

## 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?

#### Comments

North Lanarkshire Council and its partners fully acknowledge and support the need for the experience of an older person (or anyone else with health and support needs) to be as seamless and integrated as possible and are committed to achieving that end. Locally there are a suite of integrated services that support consistently high levels of performance, findings on which are endorsed by reported local and national performance measures.

It is recognised that different local partnerships are at different stages of evolution and development in terms of integrated working and achieving positive outcomes. The creation of any new organisational boundaries inevitably draws an alternative set of boundaries so it is therefore incumbent on each partnership to devise arrangements that best meet the needs of their local population. For this reason much of what is proposed is more appropriate for local determination than for national prescription, as all partnerships are not operating from the same starting position or performing to the same level.

The Scottish Government already has legislative powers to address poorly performing partnerships under the Community Care & Health (Scotland) Act 2002: Ministerial Powers of Intervention. Guidance issued on the 'Ladder of Support and Intervention' makes this explicit. It is not clear why these powers are not used where required, rather than the imposition of a prescriptive national approach.

There is now a wealth of research evidence on integration. An independently facilitated event in North Lanarkshire in 2011 organised by NHS Lanarkshire shared the findings to date. Successful partnerships tend to be characterised by strong, embedded partnership working; shared vision; co-terminosity; and committed leadership. Unsuccessful approaches tend to be characterised by top-down imposition; performance regimes; financial pressures; and organisational and financial complexity. The factors that localities say most *help* integration are local and cultural, the factors that localities say most *hinder* integration are national and structural. The document as it stands appears to pay little heed to this evidence.

The efficacy of our own approach gained high profile recognition as recently as July 2011 when the Nuffield Trust published "Integration in Action: Four International Case Studies" featuring North Lanarkshire Health & Care Partnership, Community Care North Carolina (USA), Greater Rochester Independent Practice Association (USA), and Regionale HuisartsenZorg Heuvelland (Netherlands). The desire to be outcomes-focussed is fully supported but the Council has significant concerns that central prescription will not deliver the desired improvements.

The proposals and accompanying questions are concerned mostly with organisational arrangements and are not set out in ways that suggest outcomes for the person are foremost in the Government's thinking.

Finally it is simply not appropriate to seek blanket "yes" or "no" responses to questions that reflect often complex issues so our responses are framed accordingly.

## 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?

### Comments

The proposals are not comprehensive in the sense that they do little to address what is typically the greatest area of disconnect in partnerships i.e. that between primary and acute health services. Neither do they address issues of co-terminosity (North Lanarkshire Council, like a number of others, works across two Health Board areas) even though evidence demonstrates this is a key impediment to integration. They ascribe powers to the role of 'jointly accountable officer' that essentially render the postholder largely unaccountable and do not conform to local authority safeguards such as standing orders and financial regulations. Crucially, there requires to be a realisation that the proposals, however well intended, are unlikely to achieve the stated policy objectives.

The proposals go significantly further than that previously indicated by the Cabinet Secretary in her public announcement in December 2011. The prescriptive nature of much of what is proposed is surprising given her evidence to the Scottish Parliament Health and Sport Committee on 20 March 2012, which strongly indicated greater flexibilities for local partnerships (within a core set of principles) than is actually the case in the consultation document.

## 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?

### Comments

It is not so much a question of whether it provides “a sufficiently strong mechanism”, it is more whether it can achieve the policy objectives. There are many reasons why some partnerships have made better progress than others in shifting the balance of care across all care groups. There are also factors that lie outside a partnerships’ direct control that can be highly influential e.g. the clinical autonomy of key professionals such as GP’s.

Partnerships are more likely to be effective where they have integrated other significant areas of activity across social work, housing and education functions. It is difficult to envisage how the proposals- in integrating some areas of activity- will not fragment others. The possible separation of community care services from justice services and services for children and families, including child protection, is ill-advised and potentially dangerous. Families do not typically organise themselves into well-ordered, age-specific groups. Issues such as addiction and homelessness are cross-cutting.

If all community care services were included in the new arrangements, the scale and budget of what is proposed may be greater than the rest of the remaining council but without anything approaching the same level of governance by local elected members.

North Lanarkshire Health & Care Partnership already has a suite of joint priorities for community care that are reported and monitored on a six monthly basis.

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

## Comments

There clearly needs to be a direct relationship between nationally agreed outcomes for health and social care and Single Outcome Agreements. The latter are intended to be strategic documents and the extent to which they could comfortably accommodate what is proposed would require further exploration.

## 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?

## Comments

No. This question assumes the Leader of a local authority is one and the same as the local authority in which (s)he leads. In fact the Leader is accountable to their own local authority. The proposal creates a direct accountability for a wide range of statutory local government functions to the Scottish Government rather than to the Council itself. Whilst this is the currently the case in the NHS, it diminishes the role of local government at a time when other ideas concerning the centralisation of other Council services have also been suggested. This also applies to the role of the Chief Executive who is formally accountable to the full Council, not the Council Leader.

The role of the Chief Social Work Officer requires to be considered in the context of governance and accountability. This is one of four statutory roles specified as part of a Council's Standing Orders with a responsibility to highlight where a Council policy may endanger lives or welfare; and to ensure members are provided with appropriate professional advice. Yet the relationship between the Chief Social Worker Officer and the Joint Accountable Officer has not been considered in the consultation document.

In terms of accountability and governance, the statutory role of the Director of Finance of the local authority must be clarified to ensure that arrangements, such as for the establishment of a Joint Accountability Officer, do not conflict with statutory requirements.

Delegation to the Health and Social Care Partnership, established as a body corporate results in VAT inefficiencies (body corporate is unable to recover any VAT and hence becomes an additional cost). For this reason, it is deemed to be a bad option with the potential to cost the "public purse".

Given the significant reductions envisaged in local authority budgets, no consideration has been given to what this means for the financial planning arrangements for a Health & Care Partnership in the longer term.

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

Comments

This should be a matter for local determination.

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

Comments

No. At present 35 elected members of North Lanarkshire Council oversee a Social Work budget of approximately £200m per annum. The proposed arrangements would see “a minimum of 3” - but in reality not many more (because of the low numbers of non-Executive Directors in the NHS) – who would be responsible for governing a budget that could conceivably be double that.

The proposed arrangements should be for local partnerships to determine and not constrained by the small number of non-Executive Directors that currently serve on NHS Boards.

**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?

Comments

This question implies that the proposed performance management arrangements somehow sit outside a much wider infrastructure of pre-existing inspection and regulation. This includes bodies such as The Care Inspectorate, The Mental Welfare Commission, The Scottish Social Services Council, QUEST and the Older Peoples Inspection Programme managed by

## Health Improvement Scotland.

The proposals seek to integrate certain areas of activity but leave the inspection and regulation of those areas of activity to bodies that themselves are not integrated. This creates even more potential than already exists for uncertainty and confusion.

Additionally, as previously stated, the Scottish Government has already assumed powers through “the ladder of support and intervention” that enable it to address where partnerships are not performing to required standards.

**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?

## Comments

In general these should be matters for local determination not for the Scottish Government.

It is not clear what functions the question is seeking a view on excluding. It is self-evident even in using a broad term such as “adult health and social care” that some key areas of activity are likely to be excluded. For example a local authority is the Strategic Housing Authority. Reshaping Care for Older People is a policy every bit as relevant to the housing function as it is to social work but the proposals are silent on that key role and the relationship between the respective duties and functions. In an integrated Housing & Social Work service such as that in North Lanarkshire these proposals carry significant risks.

## 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?

## Comments

No, not least because parallel legislation on Self-Directed Support creates a duty (supported by this authority) on local authorities to identify an individual budget and provide options for people as to how that may be drawn down. The same legislation imposes no such duty on the NHS yet planned legislation on integration seeks to “make invisible” the identify of the budget from either agency. The two positions are inherently contradictory.

Social Work is a targeted service, some elements of which are subject to charging regulations and policies. Health is a universal service free at the point of delivery. This brings with it inevitable complexities in the context of integrated working and budgets.

Most public spending on older people is in the NHS acute sector but the bulk of it is likely to be excluded from the integrated budget. It would be largely futile to include specialist acute ‘care of the elderly’ spend in the integrated budget when older people are majority uses of specialties such as orthopaedics, stroke, general surgery etc. Our experience is that the specialist care of the elderly services work very closely with the local authority on discharge planning etc but that the non-specialist areas do not always possess the expertise and knowledge (e.g. of dementia or available community resources) to make well informed judgements about a person’s future support needs. This experience seems to be supported by evidence emerging from the current round of inspections of the care of older people in acute hospital environments being undertaken by Health Improvement Scotland.

**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?

## Comments

We have a range of approaches to integrated services that are appropriate to the setting and planned outcomes. It cannot be a ‘one size fits all’ approach. There is already the opportunity to move resources across community health and social work services. This has been used in different ways to suit the purpose e.g integrated day services for older people; integrated addiction teams; integrated equipment and adaptations service etc. More information can be provided on this range of initiatives as required.

Independent evidence is cited in the answer to Question 1.

**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?

Comments

This should be a matter for local determination.

### 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?

Comments

The proposals create a greater level of financial autonomy than any public sector organisation should deem appropriate. This is not simply about financial authority – it is about an agreed set of outcomes. The level of authority suggested is such that the proposals could have the opposite effect to that intended by shifting the balance of care *towards* institutional settings as a way of meeting new government targets for delayed discharge.

Local government requires to make major reductions in funding at a time of increasing need. If resources passed into any new arrangement are ring-fenced at the levels transferred then the capacity of local authorities to achieve the scale of savings required will be substantially impaired.

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

Comments



This is not the right question. Legislation creates statutory duties for local authorities, the discharge of which is the responsibility of the authority not a single individual.

The reporting arrangements of such a post should be a matter for local partners to decide and not for the Scottish Government to prescribe.

## **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?

### Comments

No - this must be left to local determination. North Lanarkshire Partnership has agreed to base its operational arrangements around 6 localities i.e. major townships in the area. These arrangements have a local area partnership consisting of the elected members for the area together with representatives from our community planning partners and local people. The Partnership is supported by a multi agency local area team.

**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?

### Comments

This is not the right question. Legislation imposing duties cannot in itself advance effective local arrangements. See response to Question 1 on the factors that help and hinder legislation.

**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

There are existing arrangements in North Lanarkshire to support participation of clinicians and other professionals. It is for local partnerships to assume responsibility to ensure such arrangements are effective.

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

#### Comments

No. To do so would disregard the lessons of community planning and the need to organise around natural communities with which local residents can identify. In a mainly urban authority such as North Lanarkshire our townships inform those arrangements. It is for statutory agencies to recognise and work with those natural communities, not seek to impose their own professional arrangements upon them.

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

#### Comments

That is a matter for local determination. Locality planning groups are a key element in an effective approach to delivering integrated support. Their embedded nature in North Lanarkshire has been a key factor in achieving such positive balances of care for adults and children in this authority area. They are examples of successful integrated working without imposing structural change.

**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?

#### Comments

No. See response to Question 18. This should be a matter for local determination not for the Scottish Government.

**Do you have any further comments regarding the consultation proposals?**

## Comments

It is the sincere wish of North Lanarkshire Council that this document is subject of genuine, open consultation where the outcome has not been largely pre-determined and that the significant concerns of local government will be appropriately addressed.

The proposals themselves are substantially flawed. Before any further move takes place to introduce legislation it is essential that local government is involved in a redesign of what is proposed to ensure maximum local flexibility in delivery arrangements, whilst maintaining the intended outcomes.

**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