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 ☐

Delivery of health and social care services to support people should be based on need rather than age. The emphasis on older people is therefore not helpful.

Many services support both older people and other client groups, especially in rural areas such as the Borders. An emphasis on one sector would risk fragmentation of services. A concentration on one service area could divert focus from the extensive work on other areas of integration within Scottish Borders, such as Mental Health and Learning Disabilities

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 emphasis on Health and Social Care excludes other important elements of integrated working, for example health improvement and Public Health, housing etc

Explicit statements on the principles of integration are helpful, including the reference to shifting the balance of care towards greater support for people in their own homes and the focus on outcomes and needs of the person.

The consultation outlines in detail some aspects of the integration framework but has limited or no reference to other essential requirements for integration.

In particular,

1. There is minimal reference to user involvement and public engagement. We will details our concern about this in our response to Question 7

2. Clinical and professional engagement appears too limited and prescriptive. We will detail this in our response to Questions 7 and 16

3. The critical importance of leadership and the ability to manage cultural differences is not considered

4. Challenges related to shared information, both systems and data, is not considered. Incompatibility of IT systems, sharing of data and other information issues are potentially significant blocks to integration.

5. Acute sector involvement is not explicitly outlined, although the proposals will have significant implications for the acute sector. Clarity on expectations for the acute sector would be helpful.

6. There are a number of other areas that are not referenced as being included within the proposed framework, including mental health, learning disabilities and criminal justice.

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 ☐

Scottish Borders CHCP supports the focus on a single set of joint outcomes and targets with joint ownership/accountability.

The focus on user outcomes is also welcomed although the challenge of making these meaningful and measurable will be significant,

It would be helpful to have clarity over the relationship between national and locally agreed outcomes. Partnerships should have the opportunity to develop their own complementary but locally-appropriate outcome measures to reflect local needs. As there are risks that too much focus on specific national or local pressures may distort the direction of the Partnership, it would be helpful if partnerships were specifically directed to develop mechanisms for monitoring this.

Outcome measures need to replace existing national measures and be complementary to other national measures and targets.

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 ☐

Yes – nationally agreed outcomes for Health & Social Care should be included in all local SOA's but it is recognised that there may be a need for some local targets to be identified to reflect local challenges.

A link between outcome measures and SOAs will also support community planning arrangements.

There is a recognition that this will require more effective joined up performance reporting arrangements across NHS and SBC as a whole and applied across all care groups.

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 ☐

A partnership with joint accountability to Ministers and Local Authority Leaders will provide a more effective balance between local democratic accountability and accountability to central government. Implicit in this approach is a tension between national and local accountability. Clarity over the governance arrangements is essential and will need to be resolved at a national level.

Shared governance between health and social care, together with third sector and user and public partners will introduce welcome transparency and focus. Beyond the overall governance challenges between central and local government, there are some significant governance challenges that will need to be resolved however;

1. The role of the Leader of the Local Authority and the Chair of the Health Board needs to be clarified. We do not agree that being Chair or a member of the committee would compromise their governance role- indeed being Chair of the committee or a member may enhance this – accountability requires the ability to direct and lead and this should be a matter for local determination.

2. The health sector operates within 4 nationally-determined pillars of governance. These include financial, clinical, staff and corporate governance. Local authorities operate their own governance arrangements but the ways these are delivered will differ between councils. There are clear challenges in integrating these governance frameworks. In particular, an explicit recognition of the unique nature and challenge of clinical governance within the NHS and the importance of developing systems that guarantee these would be welcomed. A similar focus is also required on the statutory governance roles of the Chief Social Work Officer and other local authority proper officers, monitoring officer, Sct 95 Finance Officer and head of the paid service

3. There is a risk that there may be fundamental differences of priority between Local Authority Leader and the Minister regarding key aspects of the delivery of

services. Clarity over how the process by which these differences are resolved would be welcomed

More detail on the linkages/ relationship between the community planning arrangements and the Health and Social Care partnership would be helpful in the integration proposals.

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

Yes ☐ No ☐

The coterminous nature of boundaries for SBC with NHS Borders is considered highly important for this very rural area. It is recognised that in other areas, different arrangements may be appropriate.

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

Yes ☐ No ☐

The proposed arrangements set out an outline of how governance of integrated services could be delivered. In principle, these should ensure that governance arrangements are in place. There are a number of significant concerns with the proposed arrangements however;

1. The membership of the proposed Partnership would appear to be too small to provide effective oversight and governance. There are concerns that a minimum of 3 elected members and 3 Non-Executive Directors on the health and social care committees will not be adequate to discharge due scrutiny and governance of a significant budget given the potential size of the joint pot. In particular, the suggestion that the Chair and Vice-Chair form an 'integrated governance team' does not offer reassurance that the level of governance current within the existing organisations would not be diminished. We refer to our particular concerns regarding clinical governance discussed under Q5

2. As noted in Q5, the Statutory organisations will continue to operate separate governance systems. Coordination of partnership governance systems and Board/ Council governance systems is essential to avoid issues 'falling between cracks'

3. The role of professional advisors on the Partnership is unclear. Reference is made to Associate Medical Director Involvement, with an apparent focus on primary care, but a requirement to represent secondary care consultants. There is no reference to representation for other clinical professions. It would be more helpful if the document mandated a requirement for effective and robust clinical involvement and allowed partnerships to determine locally the appropriate means of delivering this.

4. References to user and carer involvement are minimal and tokenistic. Again we feel it would be preferable to mandate effective public and user engagement processes, including not just committee representation but a recognition that user engagement needs to be provided through additional mechanisms including user forums, panels and other methods. For example within the Scottish Borders, we have a well-established and effective joint Public Partnership Forum.

5. We note and welcome the requirement for Third Sector representation. However, we are concerned that there appears to be an assumption that the Third Sector by definition represents users. Although this may well be the case, many third sector bodies will also be providers and special interest lobby groups. Clarity on the role of the independent sector would also be welcomed.

6. The Jointly Accountable Officer is mandated as a member of the committee but no other officer and support members. In particular, we have concerns that the Chief Executives of the Health Board and the Local Authority are not members of the committee. Attendance, if not membership, of the committee will also be necessary from officers responsible for finance and other support services.

It is our understanding that the council currently is unable to establish a joint committee with full governance powers with other external bodies and therefore

the Local Government Act 1973 would need to be amended to enable the establishment of joint Committees with other public bodies.

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?

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Yes ☐ No ☐

The Scottish Borders Partnership welcomes the proposed robust performance management arrangements.

Where performance management crosses different organisations, it is inevitable that there will be occasions when dispute between organisations arises. A dispute resolution process will be essential to manage this. It would be helpful to have clarity as to whether these processes will be dictated nationally or, as would be our preference, locally developed

It will be essential to ensure that regulatory and inspection bodies coordinate both the measures and targets and that visits and inspections are coordinated and complementary to the performance management arrangements

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 ☐

The Scottish Borders Partnership considers that partnerships should have the ability to determine the overall scope of services within the partnership. The Scottish Borders Community Health and Care Partnership currently incorporates a wider range of joint services and we would want to have the ability to determine locally whether other services are brought under the Health and Social Care Partnership.

In particular, it is noted that there is very little comment in the document regarding mental health issues. Concerns have been highlighted regarding devolved arrangements relation to role of MHO/Chief Social Worker responsibilities –this is not covered in the paper but there has been some recent clarification from the Scottish Government on this matter.

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 consultation proposes two models of financial integration;

a. delegation to H&S partnership as a body corporate (aligned budget but managed by JAO)

b. delegation of functions and corresponding budget to one partner or another (eg Highland)

Option A gives some flexibility for local determination as to arrangement, however Option B would require significant structural change as per Highland model.

The Scottish Borders partnership would not support option B. It would be helpful to have clarity over whether only two models are available for consideration or whether other models of financial integration could be considered. We are aware that already the two models are being further refined.

Financial integration will facilitate flexibility of resource usage and reduce barriers but will not of itself deliver successful integration.

- Shifting resources will result in disinvestment in services. This will still be seen as taking money from one organisation to give to another. The Jointly Accountable Officer will require the skills and attributes to manage the human dimensions of these change proposals.

- It should be recognised that charging arrangements differ between council and NHS, and indeed between different councils. There is a risk that this could become a significant challenge to integration of services very rapidly. . Charging arrangements will need to be clearly defined to ensure clarity for staff and organisations.

- Shared services and backroom functions are likely to be a focus for potential efficiency gains through integration. As both councils and health boards have been exploring options for integration of shared services in other directions, it would be helpful if it was clarified whether this was a specific area for partnerships to focus on, or whether this was at discretion of partnerships.

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 ☐

Locally in the Borders we do have some positive experience of joint financial reporting and joint appointments. However agreement on shifting resources and managing efficiency savings has been more difficult to achieve.

It is recognised that the lack of flexibility in resource allocation can be a hindrance to developing seamless or integrated services. However, there are other factors that can be more challenging to manage. These include the tension between the needs of the integrated service and the priorities and pressures of the individual participating organisations. The complexity of working across organisations requires robust performance management to ensure that initiatives are delivered and timescales achieved.

There are numerous challenges that we have identified locally in terms of using budgets more flexibly. Organisational boundaries together with policies and procedures (financial regulations, reporting structures etc) make flexible use of resources difficult to achieve. Specific examples include different VAT regimes, separate auditing processes, terms and conditions of staff and capital spend/

borrowing requirements.

There are particular challenges around the tensions between financial integration and the financial pressures faced by individual partner organisations, especially the delivery of financial savings and the need to transfer resources to areas not included in the Partnership

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 Scottish Borders Partnership recognises there will be a need for a minimum group of services that will require integration. Guidance on what might be included is welcome but decisions about what is to be included should be determined locally.

It should be recognised that there may be situations where one partner would want to include a service and the other partner would not. Agreement of minimum level of services included should be reached locally, but clarity over the situation when this agreement cannot be reached would be helpful.

Ultimately, agreed delivery of outcomes should dictate which service would be included within the partnership.

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 ☐

The role of the Jointly Accountable Officer needs to be clarified in detail to allow an understanding of precisely what the role is, including a clear definition of their powers and scope. It will also be important to know whether it will be an appointed post or whether it can be an assigned role, as is the case with other statutory officers. Our preference would be that local partnerships are allowed to determine the form and organisational structure locally.

The Jointly Accountable Officer will need to be supported by appropriate arrangements and guidance to enable the ability to manage and redirect resources. There will be a need for further work on the technical arrangements for this person to carry financial accountability and delegation for a substantial budget in the joint pot. There will need to be clarification on the impact of this on the partner organisations' financial regulations, codes of practice, lines of accountability and financial / management reporting as current arrangements will not be adequate as we move towards integration. The relationship between the JAO and the financially accountable officers in the partner organisations needs to be clear as does their respective responsibilities. There needs to be further consideration of the relationship of the Single Accountable Officer and with other proper officers in both the local authority (Head of the Paid Service, Monitoring Officer, Sct 95 officer and Chief Social Work Officer) and the Health Board (Chief Executive, Chief Operating Officer, Director of Finance etc).

As previously noted, single financial authority is only one aspect of successful integration. The JAO will therefore require someone with skills to manage the wider challenges of integration, including strong vision and leadership, change management skills and the ability to engage with both clinicians and elected members.

The post will be very dependent on support and leadership from the Chief Executives and the Leader and Chair.

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

Yes ☐ No ☐

As noted above, clarity over the scope and powers of the Jointly Accountable Officer is required to determine how it most appropriately sits within individual partnerships. The position of the JAO is likely to vary depending on the partnership.

There will be challenges for this post in the relationship with other senior officer posts.

If the JAO is a new post it will need to be considered locally, and will be determined by the size of the resources delegated to it. The detail of how the post would be created and recruited to would also need to be determined locally, as different partnerships may choose to merge posts or create new positions.

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 role of localities will be important to influence planning and delivery of services, and should be involved in developing Joint Commissioning Strategies. However, it is important to ensure that overall strategic direction remains at Partnership level and economies of scale continue to be realised.

The partnership already has coterminous localities. These also on the whole reflect GP groupings.

This approach to locality planning has already supported the work undertaken to date in Borders with Cheviot and Tweeddale developments which were cited as good practice by the Christie commission and which attracted a visit from the Local Government and Regeneration Committee of the Scottish Parliament.

Therefore, determination as to what constitutes “local” should be decided locally.

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 Scottish Borders Partnership supports the need to ensure that local professional groups, both in health and social care are central to the planning and delivery of services. This reflects our current ways of working. The Partnership does however have concerns over the manner in which this is presented within the consultation;

- The consultation refers almost solely to the involvement of GPs. Other medical and wider health professionals have critical roles in the planning of integrated working. It would be helpful to have clarity over the status of local professionals other than GPs within the integration proposals.

- We recognise that GPs are independent contractors. We feel it is essential, if they are to have a central role in planning of services that they also carry accountability for decisions that they may make. Details of mechanisms for ensuring that this happens would be welcome

- We have concerns that the consultation document does not recognise the potential value of secondary care involvement in service planning and delivery. The expertise and perspective of secondary care could be equally as valid in effective planning of services

- Although this question asks about the involvement of local professionals, we feel it is important to emphasise once again, the critical importance of user and carer involvement, as they bring an expert view of services from a recipient viewpoint.

To summarise, all staff and professional groups should be involved appropriately.

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?

Effective engagement of clinicians and social care professionals will require commitment to providing appropriate resource to release them from their frontline duties. We would suggest that this role should be incorporated into job profiles and job plans to ensure that it is seen as a core responsibility.

We welcome the commitment to leadership development for GPs, but this needs to be extended to the wider professional community and should link with existing leadership development programmes.

As noted in our previous response, there needs to be accountability structures

for those involved in service planning to ensure that they carry a degree of responsibility for decision made.

NHS Borders existing organisational structures place clinical involvement at the heart of decision-making. We would therefore wish to replicate or use this existing tested structure as the means to clinical engagement. It is likely that other partnerships also have effective systems for clinical involvement in service planning. Local Authority systems have a simpler professional involvement process as social work management lines tend to be professional reporting lines as well.

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 ☐

As noted above, within the Scottish Borders partnership, there are natural congruencies between locality groupings and GP clusters. Partnerships should have the ability to develop locality structures locally and be flexible about arrangements

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

As noted above, we would welcome the opportunity for communities to have a clear role in influencing locality budgets and local service development, but this will need to be balanced against the need, particularly in small partnerships such as Scottish Borders, to ensure that services are delivered at the most effective level of organisation, both for service users and for the organisations.

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 needs to be determined locally, as localities will be different and specific to the area concerned based on locality service functions.

Do you have any further comments regarding the consultation proposals?

In summary, we welcome the direction provided by the consultation document in moving to integration of health and social care.

We have noted areas where we would wish to see more clarity or a change in the emphasis or proposals.

In particular we would note that it is disappointing there is no mention of public health and community wellbeing and the focus on prevention is limited.

We are concerned at the limited references to user and public involvement and the simplistic nature of the proposed involvement.

We are also concerned that there do not as yet appear to be solutions to the fundamental governance challenges in relation to the local accountability of the Council and the national accountability of the Health Board.

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