
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

Comments

This agenda is a huge change for health and social care and will require both care and energy to take it forward.

It should therefore be a local decision as to how integration is taken forward as it will depend on local circumstances and existing level of joint working.

One of the main points will be to engage effectively with all Stakeholders to ensure that everyone understands the potential benefits and are reassured that the main aim is to provide better services for patients.

An initial focus on older people might be useful as this would inform thinking and learning for future wider alignment and integration of health and social care services. However as health and social care issues can be experienced from an earlier age than 60/65 and evidence shows that early intervention and prevention can have a very positive effect on health and wellbeing wider alignment should be considered reasonably quickly after the older adult strand has been introduced.

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

Comments

The overall framework is helpful although further information on how the integrated budget will operate is required.

Equality and Diversity issues perhaps need to be more explicit.

Clear linkage between devolved budget responsibilities, clinician led locality service planning and strategic commissioning is crucial.

There is an issue re the shift of resource at a time of increasing demand on services across the health sector that needs to be carefully considered.

Housing, environmental health and the wider planning agenda should be part of the integration process and not just limited to health and social 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

Comments

Nationally agreed outcomes would necessitate effective integration with health and social care having to work together to achieve these. These outcomes should be agreed through wide consultation.

Currently the performance frameworks for health and council are very different with much variation in reporting and accountability – even within the SOA. This must be addressed and aligned if integration is to succeed.

Outcome measures should reflect the priorities of service users and carers.

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

Comments

Local single outcome agreements should reflect the nationally agreed outcomes. Performance measures should not be too onerous – i.e. time consuming to collect.

Where will HEAT targets fit in?

There is the potential to have governance issues that cannot be adequately addressed unless there is clear guidance re targets and reporting.

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

Comments

Joint accountability will need careful consideration if it is to achieve the required outcome. Senior management roles and the role of the Council, Health Board and Health and Social Care Committee will need to be very clearly defined. This will be almost unworkable unless there is agreement between the key partners as to the strategic direction of the partnership. Again effective governance is paramount..

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

Yes

Comments

This would be helpful. It would task the areas with more than one local authority to agree priorities but could be difficult to achieve..

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

No

Comments

The clinical advisor will act as an advisor to the partnership. This role should be undertaken by whomsoever the NHS Board considers most appropriate. This might be a senior doctor, nurse, AHP or any other clinician who has appropriate understanding of the issues to advise the non execs.

Membership of the committee should link with existing organisational committee structures. Again governance needs to be considered in agreeing an effective structure.

Where there is more than one partnership this a significant time demand will be placed on non executives.

There should be adequate consideration of this aspect of the process with a number of options identified and scrutinised to ensure that a workable solution(s) can be achieved.

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?

No

Comments

Some concerns have been expressed re this. Performance management arrangements need to be straightforward. Electronic systems do not yet facilitate information sharing. Further detail is required to fully address this.

Where there is local service failure the link to the HSCP committee is not clear enough. Health care providers might not understand why a social care service is failing, and vice versa. Clinical governance issues would again be highly relevant and there needs to be clarity around how the procedures within the partnerships would address problems/ failures as currently they are quite different.

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

Comments

This should be agreed 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?

No

Comments

Further detail is required.

The real question is whether or not when finances are constrained and there is severe pressure on one service will there be the potential to vire money appropriately? This can be straightforward on paper and through committee agreement but in practice at the point of delivery is much more difficult. There is the potential for significant external pressure that would place a huge responsibility on the joint accountable officer.

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

Comments

Clinical staff and services have been Involved in submitting bids to the Change Fund. One of the main problems is in relation to the apparent lack of a transparent scoring mechanism. This has led to clinical staff being confused and not knowing how the allocation of money was prioritised.

With an integrated budget the mechanism for access to funding will need to be absolutely clear as there is the added potential of undue influence by either party that could often be based on a lack of understanding of the service being provided/funded.

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

Comments

It will be very important to have national guidance on categories and areas of spend. There will otherwise be the potential for local variation to be a real issue.

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

Comments

This will be a difficult role. The responsibilities of the post will need to be very explicit and easily understood by a wide range of people.

The financial models and level of authority as described in the consultation should allow for appropriate shift in investment.

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

No

Comments

Further detail required in relation to where this post is expected to sit within any structure.

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?

No

Comments

This should be left to local determination.

However a continued steer towards equality and equity of access to health and social care despite post code is essential.

In addition, clear guidance on outcomes will help re directing local arrangements. Strategic commissioning will also have to link effectively with locality planning if this is to be achieved.

Strong partnership between all professions is needed and no one profession should not dominate.

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

Comments The partnerships must consult with all local health and social care professionals.

Area Clinical Fora already exist but will need to be strengthened and widened to include social care practitioners.

The chair of the ACF should have a seat at the partnership board table.

Strong leadership will be required to ensure equity of participation. The role of mutuality and effective partnership is essential.

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

Practitioners need to feel fully included in the planning function.

Their input must be allowed to influence strategic commissioning.

All practitioners need to understand the aspects of the NHS Quality Strategy and the principles of mutuality and co-production.

Currently there are huge differences between the culture of health and social care and these should not be underestimated.

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

No

Comments There is significant variation in the size of identified communities and these should be based on local “natural” communities which may or may not be based on GP boundaries. It is important to avoid, “postcode” provision of health and social care.

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

Comments

Strategic direction needs to be determined at a higher level.

There should be the opportunity to define and provide locally based services but it is also important to ensure equity of access and to have the clear aim of reducing inequalities.

Locality planning groups must therefore understand that the opportunity to ‘localise’ services comes with the need to take responsibility and accountability for said services.

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

Comments

Care should be taken when attempting to define populations. The natural geography is often a better classifier.

Do you have any further comments regarding the consultation proposals?

Comments The paper only mentions GPs.

All health and social care practitioners should be treated with equal importance and value.

There should be equal opportunity for anyone with good ideas to drive forward service development to the benefit of patients, carers and the public.

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

Comments

With the move towards people being looked after in their own homes rather than in hospitals, this has an impact on all community based services.

Careful planning is vital as workforce planning and skill mix issues need to be addressed by the partnership.

Good Data sharing is also essential.

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

Comments

Potential costs- only GPs are specifically mentioned in the paper as requiring money to be able to participate in locality planning.

They are obviously not the only primary care health professionals who should be involved in the locality groups.

Other professions must be included and therefore the potential costs associated with full involvement should be taken into consideration.