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 ☐

It is a good idea to focus on one area to achieve the model of integrated working first. The second priority would be areas of deprivation to address health inequalities

Older people are the largest users of NHS inpatient services, making up 60% of acute admissions and using 70% of bed days. It is reasonable to assume that services set up to have an organised and effective approach to the care of older people will take a similar approach to younger patients, but the reverse is not always true if staff lack awareness of some of the specific needs of frail older people.

It is important to ensure that people realise that 'unplanned' is not the same as 'unnecessary'. Patients with fractured hips and acute strokes are always ‘unplanned’ admissions. The goal should be to avoid discharge delays and **unnecessary** admissions.

More economic detail behind the plans would be helpful. Acute hospital care is expensive and some aspects of the costs quoted are not surprising. The costs tend to be front-loaded - the initial part of admission after a fractured hip or stroke is much more expensive than the later stages of rehabilitation - so it would be useful to clarify what potentially can be saved and where from.

There is a risk of distortion of priorities by adopting such a focus.

It seems sensible and practical to focus on one area initially. In order to avoid negative consequences for other areas perhaps consideration should be given to a phased approach to their inclusion, based on an evaluation of phase one.

This is perhaps the principal purpose of the changes. The concern is that a major public sector structural change has been proposed to solve this particular problem, when more modest functional/procedural changes might have sufficed.

This is a pragmatic approach in view of demographic change. However there are other groups with significant needs – especially the young disabled who fall between the extremes of age and who could be at a stage of their lives where they would otherwise be productive.

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 ☐

This is very comprehensive but will require strong leadership and clinical input to strategic implementation.

There is however a lack of detail on how problems would be addressed and the extent to which local solutions would be allowed/monitored - since there is a need to ensure equity of standards of care across Scotland, but that goal may be achieved by different means in different geographical areas.

Successful integration depends on working together in a shared culture, with the same systems and structures - but structural change alone will not achieve true integration.

There needs to be more specific information around the partnership 'control of

some expenditure on acute hospital services'. Which services? This should be explicit, to avoid any implication that acute care for older people is in some way being rationed.

A framework should set out broad principles covering the main areas required to begin the process of integration. What happens thereafter should be based on a robust evaluation of this significant change in health and social care delivery.

This sounds OK on paper, but will it work on the ground?

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 ☐

It is important to encourage flexibility in how this is implemented at a local level.

Agreed outcomes would be a welcome development but these need to be backed up by evidence of their usefulness (i.e. not just 'seems a good idea'), simple, easily and reliably measurable and supported by robust IT systems to allow accurate regular reporting. Uniform use of these outcome measures across Scotland will be essential given that many Health Boards interact with various local authorities.

This may provide the incentive, but does not guarantee the outcome.

This approach provides a sufficiently strong mechanism to start the process of change. It remains to be seen whether it is enough to achieve the breadth and depth of change that is needed. This may be unlikely and as mentioned above a robust evaluation, starting as the change rolls out, involving both quantitative and qualitative approaches should be undertaken to inform what else may be needed.

It is relatively easy to set targets - the difficulty lies in the effort and support required to meet them.

Charities/third sector are important players in this field and could be encouraged to be more integrated.

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 ☐

Uncertain about this but greater flexibility to assess local needs and priorities.

Equity across the country is important, but this may mean very different challenges in different areas.

The evidence base strongly suggests that a smaller number of outcomes should be the goal, at least initially. The changes that this paper indicates will demand different ways of working on an unprecedented scale. This is likely to throw up unintended issues that will need addressed. In addition to the issues raised in this paper, its success will also depend on time for dialogue between primary and secondary care, health and social care. Through dialogue there will come a deeper understanding of other parts of the health and social care service at local level. Without this, integration is likely to remain superficial with very limited capacity for the level of change the SG is looking for. The outcomes can be increased and extended once people and organisations have developed and are more used to different ways of working.

Outcomes can skew and distort the real picture and clinical and social priorities. Great care must be taken to avoid this.

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 ☐

There should be some Health Board accountability too.

Yes, where this is appropriate for reasons of geography or population size.

It should achieve this aim, but there may be inherent tensions in such an approach that will create its own difficulties.

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

Yes ☐ No ☐

It depends on population size and demographics.

Yes, where this is appropriate for reasons of geography or population size.

There may be situations where it is more effective and/or cost-effective to consider the provision of services across more than one authority area.

Possibly if this is felt to be the best option at a local level.

Yes - or we risk losing integration and economies of scale (particularly in larger Board areas like NHS GG&C)

May be too unwieldy. Suggest prudent to pursue proposed scheme initially and assess results.

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

Yes ☐ No ☐

But concerns about financial decision making, especially health to social care. May well be tensions between 'camps'.

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 ☐

More detail is required. For example, how do these arrangements fit with the current health and social care regulators?

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 ☐

Care of the elderly could sequester by far the majority of resources if not careful.

This may be appropriate for other care groups with similar needs.

Is there any evidence to suggest that this should be offered as an option? May be best to begin with services for older people at least initially.

Yes - following Leutz, one of the “five laws” of integration is that “You can’t integrate all of the services for all of the people” (http://www.kingsfund.org.uk/blog/integrated_care_laws.html). There should be maximal local discretion about what is and is not included in the new arrangements.

One respondent (Medical Adviser in Sexual Health) indicates that there are likely to be significant opportunities resulting from integration in sexual health and Health Boards should be encouraged to pursue this

It will be important that Boards and Local Authorities demonstrate the ability to undertake these functions.

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 ☐

There remain significant concerns about decision making and shifting resources. What mechanism(s) would be in place to assess the total care required by an individual elderly patient to enable them to stay at home, vs resources for community services to provide all necessary care for an area? Good principle for a model going forward, but will inevitably need more resources.

Potentially yes: the goal should be to provide the most appropriate assessment/ treatment/service to the patient or service user without barriers of budget ownership or organisational base. The pathway should be seamless regardless of where the client/patient initially presents.

There is insufficient evidence provided at the moment to unreservedly support this proposition - any answer would be speculative at this stage.

However, both models seem a good start. As mentioned earlier an evaluation of both models is needed as they progress to determine how money is used under each model.

On balance, integration has the potential to minimise duplication and waste, and to provide appropriate care in the least intensive (and expensive) manner.

One Medical Adviser having been involved in the merging of 2 NHS services, suggests that the most important thing to recognise is that this may take a long time. Many of the staff inherited did not (fully) reflect the needs of the integrated service, but until they retire or move on, resources cannot be efficiently "moved across" to the other side.

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 ☐

This is likely to be extremely difficult and challenging.

In various areas of Scotland there are consultant geriatricians working across the primary/secondary care interface - notably in Tayside, Grampian, Fife and Lanarkshire. It is important to learn from these initiatives. Equally it is important to keep in mind that what works in rural Tayside may not work in severely deprived urban environments.

Effective internally linkages within the NHS are already challenging and these proposed 'external' linkages will be yet more challenging. Good one-to-one links make all the difference.

There are pockets of good practice that reflect individuals thinking "outside the box". It is always easier to roll out such good practice if it is "inside the box". Integration will be good for this.

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 ☐

Principles itemised in 5.10 are excellent. Achieving this for individual patients will be challenging but important. Legislation may not be as important as creating the culture of co-operation.

There are significant concerns in the secondary care sector about potential loss of funding to acute services. General medical services (including geriatric assessment) are seeing increasing workloads as the population ages and while avoiding some unnecessary admissions will help with this, it is inevitable that the older population will continue to require acute hospital care for strokes, myocardial infarctions, severe pneumonias, etc. Cuts in acute care for these patients will make standards of care worse rather than better across the whole pathway - more boarding, fewer rehabilitation staff to expedite patients' return to functional independence and thus return home, etc. There is a danger of false economies being made.

There does not seem to be enough evidence provided to unreservedly support that conclusion. However this still appears to be an essential underpinning step.

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 ▢

This is a big challenge that requires clinical input.

This is going to come down to the leadership of individual JAOs. It is inevitable that there will be variation between individual JAOs. It therefore important that clear guidance is given about the roles and responsibilities of JAOs, accepting the need for local flexibilities.

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

Yes ▢ No ▢

Seniority is important but not enough. It will be vital to consider personal skills and attributes. For example communication, listening, negotiation, interpersonal, facilitation and conflict resolution skills to name a few.

The capabilities of the individual will outweigh the seniority question.

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 ☐

Some degree of local determination should be in place but there also needs to be some overall control to avoid duplication of effort.

The government should provide the framework to facilitate a consistent approach.

Should leave to local determination.

As the consultation notes, “Leadership is key”. Where there is good local leadership, leaving it local is fine. If there isn’t……

At the very least, there should be examples of minimum requirements.

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 ☐

Scottish Government should strongly encourage the model of locality planning groups but leave the local details to the Health Board.

This needs more detail on how this consultation would be carried out and who would have an overview of the implementation and review of these local arrangements - and what would be done if the arrangements were not working successfully.

In theory yes, but there will be issues in how this is implemented in different areas, and how the adequacy is assessed.

Consultation has distinct limitations. Consultation alone will not enable the significant changes that will be required in how people and organisations work together to deliver an integrated health and social care service. Professionals need to be engaged, actively involved and to believe and see evidence that their contributions matter and are making an impact. It would be good to have evidence/comfort that this consultation process has been meaningful and that opinions have been assimilated.

There is no clamour for 'commissioning' that has been in place in England and which is being extended there.

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?

Locality multidisciplinary workshops, including Primary and Secondary care, Social care and Voluntary Agencies, to redesign local services and pilot new ways of working, eg Change Fund.

It is vitally important that local lead clinicians from the various healthcare professions are meaningfully involved in discussions and that there are clear

mechanisms for communication with all interested parties. Integration will not succeed if staff are not fully aware of what is being done and why.

The most important step is to provide a clear mechanism by which their involvement can be seen to influence planning decisions.

Clinicians and social care professionals need to meet, to have constructive dialogue where each is able to better understand the others' perspectives and roles in health and social care delivery for the benefit of patients in their locality.

Attention may need to be paid to how this could be facilitated as each will come to the table with different backgrounds, traditions, language all of which will impact on how they may or may not be able to work together.

There is a growing body of literature shedding light on this area. Collaboration and inter-professional working are challenging and difficult. This must be acknowledged and steps taken to help people move forward.

The biggest driver would be discretion over budgets - but (see comments below) not all budgets should be devolved.

Ownership is everything. People will get involved if they believe that will make a difference. "Integration Events" should be considered where relevant people from both services come together to learn how things were in the past, how they could be in the future, and what they can do to achieve that future.

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)

Scale of "clusters" should be defined locally. LHP groups of practices may well be

the most cost effective model.

Potentially yes: but likely to vary across Scotland due to the geography and population density variability.

This needs to include appropriate specialist and generalist support.

May need to have more than one model - eg may depend on how well CHP was previously functioning, how well local practices have worked together/identified with each other in the past.

Locality planning needs economies of scale and oversight of integration, as well as local relevance. Most issues need to be planned and coordinated at a level above clusters of GP practices- at CHP level and above.

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.

Ideally locality planning groups should have some autonomy to make decisions - if the groups are populated correctly this could work well, and maintain enthusiasm in the groups.

Probably needs to be flexible according to the local situation.

Majority.

As much as possible - though (see Q18) this will probably be limited given the need to coordinate decision-making and minimise bureaucracy. Note the "democratic deficit" some have identified in Scotland (http://reidfoundation.org/wp-content/uploads/2012/04/The-Silent-Crisis-Summary1.pdf). An "assets-based" approach to community development might choose to enhance democratic involvement in these kinds of decisions.

Responsibility should be devolved to wherever it works best ie keep this flexible.

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 ☐

Variation across Scotland so there will be different sizes of groups required in different areas to meet the needs of local demographics.

The proposed scales may be too small. It would be useful to review the evidence from places where a similar model has been introduced to review what works best. However the optimal size is likely to vary with geography across Scotland.

Other geographic and demographic factors may determine different sizes for different areas.

This is a critical design issue, and consideration should be given to Ostrom's work on Common Pool Resources- eg http://en.wikipedia.org/wiki/Elinor_Ostrom#Design_Principles_for_CPR_Institutions, which describe how communities can optimally self-organise to manage shared resources.

Do you have any further comments regarding the consultation proposals?

Do you have any comments regarding the partial EQIA? *(see Annex D)*

Do you have any comments regarding the partial BRIA? *(see Annex E)*