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 √

The proposal to focus on improving outcomes for older people before extending this to improving integration of all areas of adult health and social care appears pragmatic and may help to make the process more manageable. However, many services are not delivered with such a specific separation and that practicality may well require consideration of all adult services. In the NHS, specific older people services it may be easier to identify, but we do not believe this will be clear in social care services where the separation is not explicit. The Scottish government may need to consider how to realistically manage this where people receive intervention from a range of services which will not be provided on an age basis.

We are also concerned that this may result in the development of the types of integrated approaches that meet the needs of older people which would then simply be applied to others inappropriately.

It is also difficult to see how practically budgets can be jointly allocated if services are identified on the basis of the age of service users when services are available to the whole population.

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 ☐

The College welcomes the proposal for integration of adult health and social care and to shift the balance of care from institutional care to services provided in the community (p12, 1.8). The proposal offers a real opportunity to ensure outcomes for older people, and all service users are more effective and result in the best possible outcome.

The College welcomes and endorses the ‘five asks’ of the Independent Living

Movement and agrees that the government should take these into account when planning the integration of health and social care. (http://www.ilis.co.uk/get-active/independent-living-policy/health-and-social-care-integration/)

Occupational Therapists are one of the few staff groups to work across the health and social care sector and the only Allied Health Professional to be employed in significant numbers in social work services. Occupational therapy staff make up approximately one per cent of the social work services workforce in Scotland, yet they handle approximately 35 per cent of referrals for adult social work services. There is a constant demand for the assessments and services traditionally provided by occupational therapists, and this is likely to increase in the light of demographic change, with growing numbers of older people and people living with long-term conditions in Scotland.

The proposal for health and social care partnerships appears appropriate. How will they be expected and held to account for working “in close partnership with the third and independent sectors” (p17)?

As identified above, a significant amount of work will be needed to identify which budgets, or proportions of budgets would be included for integration. The legislation will need to be explicit and robust to ensure that sufficient resource is included for the partnerships to function effectively. This will be particularly relevant if partnerships focus on older people first given that services will need to be maintained for all ages regardless of what is developed for older people. There may need to be significant flexibility to enable partnerships to act more widely in order to make this sustainable.

We welcome the strengthening of the role of clinicians, and social care professionals and will expect to see robust opportunities for therapists, including occupational therapists to inform service change and innovation. There is no explicit mention of therapists in this approach and their inclusion would drive the development of preventative and recovery focussed services which enable people to maximise health outcomes and continue to live in their own homes and communities, in line with Scottish Government policies.

The jointly appointed, Jointly Accountable Officer will be a vital role to ensure change is delivered and that both health and social care commit to the partnerships. It will be important to ensure that the employing organisation is not able to deflect any of the intended accountability routes. Will the partnerships become organisations employing staff such as this officer directly or will the workforce continue to be employed by separate organisations? There is evidence in existing integration projects where differences in employer expectation and support can inhibit good service integration. Secondments or transfers of staff or delegation of responsibility and staff employment from one to another will need to be considered and discussed with staff representative groups and Trade Unions.

The profession welcomes the potential new job opportunities in the community and the College has long recognised the impact of poor integration between health and social care on vulnerable and older people. In 2002 The College published "From Interface to Integration" a strategy identifying how to improve integrated working across health and social care occupational therapy services.

Occupational therapists contribute to the government's strategic objectives for a healthier, fairer and safer society in Scotland (Scottish Executive 2007a) by promoting individuals' self-reliance and resourcefulness, and engaging them as active participants in their communities and services. They work in partnership with individuals and carers, with other professionals and across agencies to promote and maintain service users' independence. Their skills in interagency working, complex problem-solving, reablement, prevention and environmental adaptation mean that they have an important role to play in helping local authorities to meet their statutory obligations and fully contribute to the government's agenda to transform social work services in Scotland. (COT 2010).

College of Occupational Therapists (2010) *Changing lives.* London: COT.
Scottish Executive (2007a) *Strategic objectives.* Edinburgh: Scottish Executive. Available at: *http://www.scotland.gov.uk/About/scotPerforms/objectives* Accessed on 17.11.09.

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 ☐

This is an essential element of the proposal. Nationally agreed common outcomes for health and social care will enable services to work toward the same goal instead of being pulled in different directions by conflicting performance measures. The quality and scope of these outcomes will be critical. The proposed draft outcomes appear to be very appropriate and we welcome the intention to replace the existing quality outcomes with these and not to retain two separate sets of outcomes.
It is suggested that a further measure should be reducing the number of repeat admissions due to failed discharge.
Focusing only on reducing delayed discharges could inadvertently increase this,

when what is required is for people to be able to remain in their own homes wherever possible.

Additionally, the definition of 'delayed discharge' needs to be clarified; sometimes a successful discharge requires extensive planning and for the necessary resources to be in place. This may delay discharge for a short time but will ultimately be a much better outcome for the person and will also result in the prevention of further unplanned admissions

We welcome the proposal (3.11) to enable the outcomes to be developed and changed over time by keeping them off the face of the legislation. However, that does then require the principles and intentions to be very robust on the face of the legislation in order to ensure the principles are not lost in future iterations.

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 ☐

It will be important that a clear route can be discerned from the individual agreements to the national outcomes and we would expect scrutiny of this to be robust and a clearly identified responsibility. The legislation will need to be explicit about how scrutiny can be strengthened to result in improvement where outcomes are not being achieved. It would appear sensible to ensure the development of local joint strategic commissioning plans.

At some stage there will need to be an explicit consideration of the potential impacts of integrated services where some are free at the point of delivery and others are subject to charges and eligibility criteria.

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 ☐

This will be most effective if the outcomes are unequivocal to ensure these leaders are not pulling in different directions. See also our response to question 4

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

Yes √ No ☐

This offers good opportunity for flexibility to ensure outcomes can be achieved in the most effective way. Specialist services may need larger populations to make them viable and this offers local or regional alternatives to meet that need. Occupational therapists also report that there can be significant variation in what is provided in different areas by different organisations. This legislation also needs to reduce the frequency of authorities arguing over who will pay for services across different areas. So for example, if someone moves nearer family or back to an area they originate from they should not be able to see any gaps in their services while organisations debate who is responsible. Larger partnerships will reduce the instance of these problems.

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

Yes ☐ No ☐

As well as guidance on the use of casting votes it may be valuable to develop codes of practice or guidance on a number of matters these partnerships may experience for the first time. For example, managing differences in different layers of accountability, such as between local and national government.

Voting and non-voting members: We are pleased to see the inclusion of professional, service user and carer perspectives on the committee although none of these will have any voting rights. This seems a missed opportunity for driving a step change. We recommend all members of the committee should have equal voting rights to prevent the committees developing a two tier hierarchy which will prevent good decision making.

We also believe that partnership committees need access to a far wider range of professional advice than the only the Medical / Clinical Director and the Chief Social Work Officer. There needs to be access to other clinical and professional perspectives as well. In particular Allied Health Professionals can offer significant perspectives in relation to the community work that the partnerships will be focussed on. Creating too large a committee can be avoided by ensuring there are multi professional advisors to support the advisors attending the committee and processes to enable attendance of the most appropriate of these for relevant meetings. Excluding this rich diversity of advice will limit the capacity of the committee to understand the issues in driving community based, integrated service development.

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 section of the document does not include sufficient information to give a judgement on this question. But please see our response to question 4.

As current systems are very variable, it will be vital to ensure that there is a robust system consistently applied.

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 ☐

We welcome the scope to include all services in this, including children's services, but are concerned that in the current consultation document this feels a little to vague to ensure any potential drive to achieve integrated children's or young people's services. The final legislation will need to ensure that while local determination of process is possible there is a clear indication of expectations for integration and performance of **all** the current functions. The concerns of barriers, gaps and poor transition which have led to a drive for integration in adult services also exist in children's services and the legislation offers an opportunity to ensure the culture and ethos of working together includes all public services. There is no mention of housing or education services which should justifiably be included in integrated services and thus the partnerships.

We draw attention to the different cycles of financial planning across health and social care. Local government funding is agreed in three year cycles, whereas NHS funding is annual. Long term financial planning to ensure these are stable and sustainable services will be needed and this variation may impact on budgeting and commitments.

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 ☐

The difficulty, as ever will be in the practical application of these laudable ambitions. How health and social care organisations define what is in the original budget they will begin to integrate; how elements for older people versus children or adults are separated will be very complex and may be subject to protectionist behaviours in the early stages.

Please see also our response to question one in respect of staff employment

We believe that if the legislation includes a clear set of principles, based on equality and human rights this would best facilitate the achievement of the intentions of the legislation.

Option one: delegation to a body corporate.
If the money is moved to a single budget and can be used flexibly, having lost their identity (5.6 p28; 6.3 p33) how, and what parts of the budget, will be identifiable to be "subject to the respective financial governance arrangements of each partner"?

Option two: As this is already legally possible what is the added intention of the new legislation?

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 ☐

Occupational therapists are one of the only professions to work in significant numbers in both health and social care services and thus have great experience of some of the difficulties of working across the whole system. Many occupational therapy services have developed effective systems to overcome these. For example, enabling NHS occupational therapy staff to have direct access to equipment and adaptations provided via Social Work budget. This reduces unnecessary delays to discharge and provision. It reduces duplication of work and gives a better person centred service. Co-locating community health and social services team improves close team working and thus service quality.

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 ☐

This will offer a good starting point. That direction will need to take cognisance of other existing legislation requiring provision of specific services or duties to ensure they are not in conflict with integrated budgets. If they are, services may find it difficult to delegate budgets for services they remain independently responsible to deliver. This legislation may need to change any predecessor legislation which prevents integration.

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

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

Yes √ No ☐

Comments

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 ☐

The legislation needs to identify clearly what is to be achieved and include a requirement to fully include all professional groupings in planning and decision making. The legislation must require proper inclusion, not consultation after the fact. We believe there needs to be inclusion of these groups right from the earliest planning stages and with a strong voice in evaluating and proposing change. Although there are several statements of the intention to strengthen the professional voice the proposals to do this are insufficiently strong. We expect the term ‘clinician’ to mean a broad all-inclusive term for all professions rather than meaning a medical practitioner. We would expect that to be more explicit in the legislation.

The process for doing this could be then left to local discretion.

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 ☐

The duty needs to require active involvement and inclusion of those groups, not simply a duty to consult.

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?

There are several possible ways for ensuring practical professional participation and advice informs planning. They include
Creating a voting seat for a Therapist on the Partnership committee
Establishing a Health Professions Forum, from which one or more representatives have a seat on the Partnership committee and locality planning groups, similar to the model used in Wales.
Placing a duty on the partnership to establish processes for accessing relevant professional advice to the partnership and to locality planning groups
Ensuring that there is opportunity for relevant professional representatives to attend the meetings where agenda items involve their expertise or services. This is the least effective as the representatives are not an integral part of discussions and can be intimidated or prevented from participating even though they are present and it is easy to assume items do not require advice which perpetuates existing practice and models as the partnership ar not exposed to new innovations and opportunities for change.

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 ☐

Locality planning should be arranged around logical local communities as recognised by residents. For example, local council boundaries.

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

The Partnership needs to devolve as much planning as is possible to a locality, retaining wider geographical overview and monitoring performance to give coherence to services and ensure unnecessary replication or duplication of effort is minimised,

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 ☐

See question 18
Localities need to take account of rurality and not simply population size. As per question 18 it is important that they recognise local community boundaries which are usually reflected in the local authority boundaries

Do you have any further comments regarding the consultation proposals?

These proposals are not explicit in including housing, care and repair, and other vital services which impact on health and wellbeing. How will these services be part of the integrated experience for service users and carers?

The College of Occupational Therapists (COT) is pleased to provide a response to this consultation on the integration of health and social care. The profession has a long history of working across the health and social care services in the NHS, Local Authority housing and social work departments; as well as in schools, prisons, voluntary and independent sectors, and vocational and employment rehabilitation services. We welcome the opportunities to significantly improve outcomes for the people of Scotland through this legislation. There will need to be strong and clear principles explicit in the bill with a requirement to meet the national outcomes enabling partnerships success to be measured.

As identified above, the College endorses the five asks of the Independent Living Movement, which offer a robust framework for effective integration.

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)*

Neither the College of Occupational Therapists nor the Allied Health Professions Federation Scotland listed as consultees. We would expect to be included in all future consultations on this important legislation.

The College of Occupational Therapists is the professional body for occupational therapists and represents around 29,000 occupational therapists, support workers and students from across the United Kingdom an around 3,000 in Scotland.

Occupational therapists are regulated by the Health and Care Professions Council, and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties.

The philosophy of occupational therapy is founded on the concept that occupation is essential to human existence and good health and wellbeing. Occupation includes all the things that people do or participate in. For example, living independent lives in their own homes, caring for themselves and others, working, learning, playing and interacting with others. Being deprived of or having limited access to occupation can affect physical and psychological health.