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## 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?

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Yes  No

Given that we are currently aiming for integration and service redesign of our substance misuse services, we'd be concerned that these proposals result in delay or subsequent unanticipated change.

Integration of services for those suffering problematic use of substances and those in recovery would be desirable but not all statutory services would be within the scope of these proposals.

Conditions associated with old age are also experienced by those younger than 65, for example alcohol related dementia. Arbitrary thresholds such as age may make achieving improvements in areas such as Alcohol Related Brain Damage tougher to achieve.

### 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?

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Yes  No

It is laudable to seek to remove disconnects through integration, however, the range of connections necessary to secure effective care and support for vulnerable people such as those with an addiction are much wider than covered in this proposal. This would include specialist NHS Substance Misuse Services, employability, housing and aspects of acute care and criminal justice social work.

It is unclear:

- Whether the focus will be exclusively to address a pathogenesis model or also include a focus on salutogenesis (promotion of health and well-being). There is a risk that the improved focus on prevention as envisaged in the Christie Report may be lost. This is a relevant question as the Scottish Government monitors the shift of responsibility from the NHS to Councils in England for Public Health.
- Does mandating elderly care national outcomes within the SOA in the first instance imply that this will occur subsequently for other outcome areas too? If so, it would be useful to state which new mandatory outcomes the Government anticipate adding at a later stage.
- Whether in creating new joint standards, existing related NHS HEAT targets or standards and Council Community Care targets will be repealed.
- How the framework will address the suggested disconnects between primary and secondary care that CHPs were alleged to have been unable to address. If CHP's struggled, it's not clear how the new proposals will improve matters.
- What quantified benefits will accrue? The list of potential benefits and savings in Annex E is unquantified with little evidence to demonstrate that the changes proposed will address the increased expenditure projected in Figure 1.

The proposals give the impression of a very radical solution to a specific problem of cost-shunting between the NHS and Local Authorities for older people's care with potential consequences for care groups out with the scope of the integration. It's concerning that the consultation doesn't appear to have considered the lessons from other integrations in an attempt to anticipate and mitigate unintended consequences.

We'd wish the Government to specify the anticipated future implications for other partnerships such as Alcohol and Drug Partnerships (ADPs) from the development of H&SCPs.

We wonder if something more straightforward, at least in the first instance, such as the model offered by ADPs for collaboration on substance misuse, might be a less complex approach with less risk of unintended consequences.

We'd concur with the issues that must be addressed during the development of this proposal listed in Annex B.

### 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

The proposed governance arrangements for adult health and social care appear to be very complicated. How will unanticipated intractable problems be resolved where there is a difference in view between local and national perspectives? There is also a risk that the new partnerships will be subject to three performance management infrastructures rather than a single new process.

**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

The principle that local Community Planning Partnerships (CPPs) should decide what goes into SOAs, based on their assessment of local priorities, should remain. Some elements of national outcomes may be relevant to be above or below the waterline in different CPPs depending on local circumstances.

### Governance and joint accountability

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**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?

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Yes  No

The proposed potential for variability in governance for non-adult health/ social care such as children's services may result in these areas becoming the 'poor relation', particularly if they don't have a statutory basis. Also, the dividing line between issues included or excluded within the scope of adult health and social care is rather arbitrary and the complexities of vulnerable people don't often separate so easily. An example would be the cross-over between health, community care, social care for those within the criminal justice system.

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

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Yes  No

This could potentially weaken the links to CPPs and the mandate of locally elected members. We would not support this.

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

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Yes  No

The proposals are very complex and leave many unanswered questions. They don't appear streamlined or proportionate.

It's unclear what effect the ability to make decisions without referring them "up the line" would have for LA policy and resources committees or NHS clinical governance & staff governance committees.

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**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

If local partnerships are empowered to work to locally decided priority adult health and social care outcomes and are able to collectively report on their improvement from a service users' perspective then yes. However, citizens may however have some concerns about the apparent diminution of governance around non-adult health and social care services previously delivered by CHP's.

Public confidence is a function of the performance they experience, either as a user of services or as a recipient of meaningful performance information. Consolidating and reporting performance information across different systems will be a challenge.

The relationship between CPPs and HSCPs is unclear. Will HSCPs be a member of CPP's in addition to LA's and HB's?

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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

Whilst local flexibility according to circumstances is welcomed, there should be consistency across Scotland across key areas such as addictions services or primary care independent contractors.

### **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

This depends on the instruction to be given about which resources will be within the scope of integrated budgets? Eg housing, parts of acute hospitals, mental health, GP Local Enhanced Service Contracts, etc? Also, it would be useful to clarify:

- whether the option to form a body corporate includes the ability to employ staff directly
- which parts of the HSCP would be included within the self-directed support agenda.

**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

If these arrangements are to work, there must be a singular set of obligations that all partners are equally bound to deliver. There should be no other obligations that additionally apply to one partner only. Otherwise, tensions in prioritisation will emerge resulting in difficulties in making flexible use of resources and the Accountable Officer may be pulled in different directions.

Pooling and streamlining residential detoxification budgets (held by the NHS) and residential rehabilitation budgets (held by the local authority) would be a helpful development.

**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

It is essential that ministers provide direction on the minimum categories of spend.

We'd suggest that ring fenced alcohol and drug allocations to ADPs should go

through HSCP's to enable the creation of a pooled substance misuse budget to enable greater integration and streamlining of services

### 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

Partially. Financial authority is only one part of the equation. Freedom of manoeuvre is often constrained by other factors such as a nationally defined GP contract. Notwithstanding financial authority, a shift in the balance of care will only occur if partners and stakeholders agree to this.

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

Yes  No

### 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

Leave to local determination.

**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

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in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

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Yes  No

We'd suggest that this duty be expanded to include representatives of service users, families and carers and that the duty to consult be expanded to a duty to involve. Also, in creating this duty as a precedent, GP's and others may wonder why such a duty wouldn't equally apply to other areas of their patients' or clients' lives such as children's services, etc.

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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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In our experience, making the process manageable, particularly with the provision of good intelligence and other relevant information. Also, enabling clarity of the budgets available to spend or redeploy for what purpose.

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**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

This is a matter for local determination. For example other models could include locality planning being incorporated in to existing locality community planning arrangements.

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**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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This is a matter for local determination. There will be a balance to be struck between local devolution and the scope of the agenda. Too large a scope may make local devolution unmanageable, too small a scope may not make it worthwhile or may result in inequities.

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**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

In Aberdeenshire, there are 6 Administrative areas currently in existence. It would be sensible to continue with this model. This implies an average local population of 40,000 people.

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

No

**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)**

No