

## 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?

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**No**

The Highland Partnership is clear that there requires to be integration across all age groups, including children, and that it would be disruptive to people who use services, and to services and organisations, if this was not the case. We also believe that this requires a whole system approach, not an incremental approach.

The significant change programme required to drive and implement integration should be considered further. To go through this more than once, could be detrimental to staff and services. In many rural areas services are arranged around all adults – and where there are co-morbidities particularly prevalent in the older population, this may create more barriers (not less) on an interim basis. The real benefits will be across all adult care groups as this will enable a more flexible and efficient approach to the deployment of staff and services. In Highland we took the view that if we were looking for the benefits from integration in one client group why would we not want to apply that to all. We therefore progressed the lead agency model across all client groups.

### 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?

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**Yes**

These proposals are comprehensive and reflect not only the necessary change in focus re inputs to outcomes but also the development of strategic commissioning as the desired approach to the planning and delivery of services. This term –strategic commissioning however, is subject to interpretation across the Public and Third and Independent sectors and it will be vital that organisations working together on this agenda agree the meaning at the outset. The guidance in Chapter 7 is most welcome and reflects recent reports to Highland Health Board outlining our way forward.

The Highland Partnership believes that some recommended aspects of the models, are only relevant to the 'body corporate option', involving the management of a pooled budget, and not to the lead agency model that has been implemented in Highland. We would make similar comments regarding the reporting accountabilities associated with this model, which are 'joint'. The lead agency model involves singular accountabilities.

There remains the need to further explain the role of the Jointly Accountable Officer beyond the detail in Chapter 6, particularly in relation to the Lead Agency model. NHS Highland believe that the Joint Accountable Officer is not relevant in the Lead Agency model.

We welcome the repeated reference to engagement of the Third and Independent sectors and recognise the support that Scottish Government has given to the development of the Interface. However this sector requires ongoing support to ensure they can fully contribute and be involved in a way that is effective for them and adds the value that is so needed. Highland welcome the endorsement of the model adopted across the area and referenced in section 2.7, including the recognition that this model was developed for the people of Highland and was not intended to provide a 'one-size-fits-all' solution for the rest of Scotland.

### **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?

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#### **Yes but...**

This is a very welcome approach particularly as it will come with performance indicators that reflect this approach. However after many years of Public sector focus on inputs and evidencing success on numbers of staff or services this will take some time to bed in and will require a consistent approach across local, regional and National management systems. It is a very new way of working for some staff who are task focussed and who need empowered to think more flexibly about what difference their intervention will make overall. Over the years, partnerships have had real difficulty in

a) identifying performance indicators that are not subject to challenge as being inappropriate on their own or providing inappropriate dysfunctional incentives

b) being able to record the information without an industry being created

c) creaking and incompatible IT systems getting in the way.

If we are confident about this approach and committed to this as a more effective way of working and producing and evidencing results, why would we not implement this for all client groups? GIRFEC has already taken us down this route in Children's services. This has though, to be part of agreed performance management frameworks across the Partnership, for both children and adults, that reflect local circumstances, and that enable service delivery and performance to be scrutinised.

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

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**Yes**

This is a welcomed approach and builds naturally on the philosophy and aim of the Single Outcome Agreements. . It also needs to take account of local factors. It will be important to develop a governance structure that prevents duplication of reporting and enables scrutiny at appropriate levels. We have committed in Highland to progressing the outcomes as agreed in the SOA, Joint Community Care Plan and Children’s Integrated Plan. This is explicit in our Partnership Agreement.

**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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**Perhaps**

Local democratic accountability is key if integration is to be successful and effective. In the Highland model we are developing District Partnerships by way of addressing this to ensure there are local forums which involve front line staff, managers, elected members, service users, carers, 3<sup>rd</sup> and independent sector to discuss service redesign and other issues in public.

However accountability for the services being delivered in the Lead Agency model in Highland is singular, within the governance structure of the lead agency, which is held to account by the commissioning agency. We believe that this does not then cut across the accountability to Ministers as is proposed.

The development of the health and social care partnership in NHS Highland is across all adult health and social care services in the Highland Council area.

This was felt to be appropriate so that no further barriers were developed across services e.g. independent contractors, secondary and tertiary care. This we believe will encourage integration across all of these areas of work and ensure that the health system is held to account as a whole. Previous experience of local health partnerships demonstrated a geographical governance structure which did not always facilitate effective integrated working across the primary and secondary care “divide”. The proposed membership of the Health and Social Care Partnership committee is helpful and goes someway to addressing the previous CHP guidance which at times produced committees of unwieldy and unproductive proportions. There is a need however to emphasise the inclusion of Secondary Care given their key role across the health and social care continuum. A failure to engage effectively with Secondary Care will result in an inability to release any return on investment – arguably one of the reasons that the Joint Future initiative failed to deliver the expected outcomes. The document should clarify that this proposed membership also applies to option b – the lead agency option, as it includes the jointly accountable officer

who would not be part of that option.

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

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### Perhaps

This will require further consideration given the local political element and the democratic accountability referred to previously. NHS Highland has taken the view that integration will be separate and that there is a need to explore relevant models now with Argyll and Bute as was progressed with Highland Council when Planning for Integration was initiated.

However a flexible approach would be welcomed given some of the other configurations such as the 3 Ayrshires with NHS Ayrshire and Arran.

The proposed arrangements in this consultation reflect a joint committee structure that had been present in the Highland Partnership for some time – particularly in Children’s services, and that we are now progressing beyond. The further improvement that is proposed here, regards the full integration of the budget and this will undoubtedly be of benefit.

The Highland lead agency model does not retain this joint structure but does have appropriate representation on the revised Council committee where adult services and children’s services( including Education) will be reported. Within the Health Board there are two scrutiny committees where it is envisaged that officers and members have a key role and it is at these committees that the performance against the agreed outcomes will be monitored and reported back to the Health Board.

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

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### No

The risk with the proposed structure is that the “other” services are marginalised and the importance of integration with these services is lost. In rural areas this may be particularly difficult as services are often delivered by single handed practitioners who work across a range of client groups. As with all change it is important to ensure that new barriers are not put up that will damage existing good working relationships. Because Governance is at the health and social care partnership level the question must be asked where governance of the other services will sit and how the whole system will then be held to account.

The proposed model “a” may be perceived as introducing a third organisation with its own accountability and autonomy. In our view this will not be sufficient to drive the change that is required and could be more divisive.

We feel that the role of governance committees giving assurance to Boards, partners, the public and ultimately Parliament through Ministers is key. This includes performance management, ensuring National and board strategies and policies are being implemented and that the operational units within their control are appropriately and effectively redesigning services to improve quality and efficiency.

CHP (and CHCP) governance committees as founded on the existing guidance have struggled to either provide leadership on redesign or effective assurance to boards. This is in part that their membership is large and includes a significant number of people who sit at the table by dint of the group they represent rather than their skills in scrutiny and seeking to provide assurance.

We feel that the two roles, governance and redesign, would be better served and would make the best use of the valuable time of leaders throughout the system if they were separated. We urge that consideration is given to forming governance committees that are relatively small (9 - 15 members). They should include professional leaders, staff and patient/public/carer reps along with local authority members and non executive directors as well as the professional lead and senior manager. Their remit would be to provide the necessary assurance to the board.

However, the real work to redesign services will not take place around a governance committee table. It requires genuine engagement from all relevant stakeholders which will, in relation to different redesign projects, include patients, the public, carers, clinicians, other professionals, managers, other staff groups, the independent and voluntary sector. These redesign (commissioning) groups will vary from being very local looking at specific services to Board wide pathway groups looking at very large change programmes.

We believe we need to free up a lot of clinical leadership time from attending governance meetings to playing a key role in working through redesign. It is also vital to recognise the training needs of committee and Board members in order to fulfil their Governance role effectively.

As a consequence we believe further work is required to determine the best arrangements for governance of the integrated services.

**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?

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**Yes**

Close working with and support from the Care Inspectorate and Healthcare Improvement Scotland will certainly be important. The evidence of improvement as a result of the Child Protection Inspections under the remit of HMIE is now noteworthy and in the most part due to the positive, supportive and enabling approach adopted by all and led by HMIE.

However the review of scrutiny bodies did advise the development of a light touch approach and reduction in duplication.

It is also valuable to continue to build on the existing outcome framework and clarify the key performance indicators which must be SMART and adequately reflect outcomes and impacts. It is reiterated that Performance management must focus on outcomes and not delivery so that innovation can thrive and Partnerships can focus on the impact they are making across the client groups.

**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?

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**Yes**

If this would have an impact on the outcomes sought then there should not be legislation in the way of enabling that. Each Partnership has different issues relative to their geography, demographics and need, and must be able to seek solutions relevant to this information. The delivery of services across the private and voluntary sector is also wide and varied and local decisions and proposals need to be driven locally.

#### **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?

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**Yes**

The reference to resource identity and the recommendation to eliminate the need to track this is most welcome as we acknowledge that an outcome based approach will lead to significant change in the way that we deliver care . This emphasises the need to have the outcomes clear and measurable so that value for money, quality and efficiency can be evidenced.

This may feel uncomfortable for staff and managers who are used to close monitoring of budget spend within current arrangements, and support will need to be ongoing. It will also be helpful for any in-year release of funding to be focussed on outcomes to re-enforce this approach once again.

The model adopted in Highland places responsibility for delivery in the hands of the Lead Agency and this allows for that flexible use of resource focussed on the outcomes. The agreed performance management framework and performance indicators ensure that both organisations can be held to account and evidenced through the outcomes achieved. We are therefore fully supportive of the Lead Agency option.

Option a – delegation to the health and social care partnership established as a body corporate, is in our view likely to be the less effective option. Working across two organisations has not proved overly successful and this option introduces a third dimension which could be perceived as autonomous because of it's governance structure.

There is also a danger that this replicates the Community Health Partnership approach and from a Highland perspective this is counterintuitive.

It is important to clarify that in option b, which is being progressed in Highland, the budgets will become integrated and lose their identity going forward. The use of the term hosting could imply that budgets require to be tracked in the future. It is worth highlighting that the Highland Partnership has agreed this will not be desirable, practical nor achievable if we truly move to an outcome based approach.

**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?

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**Yes**

One of the drivers for integration in the Highlands has been the difficulties arising in decision- making primarily around budgets. Processes in Children's services have been streamlined into a single process with one plan, one meeting and one lead professional and now that GIRFEC model is developing across Scotland. However despite best efforts the system still required decisions that had implications on budgets and as these were separate decision-making systems, it was difficult to keep the child and family at the centre of the process.

Similarly in adult services, the example you give is all too familiar and is reflected in the average length of stay in care homes.

Because of historical individual budgets we have developed similar groups of staff working in very similar ways and in so doing introduced even more barriers. Our integrated plans will enable us to deploy staff more flexibly as an integrated team, as well as introducing greater and broader opportunities for training and development.

**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?

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**Yes**

There must be a level of flexibility to enable that local response but if the direction is too limited the desired outcomes may not be achieved. The emphasis should be on functions and not services per se to ensure that the total resource required to deliver that function is included in the integrated pot.

**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?

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**No**

Whereas there may be some merit in having one senior officer accountable for the integrated budget, there is greater danger that decisions continue to be made in isolation and the impact across other departments, services or agencies are not considered or assessed.

This was one of the barriers that in Highland we strove to eliminate and the Accountable Officer as it applies to option a of the Integration models, could be in the position of being excluded from the decision-making process or indeed find themselves making decisions in isolation which impact across organisations in a detrimental way.

An example of this might be the development of long term condition management without cognisance of the importance of oral health on the reaction and recovery of the patient/client. Similarly the drive to meet financial savings targets and efficiencies may compromise the sustainability of services outwith the Health and Social Care Partnership on which communities are reliant.



The description of the jointly Accountable Officer in Chapter 4 specifically leads the reader to believe that this will be a mandatory appointment for both options. However the description of the options in Chapter 5 conflicts with this by not referring to this appointment at all in the detail around Option b. It would be helpful to be more explicit at the outset in relation to the governance and the requirement to have a jointly Accountable Officer.

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

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**Yes**

These need to be at a Senior level which of course will have implications for funding of posts and the numbers of senior managers in an organisation. Those “other” services will be also required to be managed at a senior level and in the more rural areas this may cause a bit of a duplication of effort.

### **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?

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**Yes – but within certain parameters**

Some guiding principles based on the benefits gained to date will be helpful.

As the Highland model developed we recognised the need for local influence not just across the professions but also in relation to the role and contribution of elected members.

With functions for adults being delegated to health there was a concern that democratic accountability would be diluted. Highland is therefore developing District Partnerships which provide an opportunity to bring together, in a public forum, practitioners, users, carers, voluntary and independent sector representatives and local managers to discuss services for children and adults. These Partnerships will be instrumental in identifying local issues and brainstorming solutions, sharing local performance and experience, influencing future commissioning.

There may be a need to reconsider how community planning functions, particularly in the context of the development of community understanding and resilience. Too much definition may restrict innovation and the development of effective communities.

**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?

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**Yes**

This is of course coupled with an outcome based approach and adopting strategic and operational commissioning. All of this together requires involvement and engagement of the full range of stakeholders. We have seen great work completed in Highland led by Clinicians in the community such as the virtual ward initiatives and anticipatory care planning. These have made significant contributions to shifting the balance of care and as this approach is adopted Highland wide, we anticipate a groundswell of enthusiasm for this new way of working evidenced by the outcomes achieved. We have learned that clinical leadership and especially the role of the GPs, is pivotal in coordinating community services.

Similarly, with regard to Children's Services, we would expect GPs and Health Visitors, as well as Head teachers and others to be fully engaged.

**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?

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Often backfill availability is cited as an issue and certainly within General Practice there are not insignificant costs associated with this. Just providing backfill does not always ensure consistency of approach or contribution however, and so there is a need to not only identify leadership at local level across the clinical /practice community but also to ensure that these practitioners are adequately trained and resourced to make the commitment. Clinical and professional leadership is very valuable and an investment in it is essential, but it must be effective and practitioners must know what is expected of the role and how it contributes to the overall objectives and delivery of outcomes.

We believe therefore that the role of clinical and professional leaders in the Health and Social Care Partnership has to be explicit.

Current CHP guidance does not reflect the need to have effective clinical and professional leadership throughout the redesign and commissioning processes focussing merely on them having a seat at the committee.

The professions do need to be represented on the Governance committee of the H&SCP where assurance will be sought as to the impact of the redesign on achieving outcomes but if this is kept to a more efficient number- for example confined to chair of ACF, APF etc, it will allow for the release of leadership resource into the redesign planning and implementation.

Revised guidance would be welcomed ahead of the legislation especially as Partnerships are now beginning to focus on the changes ahead.

Similar comments can be made about the independent and third sectors, where staff need to be supported to participate.

It is vital that these various colleagues are engaged at the outset and understand and commit to the outcomes.

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

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### Perhaps

The Local Healthcare Co-operatives were developed in this way and in many ways were very successful at engaging the GPs and wider Primary Care. However the revision of the GMS contract with the emphasis on QOF and related payments tended to focus attention back on individual practices and much of the progress made was lost. There would be some benefit to this configuration where services are specific to a population say in a rural area, but in cities and larger towns where zoning of GP practices is not always so obvious this is more complex. As we develop expertise in commissioning and especially in the first phase of identifying the relevant data to inform decision making, it may make more sense to encourage groups of practices. This would again in rural areas mirror the associated school groupings in children services and aid transitions from children to adult services.

Indeed, if we are to support people across the age ranges, associated school groupings are more relevant to the organisation of children's services, and often to communities. For many reasons, there should be linkage between the organisation of services for children and adults, and that is why we have chosen associated school groupings and natural communities as the framework in Highland.

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

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In Highland we would agree with the principle of having decision making as close to the point of delivery as possible but this cannot always be defined as there are a number of factors such as geography, level of need and deprivation and demography that will influence this. However we have committed to the District Partnerships being integral to the community planning process by way of engagement, local problem solving, developing local knowledge and expertise, communications and influence. The expectation of the lead agencies is that managers, acting within their delegated authority, will be expected and empowered to work with local practitioners, professional groups, public and patient representatives through these District Partnerships to implement local solutions. These Partnerships will focus on engagement and planning and must involve the 3<sup>rd</sup> and independent sectors. In addition we have an escalation route to Chief Executives where this is not happening.

We have found that local areas and communities often know what is best and need to be more empowered to come up with solutions. The development of self care, health improvement as well as community engagement and resilience is fundamental if we are to meet the needs of the future. Further work is perhaps needed to assess the added value of the Community Planning Partnerships as they are currently configured to ensure they are fit for purpose going forward.

**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?

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**No**

There are too many parameters to consider in a country of the size and diversity of Scotland. *No one size fits all* is a good mantra when dealing with the complex landscape that faces us. It is important that there are agreed principles on which we build our models, that outcomes are agreed across Scotland so that all get the opportunity for the best possible outcomes regardless of where they live, that lines of accountability are clear and performance management frameworks are robust and effective.

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

There is limited reflection throughout this consultation of the impact on staff who remain the most important asset of the Public sector and who are fundamental to achieving the outcomes we seek. Annex C touches on this key point recognising the need to consider staff governance in this process as we did in Highland and acknowledging that the Health Board and Local Authority have quite different approaches and can learn considerably from each other.

For staff to work together effectively in a new structure established as a “body corporate” there must be consideration of how they are involved in the decision-making, supported throughout the change and to what policies and procedures they will work after integration. In developing the Lead Agency model in Highland considerable effort was directed into engaging and working with Staff and Trade Unions across the organisations. The NHS staff partnership approach was adopted and acknowledged as good practice throughout the Highland Planning for Integration and this provided wide learning for all. In NHS Highland as the Lead agency for adult services, we are progressing the development of a Practice Forum to ensure those working in Social Work and Social Care have similar support and influence as clinicians have through the Area Clinical Forum. This will need to be considered in the body corporate model.

At an early stage in the planning for integration process, Highland Council and NHS Highland considered both models referred to in the consultation document, and identified option ‘b’, the Lead Agency Model, as the preferred approach.

We believe that there are some risks and further unnecessary complications with the body corporate option ‘a’. In particular, these relate to concerns about the viability and desirability of a Jointly Accountable Officer, and the need to have absolute clarity about professional and agency responsibilities and accountabilities.

The Highland Partnership also believes that integration should be taken forward from the outset, for services across all age groups, and that this whole system approach is more likely to be safe and effective.

Notwithstanding this, the Highland Partnership is clearly highly supportive of the principles and strategic direction set out in the consultation paper.

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

This is an essential piece of work and must be viewed as ongoing to ensure any impacts are fully analysed and necessary action taken.

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

Again this is an essential and valuable piece of work. It is useful to list the legislation that will be directly affected by this new Act and that which is superseded. However it would also be useful to reference the 2002 legislation that remains extant and in fact enables the model set out as option "b".

We wonder also if consideration might be given to a rurality impact assessment as this could be significant in a number of areas of Scotland.

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