

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 No

Comments

Given the legislative intent to remove CHPs from the statute books, NHS Boards shall have to put in place arrangements for the management of all aspects of healthcare currently managed by CHPs. To avoid fragmentation of primary and community health services, including health promotion, it would be beneficial to include all such services from the beginning and not to attempt to isolate care of the older person from these holistic population based services.

However, recognising the need to remain focused on continuing to provide services and care throughout the process of integration - the recommendation to have an initial focus on services for older people may allow all CHP services to transfer to the new management unit, but with a focus from the Integrated Partnership Committee on integrating budgets and agreeing joint outcomes for older people first.

This approach would be pragmatic given the pressures that arise from demographic change and the need to make progress rapidly and effectively whilst continuing to deliver services. The creation of a truly integrated service, with a shared culture and single ambition, will take time and effort and the people issues associated with this should not be underestimated.

In the longer term however there are advantages in considering the totality of health and social care spend in the context of the Christie Commission report and the financial challenges ahead. Ensuring a focus on the preventative and early intervention agenda for example in mental health, addictions and early years services, may be more effective at releasing public sector funding to allocate to the increased demand for services associated with the ageing population, rather than

a simple focus on re-allocating existing care of the elderly budgets alone.

There has also been considerable advantage in taking a holistic people centred approach – considering the individual, their family and community within the context of the environment they live in and being able to build community health and care services around primary care services. It would therefore be necessary to avoid creating artificial barriers by focussing too narrowly on one care group or age group. The overwhelming view of staff in NHS Grampian was a desire to build on the integrated community health and primary care services already established within Community Health Partnerships (CHPs), rather than to separate out a single care group.

Other concerns raised included, how will 'older people' be defined, and is there a risk that a focus on 'older people' would disadvantage other vulnerable groups e.g. adults with major mental illness?

To mitigate this risk NHS Grampian proposes that the legislation includes a requirement for inclusion of a development plan setting out the longer term ambitions of each partnership for integration over time in the partnership agreement. This would not only help inform decisions on structures within the new partnership body and the parent agencies, but would avoid different assumptions about the long term being made by the individual partners and other stakeholders.

The focus on improving outcomes and agreeing a set of national outcomes is welcomed, but there should be great care taken in setting these so as not to inadvertently create further disadvantage e.g. too great a focus on outcomes for those over 75 years, without considering premature mortality rates in the population under 75 years.

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

Comments

It is almost there but greater clarity is essential around the following:

- The detail regarding improving health and wellbeing, and the responsibilities of the partnerships for public health and an increasing focus on early intervention and prevention, rather than integrating the present treatment and care services provided.
- The framework should identify the partnership as a health improving organisation, given the opportunity that this provides to work with Council departments and community planning partners to improve health and tackle inequalities.
- Integration includes primary and secondary care services, and is not just between adult social work and community health services.
- The focus on outcomes is welcomed, as is the link to community planning and the single outcome agreement (SOA). However, a balance must be struck to ensure that **all** community planning partners retain a responsibility for health, care and wellbeing, and that this is not seen as being the sole responsibility of the health and social care partnership. There is also a concern that if all the outcomes for integration are included in the SOA, the balance around the five national priorities may be skewed.
- CHPs have had a significant role in public engagement. This does not seem to have the same priority within the framework, and would seem to be an opportunity to bring into a single system the process of engaging, informing and consulting the public on issues concerning health, wellbeing and health and social care services.
- It is not clear how resources associated with universal services (e.g. GP services) would be included in the new health and social care partnership. Primary care contracts (particularly for GP services) need to support and enable the changes required for integration to succeed.
- Often social care services are provided on a care group basis e.g. day services for older people, whereas many NHS services are universal (district nursing) and it is difficult to delineate what is solely dedicated to older people. This issue needs to be considered in the context of the partnership budget.
- How are services essential to the provision of health and social care, but not exclusive to these services disentangled and included e.g. transport, housing?

- The role of the third and independent care sectors will be important to the success of the partnership. Consideration as to how this will happen is essential.

The role of clinicians (and it is important to remember this is all clinicians and not just medical staff), social care professionals and the third and independent sectors in the strategic commissioning of services is welcomed. The establishment of health and social care partnerships which are the joint and equal responsibility of the NHS and local authority is welcomed. The appointment of a jointly accountable officer operating at an executive level of the parent agencies is also welcomed.

However, NHS Grampian feels it is vital that the relationships between each of these contributors to the running of the partnership body should be made explicit. There is a need to be clear about their individual roles and remits and how these fit together to give a partnership that is flexible, responsive and able to resolve differences of opinion and deal with adversity in a timely manner. In other words – what happens if they all have different views of the way forward? It would be helpful if the legislation or guidance provided clarity of the principle responsibilities and roles of each, to guide local implementation.

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

Comments:

These changes will alter the relationship between the NHS Board and the local authorities, and is welcomed. It is correct to take an outcome focused approach, but a wide range of people and partnerships will have to accept this and adapt the way in which they measure progress. A developmental approach, supporting people to learn how to work together to achieve these outcomes will be required. It will also be vitally important that the outcome measures genuinely reflect the policy direction set, and have the support of service users and their carers. The outcome measures should act as a pulling force towards the end point, and not be set based on what we can easily measure (which would tend to involve looking at the type of services we wish to leave, rather than those we wish to move towards). The measures should be a positive expression of the benefits we wish a modern health and social care system to provide (provision of early intervention, anticipatory care at home or in communities), rather than a description of the problems we wish to move away from (delayed discharge, inappropriate hospital admission).

Targeting resource to achieve the outcomes may be very challenging and involve moving resources away from historic allocations. Will this be supported politically? This may be very challenging for local elected members on the partnership committee who are elected by constituents from specific communities – how will they be supported to take a broader population view?

The different roles of the Chief Executives of the NHS and local authorities with regard to accountability could become an impediment, and therefore their joint accountability should be more explicitly described in the context of the governance arrangements for their respective organisations.

There are some specific challenges in the practical delivery of performance management as described. The NHS has a statutory responsibility to work with staff in partnership, this does not apply to local authorities. The Integrated Partnerships have the potential to change the way in which services are delivered and as such will impact on how people work, the skills required, the projected numbers of staff and employment arrangements. One of the stated aims of the proposed reforms (paragraph 2.1) is to “simplify rather than complicate existing bodies and structures.” Thought must therefore be given to how a Board with multiple partnerships can comply with the requirement to engage staff in partnership working, but enable local decision making to proceed “without needing to refer back up the line within either partner organisation” (paragraph 4.7).

This highlights the need for clarity about the relationship between the Integrated Partnership Committee and the Area Partnership Forum.

Measurement of achievement of outcomes may be difficult when our current community IT systems do not provide integrated data. **There is a strong view that the opportunity must be taken at a national level to simplify the legislation surrounding data sharing (i.e. remove the old) and embed in the primary legislation a simple and clear legal framework for the provision of integrated data and information systems to support the partnerships.**

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

Comments

This is a crucial part of ensuring strategic commitment to joint working across the public, private and third sectors. As mentioned earlier – care must be taken to retain the balance across all the national priorities and to avoid reducing the SOA to a single focus and to ensure there continues to be broad responsibility across all community planning partners to contribute to improving health and wellbeing.

There is a slight risk that community planning partners may view their role as holding the health and social care partnership to account for the achievement of the outcomes:

1. How does this fit with the role of the partnership body, Chief Executives, Cabinet Secretary, Health Board Chair and Local Authority Leaders in terms of accountability?
2. How do we ensure that all partners in the Community Planning Partnership contribute to achieving the national outcomes?

Will there be a review of HEAT Targets to reduce these and ensure those that remain support the national outcomes?

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

Comments

This is probably the area where most concerns have been raised, with a general feeling that the arrangements are complex and potentially unworkable. Greater clarity is definitely required in this area.

This question seems to omit the role of Health Board Chairs as described in paragraph 4.9 of the Consultation Document. The role of the Chairman of the Board, and also the role of the Board with regards to these partnerships is important and should be clearly expressed.

If the purpose of integrating health and social care services is to improve the delivery of services to the public and seek improved efficient and effective use of the resource, then the arrangements for accountability are relatively simple and rest with the two bodies corporate who have entered a partnership agreement.

However, if the issue is one of democratic accountability for the use of public funds for the delivery of health and social care services and whether or not this accountability can be shared between local and central Government, then this is not at all straight forward and has the potential to derail progress towards partnership. Political tension between central and local government will arise and the priorities set for the partnerships may become skewed by political imperatives. These new organisations will need clear and consistent leadership at all levels to address the challenges ahead. One option for reducing this risk is for Central and Local Government to enter an explicit partnership agreement detailing the requirements of each other in sharing this democratic responsibility.

The specific partnership agreement is between the Health Board and the Local Authority. Does this question imply that the NHS is jointly accountable to the Local Authority and Ministers, and that the Local Authority is jointly accountable

to itself and Ministers? How is the Local Authority held to account by the Health Board for playing their part in the partnership agreement?

Although the consultation paper is written at a high level and does not go into detail of the working of the partnerships, possibly the only way to remove the confusion and concerns is to be **very** clear about the detail of line management accountability, performance management arrangements and governance arrangements at partnership, Board and Council level and assurance responsibilities (including inspection bodies and audit). Perhaps the success criteria should be listed and analysed to determine how each individual criterion will be subject to governance and accountability and trace back to where this responsibility should rest. Within the consultation document these may be the characteristics as defined in paragraph 2.1.

At a practical level:

- The partnership agreement will be negotiated between the Council and the local Health Board. Therefore ensuring service delivery is consistent with the content of the partnership agreement is a role for the signatories to the partnership agreement i.e. the Health Board and the Council. Is the performance management of this carried out by the Health and Social Care Committee on behalf of both agencies?
- Various concerns have been raised about the differing processes of clinical governance and professional supervision, and that there should be guidance to support bringing these two together in a way that gives maximum assurance of quality and safety to the service user and their families.
- Does there need to be clarity about the responsibility for adult protection? In child protection the two agencies are both partners in our duty to protect children. In adult protection, the provision of care by the NHS to vulnerable adults requires a different relationship between the agencies.

Concern was also expressed about the potential for political tension to arise between national and local politicians and the Joint Accountable Officer/ partnership committee becoming trapped between the two.

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

Yes No **Comments**

Mixed views have been expressed.

Whilst agreeing that flexibility to identify the best local solution is desirable, a one to one relationship may create the best synergy with Community Planning Partnerships, Alcohol and Drug Partnerships, Early Years Partnerships and Child and Adult Protection arrangements.

It could lead to confusion over voting rights. The present proposal splits the votes 50:50 with the casting vote resting with the Chair (this role alternating annually between the two partners). The inclusion of a second local authority could change this balance. There may be something to learn from Clackmannanshire.

If a local authority delegated responsibility for provision of its social work services to a neighbouring authority they would not be partners in the partnership. This could lead to a reduction in the ability of the partnership to engage the broader range of local authority services such as community development, housing, leisure etc.

Although NHS staff are employed on national terms and conditions; local authority terms and conditions are locally determined. This could create further tensions between staff working in a single partnership body.

Would the Joint Accountable Officer be accountable to three or more Chief Executives? If the lead agency model was followed the potential disruption and confusion could be immense with staff undertaking the same role, employed in the same organisation, but with differing pay and conditions as they have been

transferred from two or more different local authorities into a single board.

Why is the question not asked about a partnership covering more than one Health Board?

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

Yes No

Comments

Clarity on the role of the Committees will be necessary in the final proposal. The role of Committees in the NHS and local authority are quite different and therefore absolute clarity is required to prevent differing assumptions being made by the partners.

- Their role and relationship to the Board and Council needs to be explicit. Are they governance committees or the equivalent of an operating division?
- The requirement for clarity of the role of the Committee is essential before a number of other concerns can be addressed. For example, NHS Boards have an employee director as a non-executive director of the Board. There is no mention of staff representation on the new Committees, which may or may not be an issue depending on the detail of the remit of the Committee.
- The joint line management responsibilities of the Chief Executives for the Jointly Accountable Officer must be harmonious with the role and remit of the Committee.
- The Committee role in relation to the professionally led locality planning and the deployment of resource needs to be clarified.
- The role of the Committees with regard to professional governance, clinical governance and staff governance and how this dovetails with NHS Board responsibilities must be clarified. The difference in legal requirements for staff governance must be considered and resolved at a national level.
- There are advantages in keeping the membership of the Committee reasonably small, however a number of concerns have been raised regarding the need to ensure the breadth of clinical views (and in particular nursing and AHP)

are represented. One potential solution may be to outline the need for a clinical/professional reference group to the Committee with the Chair or leader of the group having a place on the Committee as a non-voting member.

- This raises the need to provide clarity of the relationship of the new Committees to the NHS Board statutory advisory structure.
- The role of the Public Partnership Forums of the CHPs was very valuable and recognised that an individual public representative finds it very difficult to influence as a lone voice. Perhaps this success from the CHPs should be carried forward into the new partnerships?
- The relationship between the Partnership Committee and other local groups and planning structures (e.g. the Alcohol and Drug Partnership) will require consideration.

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

Comments

The arrangements are too complex to readily explain to the public. There is also the role of the local elected member representing their constituent to consider. This should be clearly articulated to clarify the difference between fulfilling the responsibilities of representing constituents and representing the Council on the partnership Committee to avoid the Committee meetings being dominated by personal agendas.

Patient and public involvement should be included in the performance management arrangements.

Will feedback/complaints guidance be altered to take account of the integrated partnerships – or will the partnership be expected to follow two separate processes?

Will guidance be prepared on Freedom of Information (FOI)? For example the same query issued to both partner agencies – does the information get released twice and does this give the potential for ‘double counting’?

The issue of staff confidence is not raised and staff confidence in the new arrangements would have a critical impact on the outcome, and is required by NHS staff governance 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?

Yes No

Comments

The local view is that ultimately services for all age groups and conditions should be included within the Health and Social Care Partnership, with a focus on meeting the needs of local communities. However, recognising the challenge such a redesign would take, to avoid disruption of services we support starting with all the functions of a CHP transferring to the partnership unless there is an explicit and clear reason for removing something.

Initial flexibility to suit local circumstances is welcomed, but with a need to ensure all partnerships eventually complete their journey at the same end point to avoid attracting the same criticism as CHPs.

Staff side were particularly concerned that integration may have unintended consequences for health workers including erosion of skill mix, erosion of terms and conditions and erosion of job opportunities. They also felt it may impact on the roles staff carry out, leading to unwieldy arrangements that lead to loss of professional distinction and disempowerment.

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

Comments

In theory yes, the pooling of budgets will allow for more efficient use of resource, and less negotiation about the allocation of resource to meet need. This, however, may take time to realise all the potential benefits, e.g. taking forward releasing time to care on an integrated basis.

There is, however, a risk that not all existing spend is delegated to the partnership but the responsibility for service delivery is. Consideration must be given to how this risk can be mitigated.

There is also concern that we do not wish to inadvertently introduce a transactional process around acute sector budgets and that care must be taken to ensure a collective budgeting approach is adopted that gives accountability for and influence over the use of acute resources to the partnership without creating a purchasing bureaucracy and relationship.

The financial arrangements must be simple and with clear accountability for delivery of the partnership agreement and joint commissioning plan.

Boards and Councils may require support to develop greater financial planning skills to allocate resource in line with the desired outcomes, and to reduce dependency on budget setting largely focused on historic allocation.

Concern was expressed from one sector that there was too great an emphasis on integrated budgets and insufficient focus on shared outcomes, and it is essential that there is a balance between the two.

The Lead Agency model is not generally supported by NHS Grampian for the following reasons:

- The risk of disruption to services and an adverse effect on staff morale and confidence as staff transfer from one employer to another,
- the potential to create new barriers between health and social care and the broader services that also contribute to health and wellbeing (housing, environmental health, leisure and recreation etc),
- The potential to create barriers within health care between adult and children's services is detrimental to child development, child protection, teenage transition and supporting the early years agenda.
- the focus is on structural change rather than service delivery modernisation.
- Reduced opportunity to build services around individuals, families and communities as family based services are divided into adult and childrens teams.

Capital resources and Assets:

As with information sharing and data protection, NHS Grampian believes that the integration of health and social work provides an opportunity to simplify the legislation on property transactions between local authorities and NHS bodies. The property transaction guidance should be amended to accommodate property issues that arise in the context of integration, and to place a duty to assess best value for the public pound – rather than best value for the NHS or Local Authority separately.

Greater consideration should also be given to the issue of physical asset planning and deployment of resources in the context of integrated working and guidance developed on this and asset management to support the partnerships as they move forward in time.

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

Comments

Equipment purchase – NHS purchases all free standing hoists regardless of who uses them and the Local Authority supply all 'built-in' hoists, again, regardless of who uses them.

Highly complex and changing packages of care at home when, rather than argue who should pay for what, each agency paid 50% and commissioned the care package as needed.

Delayed discharge/winter planning funding used to create a single budget to purchase equipment and services to ensure discharge occurred promptly and effectively.

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

Comments

With minimum direction, decisions can be made locally as to which budgets to include. Too much central direction may lead to complexity locally (disaggregating budgets) which may otherwise be avoided.

Much greater clarity on the involvement of acute resources is required and we also feel there should be greater reference to the issue of improving health and addressing inequality. Without this clarity there will be potential for great variation across partnerships.

There is also an omission in terms of the wider support that could come from community planning and community development. It will be important to also consider the potential contribution that these services can make to improving the outcomes for older people.

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

Comments

Paragraph 6.6 states that the duty will be placed on the Health and Social Care Partnership to jointly appoint a senior Jointly Accountable Officer. Surely the appointment will be undertaken jointly by the Partners (i.e. Local Authority and Health Board) as the employing authorities, or is it intended that the Health and Social Care Partnership is a separate legal entity with the ability to employ people? NHS Grampian would not support the creation of a separate legal entity.

Experience in integrated Community Health and Care Partnerships (CHCPs) and further afield has demonstrated that the joint appointment of a senior executive leader with sufficient delegated authority is a critical success factor. Delegating this level of authority to even an executive officer will be culturally challenging and it may be necessary to build confidence in such arrangements with Councils and Health Boards.

The arrangements alone, however, are not sufficient and we would recommend an intensive development programme be organised for the circa 30 officers appointed to these posts over the first 6 months of their appointment. The need to rapidly assimilate knowledge (particularly legal requirements) and understanding of the two agencies they are employed by will be essential for them to be successful.

Having authority without knowledge could be high risk. Similarly, an absence of authority due to a lack of confidence in their knowledge may also undermine their influence.

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

Yes No

Comments

The appointment of Jointly Accountable Officers will have considerable implications for the existing management arrangements within a Board, and particularly for those Boards with a single operating division. The appointment must be made at a level which would make such a complex role possible and provide the opportunity to create a true partnership approach between the health boards and local authorities through influence at a corporate level.

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

Comments

Different parts of Scotland will have different strengths to build on. The requirements of planning at a locality level in a city are very different to those in a large town, village, rural area or island community. The principles or features of what locality planning should cover may be helpfully guided at a national level.

Some specialist services have expressed a view that too great a focus on locality planning may lead to inefficiency through duplication and disintegration of established patterns of joint working.

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

Comments

NHS Grampian believe that the duty should be to do more than consult, but to engage and involve. It is also important that this duty is for all local professionals, and all primary care contractor services not only GPs.

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 is no shortcut to this and a change management approach, working at professional level to achieve ownership and buy-in is essential. This requires both capacity and skills –

1. capacity for a ‘change agent’ to engage professionals, and
2. capacity for professionals (e.g. backfilling for primary care contractors) to be engaged.

There is a necessity to ensure the ‘change agent’ has the skills to successfully engage people in planning, with an excellent return on time invested to output achieved. These should be planning enablers – not service planners.

At the same time, consideration needs to be given to the formal Board Advisory Structures – there is not an equivalent for social work. Also for a multi-partnership Board area, does one Area Clinical Forum (ACF) provide advice to all partnerships or is the ACF the advisory structure to the Board? Would partnerships establish their own professional/clinical advisory structure? (The vision expressed in paragraph 2.1 to simplify rather than complicate existing bodies and structures should influence this).

In addition to the specified need to involve clinicians (all) and social care professionals the skills and knowledge of public health staff would be critical to supporting the development of effective locality plans.

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

Comments

The public register with a GP practice. The GP provides a universal service to this registered population and is responsible for the allocation of a significant amount of joint resources (prescribing, referrals for elective treatment, unscheduled admissions, referrals to social work) on their behalf. Certain resources are already organised around GP practices e.g. community hospitals. It is therefore critical to ensure GPs are fully engaged in the process of planning the most effective and efficient use of the joint resource. By grouping a number of GP practices together we have achieved a population level at which an old age psychiatry team or geriatric medicine team can deliver coterminous care, creating a multi-disciplinary approach to care in the community.

By putting the registered service user at the heart of the model for locality planning, need can be assessed at individual, practice, community or community of special interest level and teams of multi-disciplinary/multi-agency staff can share responsibility to support these people to remain healthy and well in their community.

However, it is essential to remember that not all services can be planned effectively at a locality level, and that there are disadvantages in clusters that share a single acute hospital developing different care pathways. There is an absolute requirement for consistency and in Grampian we are attempting to prevent these disadvantages by giving clusters responsibility to plan services for a particular client group or service area on behalf of all the clusters on a 'lead and share model' in a collaborative way. For example one cluster may lead on Getting It Right for Every Child (GIRFEC) and another on Reshaping Care for Older People. Another tool for preventing inappropriate variation is the use of the General Medical Services (GMS) contract to co-ordinate the development of patient pathways.

The need to plan tertiary specialist services and provide suitable teaching arrangements must also be remembered, and it is almost impossible to do that at

a cluster level.

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

Comments

This should not be prescribed but agreed as part of the consultation on locality planning arrangements. The need to avoid competition between clusters or locality planning areas, avoid wasting capacity by having multiple attendances at meetings, whilst maximising the freedom to plan for local need will require a balanced approach.

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

Comments

This should not be prescribed. The requirements of cities, towns, villages, rural communities and islands will all vary. There are some practices with populations that would fall within that range and other areas where that would constitute almost the entire Board area. In Grampian we have aimed for larger populations to allow traditionally secondary care services (mental health, old age psychiatry and geriatric medicine) to also align to the clusters.

Do you have any further comments regarding the consultation proposals?

Comments

There is concern that insufficient consideration has been taken in the consultation on the impact the proposed changes may have on the people employed by the partners, and therefore on the support and time that will be necessary to ease transition into these new working arrangements. This is especially relevant within the Lead Agency Model.

There may be employment relations issues going forward with staff in partnerships on differing terms and conditions and it is essential that these are considered at a national level and not left to local resolution. The legal status of staff governance

in the NHS but not in local authorities is not mentioned within the consultation.

The proposals generally have broad support. The need for significant work to create a shared vision and to achieve progress towards a single culture with supporting changes in working practice is recognised. Will there be plans to look at the role of national services e.g. NHS Education Scotland (NES) etc in supporting this?

The need to support NHS Non-Executive Board Members/Elected Members to undertake this significantly different role has also been highlighted. Would there be development support available nationally?

The exemption of Board Chairmen and Council Leaders from the membership of the partnership Committees is supported. It is also considered appropriate to exclude the Employee Director and the Chair of the Area Clinical Forum. This is due to the potential requirement for the Board to seek independent advice should a difficulty arise in a partnership.

Finally there is a need to agree a common language. The partner agencies often use different terms for the same things, and a single term to mean different things. This can get in the way of understanding each other and progressing the agenda.

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