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?

Fully support the inclusion of all adult services, beginning with older people. There is no mention of eligibility in terms of age and consideration should be given to sub populations who present earlier in life with long term conditions / chronic need. Consideration should also be given to all social care services including children within the proposals as:

- priority should be given to early intervention and prevention through seamless integrated services
- current integrated services may have to develop new organisational constructs if all social care are excluded
- the proposals potentially create further risk at transition from children to adult services for already vulnerable families / children
- if all services are not included potential to create to organisational constructs in terms of finance; governance etc
- if all services are not included there is the potential to create costly interface arrangements

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?

It would be useful to have some indication of a substructure underneath which will allow for appropriate representation. The critical nature of involvement/ engagement and leadership of professionals in planning/ commissioning 'integrated' services is highlighted, however only medics are cited

as an example.

Budget and planning to include 'appropriate aspects of acute health activity' is a critical element of achieving this whole system approach yet requires more detail in terms of definition and direction within.

Health and Care Integration Outcome 6 "Engaged Workforce" is an important element of the planned migration of the 6 Quality Outcomes into 7 integrated health and social care quality outcomes and this is a key area. How people who work in health and social care services are supported to be positive and supported in their roles to improve care and treatment is fundamental. Previous experiences of integrated working which were successful at strategic levels, faltered due to the fact that staff delivering services had experience of different terms and conditions including work patterns; working hours; remuneration; holiday entitlement, etc,. In Annex C (C.14) these issues are referenced with regards to joint appointments however it is the cultural differences in the current workforces which requires to be sensitively addressed.

Annex C also refers to the training and education of frontline staff but it is not clear if this refers to trainees. Consideration must be given to the training and education of professional staff in order to prepare them for the new, integrated model of care consequently professional regulators and HEIs should be involved in discussions.

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 and No

Far more detail required, for example the impact on the existing concordat; the complex issues around statutory responsibilities and equalities. Details of how clinical and current contractual arrangements fit into new national outcomes are

required, e.g. the GP contract. Details on how national outcomes will protect the health inequality gap faced by certain sub populations are required e.g. for those whose leading cause of death differs from that of the general population.

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

Nationally agreed outcomes are essential to measure not only the impact of the new arrangements but also patient/ public and staff experience of such. It is of note that the RAND evaluation of integrated health and social care in England reported a decrease in positive experiences of care in many services and it would be useful to know how in Scotland, we have learned from this within our approach.

There is a lack of clarity on future of HEAT. If all social care services are not included will this result in separate targets for children etc / complex reporting. Will this result in all adult health services being part of SOA's and if so how will financial arrangements take place given there are no ring fenced budgets in SOA as part of the concordat, would this result in adult health services competing with LA education for resource?

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?

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Yes for social care, however with regard to health services this proposes a shift in the role of locally elected members and requires more detail around governance arrangements.

Consideration will have to be given to smaller services where economies of scale are essential (currently 'hosted' services). A challenge will be that of scale/ geography of the service boundaries, i.e. potentially 6 partnerships in GG&C.

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

Yes

This is important to avoid service fragmentation HOWEVER it is critical that if more than one LA area is covered, seamless arrangements are in place including IT structures; reporting and governance arrangements etc

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

No

Further guidance around 'good use' of a casting vote would be welcomed. Engagement with the full range of professionals is critical. Parity of committee 'voting members' is accepted.

'Non voting' members signifies a change in our local Public Partnership arrangements and there is a need to ensure the success of PP for a is a core element of this reform.

How will the 'clinical advisor' assure that input, advice etc is accurate, evidence based and encompassing of the many facets of specialism/ sub specialism required?

What methodology will be used for this 'sliding scale of support'? What triggers and timescales will be employed?

Important to seriously consider the risks to children's services and include where possible in this system change.

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?

The information provided is not sufficient to form an opinion for example what

would the sanction arrangements be if the partnerships fail to deliver? Would these be linked to SOA's?

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 and No

There is a danger of budgets being manipulated and targeted towards meeting national outcome agreements, taking money into reactive services rather than preventative services. There would have to be rigorous central guidance to avoid geographical disparity of services. If children's services were to be included this may impact on the answer to this question. CHP functions requires clarification. This highlights very complex financial governance issues

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 and No

Crucial to this question is point 5.7 and the 'enablement' of 'trustworthy and robust' information available to ensure 'best effect' at the material time in addition to effective planning. IT systems are of particular value here and require investment to ensure a 'single' system is in place to facilitate such. Whilst the flexibility of money losing its health or social identity is welcomed, robust financial governance is required with nationally agreed criteria.

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 x

Within GG&C we have experience of this. The main barriers to flexible use of budgets has been the perception of whether money is health or social care. Transparency and evidence based decision making are also critical to success. For example if it is perceived money is being used to recruit to social work staff

from a nursing budget or vice versa, can result in negative impact on frontline staff and morale. Clear transparent and evidence based planning and effective communication systems to defend decision making are critical.

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?

No x

There will be a requirement to provide succinct details. There is evidence of the huge disparity spent on older peoples' services across all Local authorities. There is also a need to take into account geographical health inequalities

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 and No

Fully support the jointly accountability officer however the jointly accountable Officer can be voted against by the non executive directors and locally elected members. This introduces a political element to the process and should be carefully considered.

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

Yes and No

This role is crucial to effective governance and service arrangements. Again more detailed direction around the appointment process, skills required etc. would be welcomed as varying high level influences can have a bearing here and given the fundamental requirements of this post, how this role is expedited will have a direct influence on the success or otherwise of the new 'partnership'.

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 X

Central direction is required. Previous CHP 'Scheme of Establishment' clearly noted that a 'nurse' must be a member of the CHP Committee yet this was not consistently addressed with most Committees having a gap here. Stronger direction and framework is most definitely required.

As previously noted this direction should also include which professionals/ clinicians should be involved – accepting that some are mentioned by name in 7.2. The trick is how this will be managed equitably for all? Professional engagement and leadership has to be recognised and valued at the outset and consciously facilitated. The process to establish the 'who/ which professionals, where from (specialism or generic) needs specific consideration and catalysing to ensure effective leadership.

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?

No x

This is not explicit within the consultation and needs to be made much more so. There appears to be a lack of representation of disciplines other than medical staff. Reporting mechanisms back to ministers needs to ask for evidence of consultation with VARIOUS professional groups, least of all nursing / social workers etc, there is a need for an involvement plan

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?

Equality of representation within partnerships: general management; professional leaders from all disciplines. Robust professional leadership arrangements. Co production approaches.

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

Yes and No

If such practices reflect local populations and not at the exclusion of other primary care contractors

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

Further detail required. Until details of sub structures emerge difficult to respond, however locality planning groups will have better the expert knowledge to inform overall decision making. If significantly devolved robust lines of delegation are required

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?

No

Organisation around needs of population.

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