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?

It seems reasonable to start with one population and then review the progress and processes involved before extending it further. Given the national priorties for Reshaping Care for Older People, Standards of Care for Dementia and the ageing population it is reasonable to prioritise this population. Additionally, it is the largest population, with highest projected growth in numbers.

There is a need to consider how much would require to be altered when other populations are eventually included. When things that have started in adult services come to older adult they do not always 'fit' – what processes would be implemented to ensure the reverse does not happen in this instance?

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?

Redirecting resources towards community services in order for them to be more efficient and better able to respond to crisis without hospital admission is desirable. However directing resources towards community services shouldn't lead to under resourced inpatient services for those who need them or are unable to remain at home.

A possible addition to the framework is further information about how the process of planning and commissioning will look.

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?

An alternative is to completely merge local authorities and NHS, but given the enormous complexities associated with that course of action, joint outcomes would appear to a sensible compromise to achieve a level of integration. A structure for monitoring whether nationally agreed outcomes are met would be essential.

Extremely careful consideration would require to be given to agreeing and defining the joint outcomes, taking into account the difficulties inherent in measuring some of the key areas e.g. how do you measure 'healthier living'? How much 'healthier' is required for a successful outcome? It's also important that an inevitable focus on numerically measured outcomes does not discount the value of more intangible but nonetheless valuable outcomes related to the lived experiences of service users.

How are the national outcomes being chosen and how are they being evaluated? Will there be consultation about this?

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

It's difficult to envisage how the system could possibly work without 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?

It is hard to see how else it could be done. Have there been other models or services that have utilised this reporting model before and been shown to be effective in balancing accountability?

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

Yes, otherwise there will be significant duplication of work and demands on NHS

staff in areas where there is more than one local authority operating within a single health board.

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

Annual rotation of the chair seems too short a period of office for such a complex role, but it's acknowledged that the likely intention of this is to reduce potential bias.

Previous examples of integration of NHS and local authority have indicated that attempted joint decisions were frequently affected by a 'them and us' view. How this could be addressed and overcome needs consideration by and guidance from the centre.

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, although it depends on how it is enforced.There needs to be more information on what 'effective action' in such situations would be and the support that would put in place if necessary.

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?

Direction from the centre would be easier, not because either option is obviously superior to the other, but because a lot of unnecessary time and effort could be expended reaching local agreement on this.

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?

May see differences in provision prioritisation if hosts vary from health board to health board. How would we decide who is most appropriate to host funds? There is less ownership with option 2.

What can we learn from the model currently being used in Highland?

Does the proposed delegation of budget between partners make things more or less efficient? There is no new body to establish but it would possibly lead to less sense of ownership.

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?

Integrated day services in North Lanarkshire.
Behaviour support service for people with dementia in Lothian

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?

The ministerial direction needs to be fairly specific, but generally yes providing partners are prepared to negotiate and work together.

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 – it is essential for the Jointly Accountable Officer to have financial autonomy to allow for the efficient running of the Health & Social Care Partnership on a day-to-day basis.

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

Yes, this absolutely needs to be at a senior level - this is would be a very demanding role requiring significant experience.

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?

A central degree of decision making could be beneficial in standardizing the approach, as it may minimize massive variances across areas. However it would require close liaison with areas to ensure government recommendations are fit for purpose in different areas.

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, but this may have to be reinforced strongly in some NHS Areas where clinicians have been excluded from planning over recent years. It is then incumbent on GPs and other health professionals to respond. Whilst GPs are likely to have a good overview they would lack the specialist knowledge for specific areas of health and social care, so it would be important that a range of relevant professionals in specialist areas were involved.

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?

Professionals may need to be helped to see that this is a core part of their job. Equally, they would need support re any impact on levels of clinical activity. In some areas clinicians have been excluded from planning to the detriment of services over recent years and there would need to be a clear message to managers that existing structures must be changed to ensure good clinical representation.

Clear guidance on the role expected by those involved needs to be added in to job descriptions/job plans.

A sense of ownership by all staff would increase should they have roles and

responsibilities at all levels rather than solely at management levels. Focus groups within each locality area bringing together health and social care staff may be beneficial, to then feedback to the larger consultation group.

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

This could be more difficult in rural areas. It is also vital to recognize that some functions would still require an area-wide structure (e.g. dementia pathways) and that these would need specialist clinical and social work leadership. It would be unfortunate if local level planning led to greater fragmentation of services, and that in turn led to inequities. As a rule of thumb the fewer structures the better – CHPs have shown us the risks of duplication of effort and poor internal communication across NHS Board areas.

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

Not too much, or the inconsistency that Health & Social Care Partnerships are intended to reduce will instead increase. Locality Planning Groups should perhaps have more of a focus on the 'how' than the 'what'.

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?

This could potentially lead to slightly random divisions. Size/ population numbers do not convert/ translate into budgetary or care requirements – complexity of difficulties, social deprivation, historical factors informing future planning concerns all need to also be considered.

Do you have any further comments regarding the consultation proposals?

With a proposed change of this magnitude there is clearly the need for wide consultation across services. Further clarification and definition around what this would mean operationally, in terms of both staff governance and service delivery, is also required. It is important that staff understand the potential benefits but also that they are reassured that this will not be 'change for change's sake' and services which are running well will not be forced into new management structures.

It is important that consideration is given to the resourcing and organization of mental health services within an integrated service. Mental health is frequently under-resourced within the context of health, and it is essential to ensure that this

is not exacerbated by mental health being considered within a wider health and social care context. This is particularly true in the case of older people where common mental health problems such as anxiety and depression are under diagnosed and can have a profound effect on recovery from illness and rehabilitation outcomes. As well as the obvious impact on quality of life this has significant implications for the future cost of health and social care for older people.

In 6.4 there is mention of existing examples of senior joint partnerships. Information about where these were and how they worked would be useful.

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