
Appendix 1 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

We support the Government's aspirations to improve outcomes for older people and in Aberdeen we are able to evidence that we are working in partnership and shifting the balance of care in support of these.

The Reshaping Care programme has given a start to the work around the government's current intentions for integration for older people's services and the risk in pursuing integration of all adult services at one time is that the older people's agenda would be slowed. However, integration of adult services should not wait until integration of older people's services is implemented as there are risks of discontinuity of provision from an increasing separation of adult and older people's services, particularly in relation to mental health, that may impact on outcomes for older people. Integrated working is already a feature of adult services in Aberdeen City so the basis for improving this is already in place.

The focus should be on outcomes. It is not necessary to integrate health and social care in order to improve outcomes and integration of itself is not a guarantee of improved outcomes.

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

It is not comprehensive as it does not deal adequately with the matter of the role of the acute sector & the acute hospital budget contribution, critical to the issue of resourcing of primary and community care to ensure the ongoing shift in balance

of care.

More emphasis should be given to the possibility of local solutions to integration where it can be evidenced that these have the potential to achieve improved outcomes. It is vital in partnerships where this agenda has already progressed that there is the flexibility to build on what is already working.

The importance of other partnerships should be recognised e.g. in Aberdeen, Housing is included in out integrated working arrangements.

There should be greater emphasis on the role & remit of Local Authorities and Health Boards in partnerships to tackle health and social inequalities.

It is disingenuous to say that proposals for reform are not based on centrally directed, structural re-organisation (2.4) when there will be a requirement to set up a HSCP (redesigned CHPs) as a structural vehicle and the governance arrangements for this are very prescriptive (Chpt 4.)

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

Joint performance reporting goes in hand with integration and a requirement of joint accountability for agreed outcomes is to be expected but is not the mechanism that will deliver change. It is vital that the outcome measures genuinely reflect the priorities of service users and carers and the contributions of health and social care across the spectrum. The HSCP should be held to account through Community Planning mechanisms for delivery of outcomes. We already have joint community care performance measures, some of which

are underdeveloped, and in social care we are increasingly held to account for performance of NHS on specific HEAT targets. We already collaborate to improve performance.

Does the proposed change mean a move away from HEAT targets, which are currently driving the NHS agenda for older people and skewing the social care agenda rather than focusing on outcomes for older people?

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

Only in as much as SOA's will need to **recognise** any nationally agreed outcomes and ensure that local priorities/outcomes support their achievement. To include nationally agreed outcomes in SOAs detracts from their purpose in establishing local priorities/outcomes. Tensions may arise in setting national outcomes with local Single Outcome Agreements.

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

It should be noted that it is not the Council Leader but the Council which is responsible & accountable.

The proposal for joint accountability potentially represents an erosion of democratic accountability in relation to social care services within local government and introduces an additional layer of bureaucracy in the more prominent role of the Cabinet secretary in relation to social care within an integrated service. Accountability for delivery to a tri-partite arrangement (4.9) suggests equality of status when the reality is that the hierarchy of this arrangement potentially means that the Cabinet Secretary will be directing integrated services in the way that NHS is currently directed. To suggest a 'balance' of accountability, a complex system is proposed which will require significant input to the management of relationships within this and may not be

conducive to the good working relationships and shared commitment that are needed for better outcomes (consider Prof. Alison Petch's report for ADSW). More clarification and simplification is needed.

It should be borne in mind that Audit Scotland viewed the governance and accountability of CHPs as 'complex' and 'not always clear' and this should not be repeated for HSCP.

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

Yes No

In principle, yes. However, it is imperative that the nature and shape of local arrangements are determined locally and based upon the best possible opportunity to achieve outcomes for individuals, families and communities

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

Yes No

The proposed Committee arrangements are an extension of the CHP model and as such are health oriented in concept. They do offer a greater degree of local accountability for health services, which is to be welcomed. They are inadequate in their links to democratically elected Councils. The possibility of only 3 elected members with 3 non-executive board members gives insufficient level of scrutiny – councillors in Aberdeen suggest 5.

There is a lack of understanding at some levels in NHS, which is reflected in this consultation, of the importance of local, democratic accountability for social care and of the significance of the duties of Councils under 1968 Social Work Scotland Act as the unifying act for social work services (Kilbrandon principles). The risk of fragmentation of provision to individuals/families who may need social work support from various aspects of service is not taken sufficiently into account, nor is the potential for disconnect from other Council functions.

In Aberdeen City, our current partnership arrangements include housing and there should be more emphasis on health and care in the wider context, given the social

determinants of health.

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

This needs to be addressed to the 'public'. The joint accountability arrangements will ensure that reporting on national outcomes/targets is to the highest level so this may give the public confidence but people are more likely to have confidence if the options for action are clear. Outcomes reported will need to reflect people's priorities and there will need to be transparency and proportionality about action for local failure.

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

As the legislation will apply to adult social care services, anything beyond this should be for the HSCP to determine, through a process of strategic planning and consultation, and by agreement with Council and NHS Board.

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

It is not models that deliver objectives but people. Successful delivery will depend on a common vision, a shared understanding of the respective roles and distinctions between health and social care, and a shared commitment to putting

the person at the centre and providing the best possible response to agreed needs: and all of this within finite, possibly reducing, resources which need to be protected to achieve the outcomes for which they are intended – not in any circumstances to fill a resource ‘hole’ somewhere else. Health and social care perspectives and priorities are different at times, sometimes in conflict, and healthy debate will continue, even with integration.

A strong focus on outcomes is required for a ‘seamless’ service to users/patients, rather than structural change.

Whilst it is acknowledged that our joint priority is to support people to remain at home/keep them out of hospital, at the present time social care is increasingly driven by and responding to the NHS agenda around the use of the acute sector and this is unhelpfully skewing the allocation of resources. If integrated working is to be successful, the money needs to follow the patient/service user, allocated according to assessed need and local thresholds for eligibility for social care. Decision making needs to be as close as possible to and involve the service user.

In Aberdeen, care managers and OTs are aligned to GP practices, which are organised in clusters with manager alignment, and these arrangements offer the possibility of integrated, delegated budgets/decision making that is necessary to achieve outcomes. It should be said that what is most important is the delegation of decision making, linked to budget accountability, rather than delegated budgets per se.

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

We have many examples of good, integrated working built up over 10-15 years that we would be happy to share. We continue to plan and deliver integrated services. We are endeavouring not to become distracted from developing integrated working because of the proposed focus on structural change. Please contact for details of integrated working e.g. Health and Social Care Partnership Committee & Executive, Integrated Senior Management Group and Operational Management Team taking joint decisions on use of resources and service development; joint Rapid Response Team, Horizons joint rehabilitation day centre/ service, joint equipment service, integrated substance misuse service with pooled budget, community mental health teams, integrated out of hours home care & community nursing service.

We have had issues, also: with resource transfer failing to keep abreast of service costs, NHS continuing to plan service changes that impact on social care without our involvement (NHS may say the same about impact of social care budget cuts in past years), many beds being closed (around 300) with no release of resources to primary/community or social care, some parts of NHS increasingly behaving as though the purpose of social care is to serve the NHS agenda etc. .

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

The principle of minimum direction is welcomed, with caveats. It should be borne in mind that social care budgets for older people/adults can be clearly identified, with detail of the spend (given that they are targeted budgets, spent on the basis of defined eligibility criteria and thresholds) whilst many of those in health are concerned with universal provision and will need to be disaggregated through a process of apportionment of costs, which is much less transparent.

In relation to the acute sector, it is our view that the without direction from Ministers, the likelihood of any contribution that will genuinely represent a significant shift in resources to community based expenditure is remote, and the risk is that social care resources will gravitate further towards meeting the demand pressures on the acute sector.

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

We do not think this role/post adds value to the proposed model and the duality of its governance may prove to be a hindrance rather than a benefit. What will the relationship be to the Council's Chief Financial Officer (Sect. 95)?

One post should not be seen as the key to shifting investment and if the postholder has and exercises authority to do so unilaterally, then partnership working will have failed. More needs to be done to describe and justify the proposed role of the Jointly Accountable Officer.

If the HSCP is doing its job - setting its priorities in terms of outcomes, determining the allocation of budgets against these, ensuring the commissioning of appropriate services, and empowering person-centred decision making at a local level, with sound systems for financial reporting and monitoring, there should be no need for such a role/post.

The proposal that such a post is necessary suggests that the government has insufficient faith in the potential of partnerships to make the necessary investment shifts.

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

Yes No

If there is to be such a role/post it needs to be at a high level of seniority. However, the aim should be to enable the delegation of budgets/decision making closer to the front line/patient/ service user, within a robust framework, not to reinforce a top down process by conferring authority in a single post/role.

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

Locality planning has to be determined locally so that local circumstances and needs are directing the future of service provision.

There should be greater emphasis on the importance of working with communities to increase community capacity and give local people the skills and confidence to take part in service design, delivery and evaluation and in co-production of services.

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

If there is a duty to consult then HSCPs will be required to do so. What a stronger duty might be is not clear.

Good partnership working should ensure consultation with professionals.

It should be recognised that consultation is vital with all stakeholders.

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?

Again, planning at a local level should be about all stakeholders. It is not clear why special steps are seen as necessary to ensure the involvement of clinicians and social care professionals. The willingness of some to be involved may be an issue – e.g. GPs may be disinclined to devote time to planning without recompense (how is this to be funded?) & the lack of engagement between acute and primary care is sometimes an issue.

In Aberdeen City, the recent organisation of GPs in 4 clusters, each with a cluster lead for a particular theme, and with a lead clinician across clusters, has resulted in greater involvement of GPs in planning and redesigning services..

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

The mechanism for locality planning should be determined locally. While clusters of GP practices may make practical sense for some areas it will not be a suitable model universally.

In Aberdeen City, GPs are organised in 4 clusters, each with a cluster lead for a particular theme, and with a lead clinician, and we have aligned appropriate social care staff and managers in older people's services with these clusters. We are planning to accelerate integrated working around the clusters

Much of social care delivery in the wider adult care world, e.g. Learning Disability and Mental Health is not linked to the clusters and it may or may not be appropriate to connect in this way.

The matter of the independence of GPs /GP practices as private contractors to the NHS and will need to be considered in determining how they will be held to account for agreed outcomes.

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

This should be a matter for Health and Social Care Partnerships and not for prescription by Scottish Government. A strong commitment to the principle of involvement of all stakeholders, which would include local communities, is more likely to result in involvement and empowerment than prescriptive arrangements that may not suit every local situation.

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

This is a matter for local determination. Localities are defined by more than population size.

Do you have any further comments regarding the consultation proposals?

General

The expectation that we can give YES/NO answers to complex proposals suggests a reluctance to engage in the serious debate that is necessary about the implications of some of the proposals.

It is disingenuous to say in the consultation paper that proposals for reform are not based on centrally directed, structural re-organisation (2.4) when there will be a requirement to set up a HSCP (redesigned CHPs) as a structural vehicle and the governance arrangements for this are very prescriptive (Chpt 4.). It would have been helpful to have allowed for alternative models to be proposed at this stage rather than the limited range of 'choice' presented by this document.

The consultation is very imbalanced – 6 out of 20 questions on the issue of locality planning, which by its nature ought to be left to local determination and not directed by government.

Integrated budgets

The consultation fails to address the most significant issue of integrated budgets and, related to this, the contribution of the acute sector to ‘the pot’. Whilst Ministers intend to provide direction on minimum categories of spend, it should be borne in mind that social care budgets for older people/adults can be clearly identified whilst many of those in health will need to be disaggregated through a process of apportionment of costs, much less transparent. So far, the IRF has not achieved this. In relation to the acute sector, it is our view that the without direction from Ministers, the likelihood of any contribution that will genuinely represent a significant shift in resources to community based expenditure is remote.

The issue of integration within the health service (acute v primary care) should be as much the focus of government interest and integration between health and social care.

The principle that budgets lose their identity with integration is of concern:

- local authorities will determine their spend on social care, will be required to account publicly for the use of budgets and must be able to identify that budgets are spent for the purpose intended, i.e. social work/care
- local authorities have statutory duties to meet and a degree of protection of budgets is needed to ensure that responsibilities for community care and carer assessments; duties under disability discrimination, adult protection, vulnerable adult and mental health (MHO) legislation, etc. are met.

There is a failure to recognise the need to consider the issues for integration, especially of budgets, arising from the fundamental difference between health and social care, that the former is a universal service and the latter is now a highly targeted service, focussed on the most vulnerable citizens.

Governance

The proposals take insufficient account of the requirements on Councils to account for their budget spend and how these are to be addressed when the social care budget loses its 'identity' in the integrated pot. What is the role of the Jointly Accountable Officer vis a vis S. 95 Officer?

There were lessons to learn from 4 /5 years of work in Joint Future Unit which did not resolve the issue. What is the view of the Accounts Commission/Audit Scotland on integrated budget proposals, especially budgets losing their 'identity'?

Culture change

There needs to be recognition of the very different cultural contexts of health and social care, with the opposing tenets of social and medical models of need and delivery and different value bases of professional groups. Staff in social care have concerns about erosion of the social model and its importance to personalisation, prevention, early intervention and co-production should be emphasised. The potential impact of integration on other partnerships and relationships across sectors and within councils needs to be recognised. The extent of the cultural change required for genuine partnership, where mutual trust and respect is the norm rather than expectations of assimilation, should not be underestimated and organisational development to achieve this must be resourced. There are differences in legislative requirements in industrial relations to be considered as the rights and roles of TUs in the NHS can create tensions in joint working where Councils have a different approach to their involvement.

The role and authority of the Chief Social Work Officer needs to be confirmed in the context of integration and in relation to the role of the Jointly Accountable Officer.

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

No

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

No