Annex G Consultation Questionnaire
Response from Hospital Patients Council. NHS Ayrshire & Arran

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 Yes, in a way it is fair to focus on outcomes for older people. This is because of the ageing population and the sheer quantity of numbers. Also the specific problems of unnecessary hospital admissions and delayed discharges - a huge problem currently. However other areas should not be forgotten e.g. young chronic sick and children's services.

We notice that the consultation document is careful to couch its references to care for older people in terms of 'improving outcomes' and 'performance management', but we worry that there may be an anticipated need to reduce per capita spend on older people as their number increases. We point out that age, as a protected characteristic under the 2010 Equalities Act, can never become the basis for decisions about access to scarce health care resources. Older people have paid for, and should receive, the medical interventions appropriate to life in an advanced economy. For the avoidance of doubt it should be stated explicitly that the new arrangements for adult health and social care are not intended to make emergency admission to hospital, or any other pathway to healthcare, more difficult for older people. Of course nobody wants to be admitted to hospital when they don't have to be, or to stay there longer than they need. It is the avoidance for all service users of unnecessary admission and delayed discharge which is the proper focus for an integration of services and a shift from acute hospital to community care.

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 The framework for integration only states that an approved and standard level of care throughout Scotland will be achieved at each local level by a combined health service and social work merger with a combined budget. Various ways of implementing this are discussed later. But in effect each local area will set up its own variant. We doubt this could be described as comprehensive as there are many variables and how this will function in our own area is anyone's guess. Adequate funding is essential. We have a huge fear that if the system does not

achieve targets due to inadequate funding it is too easy for the Scottish government to abrogate responsibility by saying the fault lies at a local level.

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 We agree that radical reform is needed to improve planning and delivery of services, and to make much better use of available resources, though the success of the proposals will depend on more resources (financial and human) being invested in community provision and a much larger degree of involvement for GP's. We agree that nationally agreed outcomes should apply across all of Scotland to remove any risk of postcode lottery.

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 3.10 states areas will be free to set local joint outcomes for some matters. No details are given. It would be interesting to know which matters. Legislation will provide a significantly strong mechanism for this but again only as long as the budget is adequate.

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 Yes, accountability to ministers and LA leaders would seem to provide proper accountability. Although in the end Scottish government ministers would themselves have to be held accountable in terms of making certain there is adequate funding.

But there may be a more radical way. Councils are directly elected, and feel responsible only

to their electors. They cannot be held to account for their lawful decisions by any other party. NHS boards, on the other hand, are appointed directly by the minister. Many believe in the light of some spectacular recent failings that this arrangement introduces a problematic lack of democratic accountability. The introduction of a third tier of provision under the direction of a Jointly Accountable Officer reporting to as many as four Chief Executives could make this worse. The issues may perhaps be amenable to a simpler solution: consideration should be given to democratising health boards. Perhaps these should in future be comprised entirely of councillors appointed by their councils.

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

Yes ☐ No ☐

Comments Each local authority area has its own demographic features and particular problems so we don't particularly see value of health and social care partnership covering more than one area.

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

Yes ☐ No ☐

Comments Difficult to know whether proposed committee arrangements are appropriate or not for governance. Difficult to know how well they will function as is untried system. However it is very important that senior figures in the partnership e.g. the JAO listen to and take account of the views of healthcare and LA staff in the way that the system is working and pass these views to chief execs and the partnership committee.

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 There is little said about what happens if local services are failing. Would the partnership be disbanded? Who would take responsibility for running services? Much more needs to be known about this.

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 We don't see any reason not to merge budgets for other CHP functions with the partnership budget if health boards and LAs thought appropriate.

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 ☐

Comments We are not sure as to which model described will use money for best effect. It will be a matter of trying and then modifying the system if necessary. Flexibility is important. Again it is incumbent upon each partnership through its health board and local authority to make certain that the Scottish government through its ministers provides adequate funding. Here are some additional thoughts:

Three better than Two?

In principle it seems improbable that poor integration between two providers will be alleviated by the creation of a third. It's more likely the problem will simply be shifted to new boundaries, unless it is envisaged that the third provider will have responsibility for all aspects of adult health and social care. (It's hard to see from the document that this is actually precluded?) Clarification on the scope envisaged for the new arrangements would let people form some useful estimate of their chances of success.

First Integration Model: Delegation to the Partnership

This model gives the Partnership responsibility for those areas of adult health and social care delegated to it under the Partnership Agreement. Presumably the Joint Accountable Officer may

discharge this responsibility directly, by employing front-line and support staff many of whom will currently work for the NHS or the Council. Or he may do so indirectly, by using his budget to purchase items of service from the NHS or Council as appropriate. Of these alternatives, only the latter seems feasible, since the former would raise immense practical problems of staff transfer and management.

Item-of-service purchasing may also be problematic, however, since it doesn't deliver integration. The same people in the same organisations would deliver the same services; only the money would be pooled, before being spent.

Second Integration Model: Delegation to the Partners

In this model the Council delegates to the NHS (and vice-versa) those care categories where lack of integration has proved troublesome. For example, the Council, which currently arranges and pays for home care packages, might in future ask the NHS to do so, transferring to the NHS the funding it budgets for this purpose. The NHS would spend the funds to supply the service. It would therefore manage all the staff concerned in the delivery of the service; it would have control of an individual patient's whole care package; and it would thus be in a position by and of itself to 'shift the balance of care'.

This model appears practicable, and it is the one most worthy of support. But it will require elected councils to commit budget for others to spend. They would have to work with the Joint Accountable Officer in the Partnership Committee to assure quality of services and value for money.

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 See answer to Q10.

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 See answer to Q10.

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 The JAO appears to have the authority to make the shift in investments required. However, we have concerns re the reporting structure for the JAO - to the CEOs of the Council & Health Board.

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

Yes ☐ No ☐

Comments The JAO appears to be suitably senior.

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 Locality planning should be taken at a local level and must involve local professionals.

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 The partnership should be involved in the majority of decision making but they must consult with and listen carefully to local professionals and other groups.

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?

Comments Revision of GP contract to require participation and to include relevant duties. Training for GP's and surgery staff.

GP's have a key role in controlling access to acute and community-based services and in caring for patients at home. Their surgeries could be important logistical and information centres. The place of GP's in this initiative needs to be thoroughly planned and contracts revised to ensure their enthusiastic participation.

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 ☐

Comments No comment here.

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

Comments No comment here.

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 ☐

Comments No comment here.

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