

## 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

We recognise that the on-going increase in the number of older people makes the provision of integrated support increasingly important for that age group. Also that lack of joined up services causes considerable problems to carers, potentially impacting on their ability to hold down jobs, and on their physical and mental health.

However, we feel that it is extremely important to ensure that the improvement of services for older people does not impact adversely on services aimed at other adults. Also, we are not sure how some services could practically be split, for example, where would a 40 year old person debilitated because of multiple sclerosis fit? And would services for somebody with the same condition be different if they were aged 64 or 66? People with disabilities and some health conditions could potentially be disadvantaged.

As mentioned on clause 1.12 of the consultation document, some conditions which are thought to be those of old age may be prevalent among much younger people in deprived areas. We believe that a stated "a focus on older people alone would create an artificial divide within adult services, with people in transition from children's services, and with younger adults with physical and learning difficulties" – particularly in more deprived areas.

If we are going to have a joint vision of Health and Social Care the whole service agenda including children, people with disabilities, young people, older people etc should be brought together.

We would prefer to see focus be initially on particular services rather than on a particular age.

### 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

We would like to see more importance placed on the Community Planning Partnership.

### 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

Despite the reference to Community Planning it is unfortunate that Community Planning is also being radically revised with proposals at this stage. There is not a

strong enough linkage with Community Planning proposed in this document

**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

The Scottish Government needs to integrate much more effectively their Department that develops HEAT targets with Health and the Department that oversees Community Planning and SOAs for this to be workable.

### 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

It is crucial to local accountability that the Community Planning Partnership should have a much more vital role.

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

Yes  No

Comments

To allow efficiencies of scale and pooled resources there must be the opportunity to work across Local Authorities if required. In addition some areas, for example, Midlothian have very few acute services based within the local authority boundaries. This could potentially disadvantage some Health and Social Care Partnerships. However, for most effective “working across boundaries” the number of local authorities in Scotland needs to be reduced to allow one

Community Planning Partnership to cover the whole area under consideration.

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

Yes  No

#### Comments

We welcome the proposal that “*within local partnerships, partners beyond health and social care are also fully and appropriately involved in planning and decision making within the partnership arrangements*”, however, we are concerned that these sentiments do not translate into real influence and that in fact community planning partnership involvement in adult services in particular will actually decrease.

We welcome the references made to the importance of the third sector (see sections 1.17 “*It will be important that, in bringing primary and secondary health closer together, and health and social care closer together, partners ensure that housing services (including those provided by housing associations and the third sector, as well as by local authorities) are fully included in the integrated approach to service planning and provision, and that health and social care planning and local housing strategies are mutually supportive*”; 1.18 “*The third and independent sectors, including carers’ organisations, also provide significant levels of care and support and are crucial partners .... we will not succeed if, in bringing health and social care together, we overlook the need to build upon the progress that has been made in bringing third and independent sector partners to the table when planning delivery of services. The contribution of the third and independent sectors in enabling delivery of better outcomes is also a crucial factor in our wider public service reform plans.*”; and 2.2 (d) “*the role of clinicians and care professionals will be strengthened, along with engagement of the third and independent sectors, in the commissioning and planning of services*” and 2.2 “*will work in close partnership with the third and independent sectors and with carer representatives*”.

However, we are concerned that these references have not translated into real

and meaningful involvement for the third sector in the governance of the actual Partnership. We are concerned that, unlike with existing Community Health Partnerships, the proposals include a split into voting and non-voting members. We are also concerned that reference is made to “Third sector representation of the service user and carer experience of care” but does not quantify representation. In addition, although the above sections 1.17, 1.18 and 2.2 refer to the importance third sector services there have been no places allocated for third sector (or independent sector) service providers.

We feel that these proposals contradict the underlying principles of community planning by reducing the effective management to elected members and Non-Executive Directors only.

In addition, we feel it is unrealistic to expect all local authority elected members who are responsible for a wide range of services to have the level of expertise in the specialist areas of health and social care that the NHS Non-Executive Directors have, which could potentially lead to an imbalance of power. It is possible that local authorities would need additional specialist expertise.

**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

It is important that the proposed new set of nationally agreed outcome measures and standards for adult health and social incorporate fully the Community Planning/Single Outcome Agreement (SOA) and HEAT targets into an integrated approach that is outcomes focused with a stronger balance towards a social model of care. We also feel that it is important that a co-production and preventative model is followed.

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**Question 9:** Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

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Yes  No

Comments

Requires a broader remit than solely older people.

### Integrated budgets and resourcing

**Question 10:** Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?

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Yes  No

Comments

Not without more community planning involvement. There would probably also require to be obligations for acute services to participate. One particular concern would be that the majority of acute services for Midlothian residents are based outwith the local authority area. How realistic is that acute services that serve a wide area e.g. Edinburgh Royal Infirmary, would be able/willing to release part of their funding to a number of different Health and Social Care Partnerships.

It is important that disaggregation of budgets ensures that there is adequate funding to ensure the new Partnerships are effective and successful.

**Question 11:** Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

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Yes  No

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**Comments**

The Midlothian Substance Misuse Service across Midlothian and East Lothian is now operating successfully but has taken a lengthy period to get to this stage. Responsibility is jointly shared between NHS Lothian and the Social Work Departments of Midlothian and East Lothian and it took considerable effort by key officers and elected members to get to this stage.

**Question 12:** If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

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Yes  No

**Comments**

It is essential that there is national clarity but with a light touch for local decision making to be effective.

**Jointly Accountable Officer**

**Question 13:** Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

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Yes  No

**Comments**

From a Human Resources point of view this is not an ideal structure for an individual to be directly answerable to two different masters.

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

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Yes  No

Comments

As above – more detail required.

### 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

Scottish Government should give clear adhering guidelines but the detail to be locally determined.

**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

It is difficult to know without further detail on what is proposed. Existing Community Health Partnerships and Community Planning Partnerships, for example, in Midlothian, have existing arrangements for involving local professionals.

We are concerned that there is no proposal to include a duty to consult the local population and the third sector.

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**Question 17:** What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

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Comments

*Community Planning process must have a vital role.*

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

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Yes  No

Comments

*We feel it should be organised around existing Community Planning areas, e.g. Integration Team or Ward areas with reference to Neighbourhood Planning areas.*

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

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Comments

*Phased basis with great care and relevant training.*

**Question 20:** Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

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Yes  No

Comments

On a Scotland-wide basis, Localities arranged around a population size of 15,000-25,000 people could entail a large and unwieldy geographic area and not take into account accessibility and public transport.

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

Comments

Comments

*We welcome the objectives, in particular, “Health and social care services are firmly integrated around the needs of individuals, their carers and other family members”, and “that services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve – rather than the organisations through which they are delivered”, however we have some concerns as follows:*

Much of this document reads like a fait accompli and we are concerned that there could be a move away from local accountability through the community planning process.

Social model of care gave us Public Partnership Forums (PPF) but if serious of social mode of care and community planning on revised organisation which integrates PPFs with neighbourhood planning is a vital requirement.

Current proposals driven by a clinical model of care in no way helps to strengthen community participation and co-production.

Although the time period is now fairly lengthy it is over the summer holiday period when many voluntary sector organisations and community groups are either short staffed or closed altogether, this means that it is very difficult to get responses from voluntary sector staff and, in particular, service users.

We welcome the proposal that regulations and statutory guidance will be developed with input from “stakeholders, patients and service users”.

We welcome the recognition the importance of “*ensuring alignment and coherence between these proposals and the concurrent legislative proposals for planning, design and delivery of children’s services.*”

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

Comments

Move towards home based care away from residential care:

- likely to place additional burdens on close family members (e.g. potential impact on their health; income (giving up job to care); family relationships);
- Impact on jobs in residential homes;
- Family members may have to deal with contracts;

- Potential reduction in respite opportunities;
- Potential increased isolation for individuals – particularly if they have no family/ family members do not live near at hand.

This is happening in a climate of Welfare Benefit Reform which could potentially lead to decreased incomes and increased stress.

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

Comments

None