



**Royal College of Speech and Language Therapists**  
response to  
**Integration of Adult Health and Social Care in Scotland**  
**Consultation on Proposals (May 2012)**

**Headline Response**

- 1. RCSLT members support the integration of health and social care and believe the proposals, if implemented, will lead to improved outcomes for the people of Scotland.**
- 2. RCSLT fully support the outcomes approach to service improvement.**  
SLTs are already actively committed to enabling AHP service users to achieve and enjoy the outcomes set out (see for example RCSLT Innovations Brief, April 2012<sup>1</sup>).
- 3. RCSLT members are committed to putting quality AHP services at the vanguard of delivering the outcomes described for health and social care recipients and services.**

SLTs contribute to all 7 of the “*Health and Care Integration Outcomes*” by, for example, optimising service providers inclusive communication practice; carers capacity to care and individuals communication capacity and safe eating, drinking and swallowing ability

For a further exposition of the AHP role and impact on outcomes see, for example,

- RCSLT Innovations Brief (April 2012)<sup>2</sup>
  - An economic evaluation of speech and language therapy, Final Report (December 2010)<sup>3</sup>
  - Presentations and posters featured at the recent “*The AHPs as Agents of Change in Health and Social Care Conference*”, supported by the Scottish Government in association with the Allied Health Professions Federation of Scotland<sup>4</sup>
- 4. Given SLTs potential to contribute to all 7 of the Health and Care Integration Outcomes RCSLT would be keen to be directly involved in**

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<sup>1</sup> [http://www.rcslt.org/governments/response\\_ahp\\_national\\_delivery\\_plan](http://www.rcslt.org/governments/response_ahp_national_delivery_plan)

<sup>2</sup> [http://www.rcslt.org/governments/response\\_ahp\\_national\\_delivery\\_plan](http://www.rcslt.org/governments/response_ahp_national_delivery_plan)

<sup>3</sup> [http://www.rcslt.org/giving\\_voice/matrix\\_report](http://www.rcslt.org/giving_voice/matrix_report)

<sup>4</sup> <http://www.video3uk.com/ahp>

**the development of outcomes measures for all care groups – starting with older people.** We would also strongly encourage and be able to provide support for “communication accessible” involvement of service users in this process (e.g. Patient Reported Outcome Measures)

SLTs, could for example, provide specialist input on indicators to do with communication accessibility of services, nutrition and safety for high risk vulnerable groups (see SLT led Adult Support and Protection information below).

## **5. Integrated Health and Social Care could present particular challenges for people with communication support needs**

### **Safety for vulnerable groups**

Evidence shows that people with communication support needs are at higher risk from harm than non communication disabled groups<sup>5</sup>.

Care in isolated “unobserved” locations (such as people’s homes) may increase the vulnerability of people with CSN. Services can counter these risks to some extent through service innovations which effectively integrate quality inclusive communication approaches.

For good practice in this area see Scottish Government commissioned SLT led projects and toolkits;

- Adult Support and Protection Toolkit - information and practical resources for service providers with responsibilities under Adult Support and Protection Act: [http://www.rcslt.org/asp\\_toolkit/adult\\_protection\\_communication\\_support\\_toolkit/welcome](http://www.rcslt.org/asp_toolkit/adult_protection_communication_support_toolkit/welcome)
- Adult Support and Protection Project 2 (ASP2): ‘You have to be told, in a language you can understand, what your rights are’ : Communication accessible workshops and SLT trainers trained to deliver workshops (Contact [lois@talkingmats.com](mailto:lois@talkingmats.com))
- ASP3: Extending the Reach – Project 3 (ASP3): Communication accessible workshops and training the trainers programme (Contact [lois@talkingmats.com](mailto:lois@talkingmats.com))

### **Equal opportunity to achieve outcomes:**

Achievement of at least 1-5 of the “*Health and Care Integration Outcomes*” requires service users to have and use their communication capacities.

Shifting balance towards self management places a heavier “communication” burden on service users and carers – who themselves may have communication support needs (CSN)<sup>6</sup>, e.g. to self refer and self manage; to seek out and understand care advice; to alert services when a crisis arises etc.). Shifting the balance of care

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<sup>5</sup> See [http://www.rcslt.org/asp\\_toolkit/csn/communication\\_for\\_asp](http://www.rcslt.org/asp_toolkit/csn/communication_for_asp) for list of evidence

<sup>6</sup> See, for example, Communication Support Needs: a Review of the Literature: Law et al, Social Research Unit; Research Findings No.34/2007

towards individuals and carers, although clearly delivering huge benefits for those people, carers and services can therefore make life harder for people with CSN.

Evidence shows people with CSN are disproportionately represented in areas of high deprivation and in areas with the poorest health outcomes and, like people from minority ethnic communities, the numbers of people with CSN accessing services is low<sup>7</sup>.

Services therefore need to take account of the needs of all people with CSN – beyond sensory impairment – or they will be disadvantaged in the same way as those requiring access to community language support services.

**Equal service user and carer involvement in planning and commissioning:**

Agencies need to recognise the communication access needs of older people and carers in any public involvement activities.

See for example SLT and user led toolkits and guidelines;

- Talk for Scotland Toolkit: engaging people with communication support needs. [http://www.communicationforumscotland.org.uk/2010/TK\\_Home.php](http://www.communicationforumscotland.org.uk/2010/TK_Home.php)
- Principles of Inclusive Communication: An information and self assessment tool for public authorities;  
<http://www.scotland.gov.uk/Publications/2011/09/14082209/0>

**Service access costs:**

SLTs in rural areas highlight that service users currently accessing acute have their transport cost covered. It is not clear if Health and Social Care Partnerships (HSCP) will cover the same transport costs incurred by service users when services move outside acute care sites.

- 6. RCSLT strongly agree there a range of “barriers *in the current system that prevent professionals and staff from using considerable skills and resources to best effect.*”**
- 7. RCSLT support all attempts to remove barriers to delivery of quality services – *but we would wish the Bill could go further.***
- 8. RCSLT welcome the key principle concerning strengthening the role of clinicians and others in the commissioning and planning of services.**
- 9. RCSLT also welcomes the commitment to place a duty on Health Boards and Local Authorities “... *to consult local professionals, across extended multi-disciplinary health and social care teams ...on how best***

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<sup>7</sup> See Communication Support Needs: a Review of the Literature: Law et al, Social Research Unit; Research Findings No.34/2007)

***to put in place local arrangements for planning service provision,” and “... to put in place, and to subsequently support, review and maintain, such arrangements.”***

- 10. RCSLT are disappointed however that the proposals give particular and, in appearance at least, inequitable focus on the GPs role in planning and commissioning.**

In expressing disappointment RCSLT hasten to add, we do not intend to imply GPs are not an important party in the process of planning and commissioning integrated services.

Our point is that they are only part of the services users and carers want and need. Service users proclaimed support and need for self management and independent living require rehabilitation, reablement, “social model”, asset based approaches to care (delivered predominantly by AHPs) - as well as a “medical model” of care.

We are disappointed therefore that the proposals for structures appear to promote an erroneous, traditional view of the health service and particularly a “medical model” approach to service planning, indicated by repeated and special reference to GPs in particular.

Our confidence that alternatives to the “medical model” of health care will be consistently and equally mainstreamed in planning and commissioning is further dented by the following.

Para.4.18: professional advisers to HSC boards will as *“a minimum would be an Associated Medical Director or the Clinical Director...”*

It would be encouraging of course if there was clarity regarding who can fulfil the role of Clinical Director - for example a consultant AHP.

*Para 7.11: In terms of GP engagement, we anticipate the need to consider workload issues, and therefore availability of time to participate in locality planning, particularly in areas of high deprivation; and recruitment and retention of GPs, particularly in areas with the poorest health outcomes.*

*Para 7.12: As with every aspect of these proposals, leadership is key. We will use our ongoing development of a leadership programme for primary care practitioners to support improvement. We will also work with stakeholders, and all relevant professions, to develop guidance to support effective development and implementation of locality planning arrangements that meet local requirements.*

**In response to above:**

- 11. RCSLT call for delivery of quality AHP services to be more explicitly and transparently owned by Health and Social Care Boards.**

**12. RCSLT call for AHP professional leaders/ advisers to be defined, in statute (either in the Bill or subsequent regulation), as essential members of commissioning and planning bodies – above, at and below - Health and Social Care Board level.**

**Advantages of AHP Advisers above, at and below HSC Board level**

- i. Would ensure delivery of the vision of
  - *Consistency of outcomes across Scotland, so that people have a similar experience of services, and carers have a similar experience of support, whichever Health Board or Local Authority area they live within...*
  - *A statutory underpinning to assure public confidence; A clear strategic identity would provide both clarity and transparency for both the public using AHP services and AHP staff.*
  - *Clear accountability for delivering agreed national outcomes; driving accountability, identity with strategic goals and responsibility for delivery of integration among AHPs.*
  - *Professional leadership by clinicians and social workers; and*
  - *It will simplify rather than complicate existing bodies and structures. At the moment AHP services are very variably represented, managed, accountable etc. within NHS structures.*
- ii. Would ensure the needs of AHP service users are effectively represented – reflecting the disciplines delivering care in the community.
- iii. Would ensure the full potential impact of AHP resources are communicated and optimised strategically – addressing in one stroke a major disconnect particularly within and beyond the NHS. (*“Health and Care Integration Outcomes”* 7)
- iv. Fits with key principle *“The role of clinicians and care professionals will be strengthened ...in the commissioning and planning of services”* and *“Health and Care Integration Outcomes”* 6. Break up of CHCPs actually represent a diminution of the AHP role. CHCPs are currently the only planning body in which AHP services have a statutory role.
- v. Would drive culture change by introducing, through statute, a new perspective to Scotland’s Board tables – consistently across Scotland
- vi. Would represent natural progression from the welcome developments and successful model of AHP leadership within Scottish Government where establishment of a Chief Health Professions Officer – and appointment of a Minister for Health with an AHP background – have helped to drive change and increase profile of the valuable AHP workforce immeasurably.
- vii. Would have political fit in that it reflects the Scottish Parliament Health and Sports Committee recommendation;  
*The Committee considers that this must be allied to the development of strong and collaborative leadership from representatives of all sectors in commissioning services at a local level.*

**13. AHP Professional advisers at HSC Board levels and local planning groups should enjoy equal support to their other health and social care**

colleagues and including support from a strong uni-professional advisory network.

- 14. RCSSLT believe to ensure the stepped improvements sought by the Bill there should be equal consideration of workload issues, and therefore availability of time to participate in locality planning, particularly in areas of high deprivation; and recruitment and retention of ALL disciplines, particularly in areas with the poorest health outcomes.**
- 15. RCSLT believe there should be equity of funding and provision of leadership programmes for ALL disciplines to support improvement.**
- 16. Early national guidance or regulation should require partner agencies to ensure their IT systems, policy and procedures enable sharing of information about individual patients, workforce, finance etc. between agencies.**

SLTs with over 10 years experience of health and social care partnership working report the inability to share information across agencies, for both technical and procedural reasons, as a major barrier to quality service delivery.

- 17. RCSLT hope that, subject to further consultation with professional bodies and AHP service leaders, AHP services are given early consideration in Ministerial directions.**

RCSLT are concerned that without Ministerial direction on AHP services, there would be ongoing inconsistencies across Scotland in AHP patient experience, access to services and, at HSC Board level, a lack of governance of financial decision making in respect of AHP services. That is Boards might only be minded to attend to the performance of those services regulated by Ministerial direction.

**For further information on this response please contact:  
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**Royal College of Speech and Language Therapists**  
Response to  
**Integration of Adult Health and Social Care in Scotland**  
**Consultation on Proposals (May 2012)**

**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

Comments

RCSLT members agree an early focus on outcomes for older people would be helpful followed, after a set time, by a relatively quick progression to integration of health and social care for other areas of adult services.

RCSLT members seek clarification on how integrated health and social care boards will be expected to relate to statutory education agencies in relation to children and young people's services / family services.

SLTs would wish the bill to make explicit the relationships between Health and Social Care Partnerships (HSCP) with statutory Education Authorities.

**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

See headline responses 6-15 and explanations above:

6. RCSLT strongly agree there a range of "barriers *in the current system that prevent professionals and staff from using considerable skills and resources to best effect.*"
7. RCSLT support all attempts to remove barriers to delivery of quality services – *but we would wish the Bill could go further.*
8. RCSLT welcome the key principle concerning strengthening the role

of clinicians and others in the commissioning and planning of services.

9. RCSLT also welcomes the commitment to place a duty on Health Boards and Local Authorities “... *to consult local professionals, across extended multi-disciplinary health and social care teams ...on how best to put in place local arrangements for planning service provision,*” and “... *to put in place, and to subsequently support, review and maintain, such arrangements.*”
10. RCSLT are disappointed however that the proposals give particular and, in appearance at least, inequitable focus on the GPs role in planning and commissioning.

In response to above:

11. RCSLT call for delivery of quality AHP services to be more explicitly and transparently owned by Health and Social Care Boards.
12. RCSLT call for AHP professional leaders/ advisers to be defined, in statute (either in the Bill or subsequent regulation), as essential members of commissioning and planning bodies – above, at and below - Health and Social Care Board level.
13. AHP Professional advisers at HSC Board levels and local planning groups should enjoy equal support to their other health and social care colleagues and including support from a strong uni-professional advisory network.
14. RCSLT believe to ensure the stepped improvements sought by the Bill there should be equal consideration of workload issues, and therefore availability of time to participate in locality planning, particularly in areas of high deprivation; and recruitment and retention of ALL disciplines, particularly in areas with the poorest health outcomes.
15. RCSLT believe there should be equity of funding and provision of leadership programmes for ALL disciplines to support improvement.

### **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

**See Headline Responses 1-3 above.**

1. RCSLT members support the integration of health and social care and believe the proposals, if implemented, will lead to improved outcomes for the people of Scotland.
2. RCSLT fully support the outcomes approach to service improvement. SLTs are already actively committed to enabling AHP service users to achieve and enjoy the outcomes set out (see for example RCSLT Innovations Brief, April 2012<sup>8</sup>).
3. RCSLT members are committed to putting quality AHP services at the vanguard of delivering the outcomes described for health and social care recipients and services.

**However**

- **Also see headline responses 6-15 in Headline Response and listed above.**

**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

No comment

### **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

No comments

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<sup>8</sup> [http://www.rcslt.org/governments/response\\_ahp\\_national\\_delivery\\_plan](http://www.rcslt.org/governments/response_ahp_national_delivery_plan)

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

Yes  No

Comments

Many SLTs work across more than one local authority area. Aggregated SLT services within a health board area offer advantages such as enabling sharing of good practice across SLT specialism and flexibility in the deployment of the often scarce specialist SLT resource. Learning from children's services (where SLTs often hold differing service level agreements with different local authorities) indicates the 1 local authority / HSC Board model is time consuming for professional leaders and advisers and can create inequities in provision between neighbouring authorities.

If the scope of HSC Boards is limited to 1 local authority / board area SLTs could be working to three different HSC Boards and SLT leaders left trying to adequately feed into the multiple local planning partnerships in each of these partnership areas in the interests of diverse care groups.

If the majority view in this consultation is to go for the 1 local authority / HSC Board model the case for transparent AHP representation at HSC Board level is even more pressing. This would enable greater consistency of professional advice between neighbouring authorities (partnership areas) at the same time as reducing the professional advisory burden at local planning level for SLT senior professional advisers and leaders.

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

Yes  No

Comments

RCSLT do not support the suggested minimum requirements of HSC Board membership (See headline responses 6-15 and explanations above).

However RCSLT does broadly support the committee structures and powers, as described in the consultation document.

It would be helpful for the committee arrangements to be visually represented in an organisational chart to make consideration of membership, roles and powers more transparent.

**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

See Headline Responses 11-12 including explanations above.

11. RCSLT call for delivery of quality AHP services to be more explicitly and transparently owned by Health and Social Care Boards.
12. RCSLT call for AHP professional leaders/ advisers to be defined, in statute (either in the Bill or subsequent regulation), as essential members of commissioning and planning bodies – above, at and below - Health and Social Care Board level.

**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

Yes – but decisions of this nature should be subject to full and equal consultation with the full range of local professionals, third sector organisations and other stakeholders, actively engaged in the function under consideration.

### 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

RCSLT support integration of budgets to enable a shift in the patterns of resource allocation and resources.

RCSLT recognise the need for the Jointly Accountable Officer to “have

*sufficient authority over the integrated budget to make decisions about resource prioritisation without needing to refer back up the individual lines of accountability in the partner organisations.”*

However RCSLT are concerned that without direct and clear access to AHP professional advice (with an overview of services across agencies) the joint accountable officer would lack the necessary information to make evidence based decisions about resource prioritisation in relation to AHP services.

See headline responses 11-12:

11. RCSLT call for delivery of quality AHP services to be more explicitly and transparently owned by Health and Social Care Boards.
12. RCSLT call for AHP professional leaders/ advisers to be defined, in statute (either in the Bill or subsequent regulation), as essential members of commissioning and planning bodies – above, at and below - Health and Social Care Board level.

RCSLT strongly support the proposal *“A more integrated approach to sharing information across services and local systems, within appropriate boundaries, will be required to enable and evidence improvement.”*

SLTs with over 10 years experience of health and social care partnership working report the inability to share information across agencies, for both technical and procedural reasons, as a major barrier to quality service delivery.

**See headline response 16:**

16. Early national guidance or regulation should require partner agencies to ensure their IT systems, policy and procedures enable sharing of information about individual patients, workforce, finance etc. between agencies.

**Funding tensions:**

RCSLT highlight that funding tensions are not solely to do with *“financial incentives or disincentives getting in the way of ensuring the best possible outcome for the individual.”*

Lack of funds overall even when funds are integrated and subsequent levels services in the community is another significant and equally challenging source of tension which is unlikely to be overcome by changing the way public funds are dispersed among statutory agencies.

Cost avoidance generated by efficiencies is of course desirable, essential and likely if the proposed changes are implemented. Integration of funding

will not however reduce the actual cost of care. Impact on levels of unmet needs for AHP services should not therefore be assumed.

**Funding decision making:**

RCSLT agree that *“The question of who will decide what is included in the integrated budget is important.”*

RCSLT welcome the proposal *“...that Ministers will provide local Health and Social Care Partnerships with direction on the categories of spend to be included as a minimum.”*

RCSLT are disappointed that the examples given in the consultation document all reflect a singularly “medical model” idea of health in social care.

RCSLT hope that, subject to further consultation with professional bodies and AHP service leaders, AHP services are given early consideration in Ministerial directions.

RCSLT are concerned that without Ministerial direction on AHP services, there would be ongoing inconsistencies across Scotland in AHP patient experience, access to services and, at HSC Board level, a lack of governance of financial decision making in respect of AHP services. That is Boards might only be minded to attend to the performance of those services regulated by Ministerial direction.

**Efficient procurement:**

RCSLT welcome the proposal that *“any existing barriers to the Efficient procurement of facilities, goods and services will be considered.”*

RCSLT suggest that existing barriers to efficient procurement include strategic level lack of awareness and understanding of AHP impact and AHP service user’s needs.

This barrier was exposed over the last few years, for example, by the evidence which led to delivery of “The Right to Speak” guidelines, recently launched by the Minister for Health, to health and local authority agencies about procurement of Alternative and Augmentative Communication (AAC) Aids and Services<sup>9</sup>.

**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?

<sup>9</sup> See: A Right to Speak: Supporting Individuals who use Alternative and Augmentative Communication. <http://www.scotland.gov.uk/Publications/2012/06/8416>)

Yes  No

Comments

See Headline Responses 1-17 above.

Also RCSLT gathered evidence from SLTs in Highland to inform our submission to the Scottish Parliament Health and Sports Committee<sup>10</sup>.

In that submission RCSLT reported “The Learning so far – SLT experience in NHS Highland”

Based on extensive engagement with the “Lead Agency” model, the SLT Professional Head of Service in NHS Highland, is;

- a) Confident that the clinical governance and leadership proposals developed by NHS Highland thus far are good.
- b) The process so far has presented good opportunities to communicate the value of SLT at all levels of service (universal, targeted and specialist) to both health and local authority colleagues.

**Lessons learned from the exercise are;**

- a) Positive progress is crucially dependent on inclusive, mutually respectful and informed collaboration and communication between all those professions and other stakeholders involved in service changes.
- b) Even with this – change is progressive and takes time.
- c) Ensuring quality clinical governance at a uni-professional level in new agencies can prove challenging particularly where people work across care or age groups.
- d) Efficient and effective change management of this size requires clear, widely owned and understood project planning from the start.

**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 comments on Question 10 above.

**Jointly Accountable Officer**

<sup>10</sup> See

[http://www.scottish.parliament.uk/S4\\_HealthandSportCommittee/Inquiries/2012.03.29\\_RCSLT.pdf](http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Inquiries/2012.03.29_RCSLT.pdf)).

**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 proposals described here for the financial authority of the Jointly Accountable Officer (JAO) will certainly act to shift investment.

RCSLT believe however that there must be safeguards to ensure that the JAO is making the correct resource allocation decisions based on a fully informed understanding of adults health and social care needs.

RCSLT are concerned that the JAO could have too much authority to make decisions in isolation.

RCSLT strongly support the proposal set out in Appendix C11 that *“Arrangements for professional accountability of staff working within the Health and Social Care Partnerships will need to be further examined, particularly if there are to be shared management responsibilities in Partnerships.”*

RCSLT would hope and expect to be involved in this examination.

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

Yes  No

Comments

No comment

### 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

See Headline Responses 6-15 above.

**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

See Headline Responses 6-15 above.

**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

See Headline Responses 6-15 above.

**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

Locality planning boundaries should be determined by consultation, at local level, in partnership with all stakeholders.

It is not clear from the consultation document (or indeed community health services currently delivered to older people) why a cluster of primary care GP services is suggested as the unit for local planning. AHPs, for example, do not generally work within GP practice boundaries.

Alignment to social care team boundaries or council ward boundaries (with the added democratic accountability this would bring) may, RCSLT suggest, also be worthy of consideration.

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

Comments

RCSLT suggest the following examples of decision making and responsibilities which could, subject to consultation with stakeholders, devolved to local planning group:

- Proposing targets on sliding scale of outcomes (determined by HSC Board) for local area
- Detailed budget proposals and subsequent local resource allocation for delivery of outcomes
- Workforce planning (including growth and cross disciplines CPD)



needs) related to need of local population with reference to evidence based guidelines and outcomes

- Reporting on outcomes to HSC Board / JAO

**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

See answer to 18 above.

**Do you have any further comments regarding the consultation proposals?**

Comments  
No comment

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

Comments  
See Headline Response 5 above.

**Safety for vulnerable groups**

Evidence shows that people with communication support needs are at high risk from harm than non communication disabled groups<sup>11</sup>.

Care in isolated “unobserved” locations (such as people’s homes) may increase the vulnerability of people with CSN. Services can counter these risks to some extent through service innovations which effectively integrate quality inclusive communication approaches.

For good practice in this area see Scottish Government commissioned SLT led projects and toolkits;

- Adult Support and Protection Toolkit - information and practical resources for service providers with responsibilities under Adult Support and Protection Act:  
[http://www.rcslt.org/asp\\_toolkit/adult\\_protection\\_communication\\_support\\_toolkit/welcome](http://www.rcslt.org/asp_toolkit/adult_protection_communication_support_toolkit/welcome)
- Adult Support and Protection Project 2 (ASP2): ‘You have to be told, in a language you can understand, what your rights are’ : Communication accessible workshops and SLT trainers trained to deliver workshops (Contact [lois@talkingmats.com](mailto:lois@talkingmats.com))
- ASP3: Extending the Reach – Project 3 (ASP3): Communication accessible workshops and training the trainers programme (Contact [lois@talkingmats.com](mailto:lois@talkingmats.com))

**Equal opportunity to achieve outcomes:**

Achievement of atleast 1-5 of the “*Health and Care Integration Outcomes*” require service users to have and use thier communication capacities.

Shifting balance towards self management places a heavier “communication” burden on service users and carers – who themselves may have communication support needs (CSN)<sup>12</sup>, e.g. to self refer and self manage; to seek out and understand care advice; to alert services when a crisis arises etc.). Shifting the balance of care towards individuals and carers, although clearly delivering huge benefits for those people, carers and services can therefore make life harder for people with CSN.

<sup>11</sup> See [http://www.rcslt.org/asp\\_toolkit/csn/communication\\_for\\_asp](http://www.rcslt.org/asp_toolkit/csn/communication_for_asp) for list of evidence

<sup>12</sup> See, for example, Communication Support Needs: a Review of the Literature: Law et al, Social Research Unit; Research Findings No.34/2007

Evidence shows people with CSN are disproportionately represented in areas of high deprivation and in areas with the poorest health outcomes and, like people from minority ethnic communities, the numbers of people with CSN accessing services is low <sup>13</sup>.

Services therefore need to take account of the needs of all people with CSN – beyond sensory impairment – or they will be disadvantaged in the same way as those requiring access to community language support services.

**Equal service user and carer involvement in planning and commissioning:**

Agencies need to recognise the communication access needs of older people and carers in any public involvement activities.

See for example SLT and user led toolkits and guidelines;

- Talk for Scotland Toolkit: engaging people with communication support needs. [http://www.communicationforumsotland.org.uk/2010/TK\\_Home.php](http://www.communicationforumsotland.org.uk/2010/TK_Home.php)
- Principles of Inclusive Communication: An information and self assessment tool for public authorities;  
<http://www.scotland.gov.uk/Publications/2011/09/14082209/0>

**Service access costs:**

SLTs in rural areas highlight that service users currently accessing acute have their transport cost covered. It is not clear if Health and Social Care Partnerships (HSCP) will cover the same transport costs incurred by service users when services move outside acute care sites.

**For further information on this response please contact:**

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<sup>13</sup> See Communication Support Needs: a Review of the Literature: Law et al, Social Research Unit; Research Findings No.34/2007)