
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

Yes – as an organisation working with people with learning disabilities we believe that this further extension is essential as soon as possible. The current arrangement of diverse practices from individual local authorities and health boards under the name of “local democracy” has led to a patchwork of care that works inefficiently and prevents those who wish to use services from having clear expectations of what they can expect.

The separation of budgets and responsibility in different agencies who should be working together creates a disincentive for improving services and support.

We think the increased coordination for all adult care groups will greatly improved efficiency and lead to much better outcomes.

Outline of proposed reforms

Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

Yes No

Comments

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

We think this will be an improvement on the current situation when the existing National Outcomes have few indicators for people with disabilities. The idea of publicly accountable outcomes for social care is very important. These outcomes need to reflect the range of services and support that local authorities provide. Otherwise there is a danger of “target meeting” developing. Where only some or a limited range of outcomes is specified, rather than using this as a measure for the general improvement of social care, the focus may settle only on meeting specific target outcomes to the exclusion of other areas and other forms of support.

Further we are not sure whether this new requirement will be enforceable for individuals who cannot get a service or receive a poor service.

In a period of “austerity” when there are both public service spending cuts and welfare benefit cuts, life can become much more difficult for people with disabilities and being able to receive support. Those who fall out of the “eligibility criteria” may be missed by this approach unless there are “preventative” services included in the outcomes. And there must also be some quality measures to the outcomes to avoid poor quality services being used to meet simple numerical 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

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

We believe that there should be external scrutiny to complement Ministerial and Local Authority oversight.

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

Yes No

We think this would be a positive move and would like to see a situation where Health Boards which are for the most part coterminous with a number of local authorities had single health and social care partnerships which covered all local authority areas within their area.

This would be a big step forward to having standard practices within much larger areas of Scotland and where different practices could have an opportunity for large scale assessment of their effectiveness.

A reduction from 34 CHPs to 32 HSC partnerships is not a significant reduction in bureaucracy and we think there should be clear scope to go further. At a time when a number of councils are seeking much bigger cooperation between themselves, then we think this should be encouraged by allowing HSC partnerships to cover more than one local authority.

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

Yes No

We think that this system is enhanced by the inclusion of service user/patient and third sector representatives. However these are non-voting members which we think brings in a question of status over how important these members really are to the running of the committees.

Secondly there is no information on how citizens can be elected or nominated to participate within H&SCs to provide scrutiny of the actions of health and social care services. We would like to see more people with disabilities take part within these committees as part of an open system of nomination and election.

We think it is important that independent participants within these committees are seen as more than just the same old faces who have been selected because they are known to be reliable.

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

We think that this will be a start. We would like to assume that there will be good will by all partners in a HCSP and that any failures in meeting outcomes be worked through cooperatively with support being put into place.

At the same time we think that further review of the effectiveness of such performance management arrangements be looked at over time. It may be that in the long term some other arrangements may be needed for any “failing” public bodies.

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

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

We are unclear over how both of the proposals will work in practice. There are clear cases such as where people are in hospital and could be “reabled” to live in the community. In these cases budget coordination will make sense to the parties involved and are likely to work

But in other cases, existing budgets remain fully committed with only small amounts of flexibility in them. We are not sure how any change in these will work when only small amounts of money are released from any one change or cooperative act.

Control of budgets needs more than a top level manager, it also needs buy in from those further down responsible for and dependent on smaller service specific budgets. For example, district nurses are clearly a health resource even after integration and it will not be easy to convince local manager to leave vacancies unfilled in order to spend money elsewhere such as on home care when there is still a waiting list for district nursing input.

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

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

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

We think that a strong lead on locality planning is important and that this should come from the Scottish Government. However we are a bit unclear over how the move towards Self Directed Support, where individual commission their own services fits with this emphasis on professional led locality planning. We understand the need to “manage” the provision of services so people are able to get what they want but there is no mention in this section about how the individual service user or patient will be involved in locality planning. There is one reference to patient and service user representative in the principle section but nothing in the how it will work in practice sections.

We are concerned that there is a real danger of the “professional” knows best approach – which is usually a defence of current practice. We do not accept the myth that professionals whether medical or social care are neutral on issues of best practice. Many of our members remember debates with health professionals who told us people with learning disabilities would never live in the community because their needs were too complex to be dealt with outside health settings. Over time this has proven to be wrong.

We do not yet know which of the current assumptions of health and social care professionals are neutral or based on selective interpretation of scientific data. There may be some biases in the views of existing professionals that will be formalised in the planning process as a result of this measure. Of course, such biases also affect other members of the community and are not in themselves reasons not to involve people. We are all wiser in hindsight.

We believe that such professionals should be an integral part of the locality planning process but that this should be an inclusive process where those that

currently use services and those that might use them in the future take part in a joint locality planning process.

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

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?

Time needs to be set aside within the working week of such professionals to take part in such planning. We often hear of such professionals who lack the time or are too busy elsewhere to share their experience.

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

It has probably been a long time since GP practices had discrete geographical areas attached to them. It makes no sense to treat local communities such as Ettrickbridge in the same way as Edinburgh. People who stay there would recognise each as a distinct community. There needs to be a more flexible way of looking at what is meant by a community and how the resources available for that area can be best used.

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

As much as possible.

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

We tend to like small groups/sizes but feel that this misses some of the realities how people organise their way around the health and social care facilities available to different areas.

Many of the people with learning disabilities we work with have much more complex relationship with social care and health services than just the locality they live in, travelling many miles to access respite, day services and special needs education. There are many communities and this policy should be flexible in how these needs are addressed.

Do you have any further comments regarding the consultation proposals?

Comments

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

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