

## 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

The step approach may build in a two tier approach which could become entrenched.

Change may be better achieved across the board utilising an incremental approach (e.g. commencing with management structures in both care groups simultaneously).

It is likely that different issues will arise within Adults and Older Peoples services and so an incremental approach across the care groups will highlight these. As opposed to moving forward with one care group with the assumption that what works/doesn't work in one care group will be replicated in the other. Avoiding this approach will allow local areas to address issues in both services as they arise, supporting one another through the change process and provide feedback to Scottish Government.

### Outline of proposed reforms

**Question 2:** Is our proposed framework for integration comprehensive? **NO** Is there anything missing that you would want to see added to it, or anything you would suggest should be removed? **YES**

Yes  No

The major issue of bringing two entities together is that the culture of one may subsume that of the other (Barnes et al 2007). This would be a distinct disadvantage to Service Users/Patients. The skill mix and differing approaches, most starkly those of the medical model and the social model, could be eroded or lost completely. On this basis it is **extremely** important the framework clearly acknowledges the differing approaches, philosophies and models of care and

support. More importantly the framework should explicitly state the need for these to be maintained within any new structure.

Other than the above, the general outline appears to have covered the major aspects. However without the knowledge of which specific Acute Care functions would fall under the new arrangement, it is difficult to comment upon this fully.

### 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

Sharing outcomes across the agencies should assist in building services that work toward the same goals. However without a shared interpretation of these outcomes from the outset, the point made in Question 4 below could disrupt the process significantly.

In addition to this, any outcomes should include a measurement of the models of care being operated. This would require careful and clear articulation around demonstrating that the value base, professional skills and theoretical paradigms that each profession bring to the new agency are maintained. This may be partially demonstrated by agencies stating which profession manages which elements of someone's care and where the generic model is used. This should guard against agencies developing a generic case manager model which focusses on pragmatic issues and loses theoretical and professional reflection to the detriment of the Service Users/Patients' rights and quality of care. Furthermore it would be extremely useful for government and organisations, if systems captured the percentage of front line staff time spent on processes vs. direct care activities.

There has clearly been a move toward bureaucratic processes over the years and the integration agenda could address this within its structures. In turn this could identify how staff time is being used and whether the skill sets of different professionals are being effectively utilised. Highlighting this could assist in a move to more effective use of professional time with Service Users/Patients (for which they are trained) and administrative tasks being carried out by those trained to do so.

Service User engagement around organisational performance in meeting their needs is essential. However effective and meaningful engagement requires consideration of effective models and provision of appropriate resources. This should be clearly articulated within any outcomes model.

**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

Thematic 'outcomes' would be useful to allow them to be adapted to local need. However the issue of 'outcomes' will require careful management as these may be viewed differently within different agency contexts. It is also important to note that any move to outcomes could be viewed from a HEAT target perspective. This could create services/organisations that are focused upon what they will be measured against as opposed to focussing on need.

One theme that should be seriously considered is that of people protection. Certain staffing groups within the broad health and social care services find it difficult to engage with training around child and adult protection. This should be clearly addressed within any outcome measures/local planning. Supporting and protecting those we are providing services for should be seen as every professional person's responsibility, as should the need for them to be offered relevant training and importantly for them to avail themselves of this training.

## **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

This should provide an approach which is democratic. However with which set of politicians would the final decision making power rest. Were it decided to split this according to issues/type of decision, this would need to be categorised from the outset. Clear lines of demarcation and accountability will be required to ensure the new arrangement functions well and doesn't spend time and energy attempting to address issues raised by two separate governing political dimensions/bodies.

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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

There are clear advantages to creating co-terminus boundaries with regard to inter – agency working and public access to services on an equitable basis. However clear guidance would be required and consideration given to the impact in some areas of the new organisation being bigger than any of its contributors/funders.

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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 Committee arrangements appear sufficient though the effectiveness of the arrangements will rest with how well the Committee functions. Clear guidance and dispute resolution would be required from the outset along with agreement around the expected changes they will achieve.

To enhance the democratic element of what will be a powerful and resource

rich agency, perhaps two other elements could be considered. Firstly, perhaps the Chair should be someone who has been democratically elected e.g. MSP, MP, List Member or Local Councillor, with the Vice Chair rotating and providing professional advice to the Chair. Secondly, although Service User/Patient representation is noted, perhaps this should be strengthened within a 'critical friends' model, whereby a group of trained and briefed critical friends review the Committees proposals and respond publicly.

**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

As above. The role and function of Committees would require clear articulation and publication/publicity in order that the public clearly understand which body is responsible for which services/actions.

**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

Where local arrangements appear to have worked well after a period of assessment, localities should be able to take up the option of extending the arrangement. However this would require local consultation and recognition of the differences in both function and organisation of other services. Perhaps moving to this stage should only be completed following successful audit outcomes of the first phase. This said the effective splitting of functions leaving, for example, child care within local authorities and adult care moving elsewhere, could create communication and practice issues from a family perspective. Perhaps their should be provision made or protocols agreed, specifically around how the new entities will engage at the holistic family level.

### **Integrated budgets and resourcing**

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**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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Partially Yes  No

However, where the ‘delegation’ model is chosen, clear guidance would be required to ensure Service Users/Patients continue to receive the broad range of expertise available and that which is most suitable to their needs. The major point here is to mitigate against the development of an homogenised worker who neither functions as nurse, social worker, OT or Psychologist, losing their professional identity and with it their value base and ethics. This can be managed effectively with strong internal management and professional supervision arrangements. However in the initial stages it may be useful for Scottish Government to poll staff in confidence regarding these issues.

Furthermore the point made in question 3 around utilising staff to carry out the functions for which they are trained, clearly addresses the issue of using funds to best effect for Service Users/Patients. Systems that rely upon professional front line staff spending a significant amount of time on administrative functions should not be encouraged. The new arrangement should consider carefully how it will gather its data and who will record this data and where front line staff are doing so, what impact this has upon their ability to meet the needs of their Service Users/ Patients.

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**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

The main issue here would relate to how resources are allocated within the agency. This should clearly be done in response to local community level needs assessments and in response to the assessments of need made by its staff with their Service Users/Patients. Unmet need should be recorded and used for planning purposes by the Committee.

Another issue relates to contracting third sector organisations who can sometimes struggle to operate a service which meets the needs of the Service User/Patient, funding organisations, the contract and its own philosophical basis. Contract

compliance would need to be open, honest and robust and funding cycles maximised to allow third sector agencies time to develop their service fully to best meet need.

**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

However the danger of setting minimum categories is that these either become the only centres of activity taken forward or that they become established as the best funded activities. Ministerial direction would need to take account of this.

### 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 shift of investment referred to here would seem to indicate the need for *cultural change* to achieve the shift in the balance of care, so that resources become integrated not just in the budget but also in how people conceptualise

these resources. Of course, as with any change in culture, this will no doubt take time; however having a Jointly Accountable Officer to enact this change by embodying the integration of health and social care resource allocation will be an important aspect in such change. Regular, consistent communication between JAOs in areas where change is just beginning and those in senior joint appointments *currently* managing health and social care services might be an important part of effective change (this might be a more formal mentoring relationship).

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

Yes  No

Yes, senior executive level or equivalent would seem to be an appropriate level of seniority for the Jointly Accountable Officer.

### 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 Scottish Government may need to consider a framework which will allow varying models to be taken forward to best meet local need/issues.

**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 Duty to Consult should be more specific as to who should be consulted and this should include all professional 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?

Local events, up to date information, transparent outline of impacts upon roles, remits and methods of working. Most importantly Scottish Government may have to stipulate that front line staff are provided with protected time to engage with the planning agenda. Without this, the classic operational/strategic divide is likely to grow with front line staff unable to engage due the pressures of caseload work etc.

Furthermore, as noted elsewhere in this response, the systems used within these new entities should be designed from the perspective of assisting front line staff in their care and support of Service Users/Patients. The organisation could then determine how it will use this information in its planning process, rather than systems being designed to meet organisational needs.

**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

Local Authority wards may be more effective in some areas. GP clusters could serve to be a useful model but this will depend upon the locality. Another advantage may relate to involving GPs in the processes as equal planning partners with responsibilities for elements of the overall delivery.

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

This will depend upon local environment. This model may be most suited to rural and isolated areas. Within more urban areas it could create variances which make it more difficult to manage the whole.

**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

Arranging localities around existing and publicly understood boundaries would be preferable. This may mean a town, cluster of villages etc. Again the fit to Local Authority wards may make most sense here.

**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