Annex G   Consultation Questionnaire – Action on Hearing Loss Scotland

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 ☐

Given the demographic pressures and the vastness and complexity of health and social care, it is appropriate to focus on one area first and for that area to be 'older people'.

There are currently 850,000 people with some form of hearing loss in Scotland (one in six of the general population) and it is estimated that this figure will rise to 1.2 million by 2031.

This projected increase in the number of people with hearing loss is in line with the anticipated rise in the number of older people because the vast majority of people with hearing loss are older, and the prevalence of hearing loss increases with age.

Seventy-one per cent of over 70-year-olds have some kind of hearing loss and the figure for over 50-year-olds is forty-one per cent.

A higher number of older people will mean more demand on many public services, including NHS audiology (providers of hearing aids) and local social care departments (providers of assistive equipment such as flashing fire alarms and doorbells).

Hearing loss needs to be recognised and addressed as soon as possible and hearing aids need to be serviced regularly as part of a hard of hearing person's care.

We believe that working hearing aids can be seen as crucial to an older person's care as they need them to communicate their own needs effectively and to make decisions and/or understand changes in their care or even medication.

Similarly, after a diagnosis of hearing loss there are a number of rehabilitation programmes which can be undertaken, some of which can be located within or delivered by local authorities or local authority partners. It is very important that the patient pathway from diagnosis of a hearing loss (and, if applicable, fitting of hearing aids) to rehabilitation programmes and possible referral to local social work departments is seamless and speedy.

We welcome the commitment to bring the third sector to the table in the planning of service delivery.

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 ☐

Whilst recognising that it is a top-level framework, it is not easily discernible that the main responsibility of health boards and local authorities is ultimately to service users and the wider public. How will this line of accountability work?

We welcome the proposed strengthening of the role of the third sector in strategic commissioning of services for adults.

We also welcome the shift of resources and ethos towards community provision and the recognition that delivery mechanism ultimately need to be designed locally in order to fit local needs.

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 answer to this is that it depends on how clear and measurable the national outcomes are. Having joint outcomes for social care and health makes sense in principle as the 'patient journey' through the two systems should be holistic and 'integrated', that is linked closely so that the best level of care can be achieved.

Having national outcomes should in theory go some way towards addressing the different levels of provision of social care across Scotland but they need to be clear, specific and measurable. Additionally, although having some local flexibility to take into account local needs is desirable, there is a danger that 'local flexibility' will in fact replicate the current problems regarding differing levels of provision.

On a different note, it would be good to have some clarification of what the role of Community Planning Partnerships will be in the proposed new set-up.

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 ▢

We believe that national outcomes will have to be clear, specific and measurable in order to deliver for service users on the ground.

Additionally, since Single Outcome Agreements are currently agreed between the Scottish Government and the Community Planning Partnership, it would be good to know what (if any) the involvement of the new Health and Social Care Partnerships in this process will be.

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 ☐

The consultation document seems to suggest that the 'Ministers' in question are those from the Scottish Government health department but not the Minister for Local Government. There may be good reasons for making the Health and Social Care partnership accountable solely to Health Ministers but it would be good to explore what they are.

Moreover, whilst recognising that there will be elected representatives on the Health and Social Care Partnership sitting as voting members and that both Ministers and local authority leaders similarly carry out their accountability function on behalf of the public, steps need to be taken to ensure that '[a]ccountability to the public will be via publication of local performance data' is implemented in accessible formats.

Firstly, interested members of the public need to be made aware of where to find this data; secondly, 'performance data' (i.e. statistics) can be incomprehensible to those who do not routinely scrutinise them; and thirdly, from our perspective, people who are first language British Sign Language users may need additional help to understand the details around what the data means or how to complain if they believe that they or a relative have received sub-standard service or care.

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

Yes ☐ No ☐

Given that Health and Social Care Partnerships will be able to put in place local mechanism for delivery of services, it makes sense to allow them to cover more than one local authority area. Furthermore, there may be some neighbouring local authorities with very similar needs and population profiles which would benefit from further pooling of resources.

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

Yes ☐ No ☐

We welcome the explicit mention of the Chair and Vice-Chair's duty to represent the Partnership as a whole and not the NHS board or the local authority they are based in. The problem of 'turf wars' between the two statutory partners locally is perceived to be one of the main problems within the current Community Health Partnerships.

Having an equal balance of NHS non-executive directors and elected representatives as voting members also seems sensible and the inclusion of elected representatives should contribute to Partnerships being responsive to potential concerns from the voting public.

With regard to non-voting members, we welcome the inclusion of the service users' perspective and third sector perspective. However, we would like to know more about how many places will be available for service users/third sector and how these will be filled. Will the Partnership simply choose by majority decision and then proceed to invite people? The reason this is an important questions is that while third sector representation is a good thing, we need a broad range of views from the sector without making the membership of the Committee too large. The same could also be said about service user representation.

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 ☐

We have no comments on this section.

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 ☐

If some local partners decided not to integrate budgets for other services currently delivered by Community Health Partnerships and CHPs are to be removed from the statute book, the alternative arrangements which will need to be put into place could lead to confusion and potentially quite complex local arrangements. These might then be difficult to understand and navigate for service users and their families. It arguably be could simpler for service users to include all CHP budgets within the scope of the new Health and Social Care Partnerships.

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 ☐

We have no specific comments on this section.

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 ☐

We have no specific comments in relation to this question.

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 ☐

Given that one of the key objectives is that the money available loses its identity as either 'health' or 'social care', one would presume that the more areas are pooled in an integrated budget, the better. Therefore, setting minimum categories probably makes sense.

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 ☐

We have no specific comments on this section.

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

Yes ☐ No ☐

We have no specific comments on this section.

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 should have an oversight role but locality planning is best carried out in a local context with local partners and wider stakeholders.

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 ☐

From our perspective, allowing third sector stakeholders and others such as health professionals to feed into the planning of local service provision is a key aspect of these reforms. We welcome the commitment to enable the third sector to comment on proposed local arrangements for planning service provision and the commitment for these arrangements to be reviewed. However, it would be useful to consider whether a regular review should take place to ensure all the relevant voices are heard during the planning process. Additionally, simply placing a duty on health boards and local authorities does not mean that they will take account of the results of the consultation.

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?

They would need to be provided with a general awareness of the health needs and social care challenges of the particular area that they work in. This could potentially be done through CPD training, which should also help to alleviate the problem of staff moving from one Health and Social Care Partnership to another (where the population profile may be different).

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 ☐

We have no specific comments on this questions.

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

We have no specific comments on this question.

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 ☐

We have no specific comments on this question.

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.