the whole of Scotland, and we would question how representative the views expressed can be. We would like to see clarification of the basis on which the consultation was undertaken, including a summary of the issues discussed. For example, was hospital bed provision discussed? Did the 200 people include service users and carers? We note that the Chief Social Work Adviser will continue to facilitate engagement during the consultation period (paragraph B8), and trust that this will be more broadly representative of the population as a whole.

In Annex C, our previous comments about workforce issues such as the quality of training etc, apply. It is important that standards are consistent between the partner agencies, which could be achieved through initiatives such as shared training programmes.

Finally, key to the success of the overall integration proposals will be dynamic

leadership at both local and national levels, accompanied by a commitment to make this vital new service provision and delivery structure work.

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

Comments: We note that the table in paragraph D17 states “The consultation notes that the proposed legislation will enable Health Boards and Local Authorities....” It is our understanding that the legislation will, in fact, place a duty on these bodies, rather than simply enable them.

We also note with concern that later in the same table it states “health care would continue to be free at the point of need, however, social care could be means tested”.

In the table at paragraph D18 there is a reference to a potential reduction in facilities for respite for carers. We would wish to see this issue explored in more detail, as facilities are already considered to be inadequate.

Given that work on a full EQIA is to continue after the closure of the consultation process, we wonder about the conclusion in paragraph D24 that “the group identified no further parties for inclusion in the scoping workshop or to assist with the scoping report”. It is to be hoped that, for a full EQIA as outlined in paragraph D26, the group will be fully representative. We are here suggesting that there should be more representation from service users and carers.

We trust that the process to come will be carried out openly, transparently and inclusively.

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

Comments: The partial BRIA appears to be consistent with the overall content of the consultation, so our comments made throughout this apply.

We trust that the development of the full BRIA, as for the EQIA, will be carried out openly, transparently and inclusively.