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## 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?

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Yes  No

Comments The proposal that there should be integration of services is generally welcomed although there is some scepticism that this change will necessarily improve service experience of service users.

The consultation document claims that ‘the factors driving closer integration are particularly relevant to care and support for older people.’ This claim may be true but older people would not be the only group of people for whom integration would be ‘particularly relevant’. Another obvious group to focus on would be problem drug users at various stages of their recovery. Indeed there has been some integration of health and care provision for drug users. A startling feature of the paper is that it makes no mention of this experience or of the good practice or other lessons to be learned.

The consequence of the focus on older people and the development of National Outcomes is that there will be a delivery focus that will inevitably distract resources from other areas. It is hard to imagine that the significant investment in terms of management focus or resource spending on integration will be spent on any other than the area on which National Outcome indicators are not developed. It may be hard not to conclude that the focus on older people will mean that there is less focus on other service provision for others including problem drug users. Because of this, such focus is unlikely to prove entirely practical or helpful.

### 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?

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Yes  No

Comments One obvious gap in the document is the lack of any evidence that integration actually improves the quality of services. The case is not substantiated within the document. There has been experience of varying levels of integration most notably of the integrated and then disintegrated CHCP/CHP structures in Glasgow. No reference to this is made and no attempt to learn lessons from the difficulties and challenges which arose seems to have been made.

It is difficult not to conclude that ring-fenced budgets from Scottish Government to Local Authorities to Local Authorities is being reintroduced if Local Authorities are to be told which funds from the Scottish Government are to be merged with Health Board monies to form the proposed budget streams for these services.

Although the third sector is mentioned as a partner there would need to be far more detail on third sector roles and inclusion to ensure there was the necessary impetus to the cultural shift which would be required in many areas.

SDF worked with partners including the Scottish Government to develop recommendations for housing providers and others in the prevention of homelessness among drug users. This type of practice, involving partners beyond health and statutory care services is required to support many vulnerable groups but is largely absent from the document.

The Government should take into account the Advisory Group on Homelessness and Substance Misuse's recommendations as an example of good practice

[http://www.drugsandalcohol.ie/12854/1/AGHSU\\_Recommendations\\_Paper.29.1.10..pdf](http://www.drugsandalcohol.ie/12854/1/AGHSU_Recommendations_Paper.29.1.10..pdf)

### **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 The document makes no reference to Alcohol and Drug Partnerships. These offer a limited and smaller scale model for the integration proposed. The ADP structure is based on negotiation rather than a mandated approach. However, they share enough features with the proposed integrated structures for lessons to be derived. ADP are not seen as having anything like a strong enough mechanism to achieve the extent of change proposed. Reasons for this should be explored – it is unlikely that this is entirely due to the structural differences between ADPs and proposed structures and perhaps likely that the issues may be cultural and professional discourses, standards and practical approaches.

**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 This does provide a mechanism for Scottish Government oversight of the process and delivery – indeed this seems the last surviving mechanism available to Government. In this sense, it seems necessary if these changes are to be implemented across Scotland.

### **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 This is a speculative question on which SDF has no view at this time.

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

Yes  No

Comments This is a question on which SDF has no view at this time.

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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

Comments Like many committee arrangements they seem quite cumbersome. Whether they are appropriate will be decided by their effectiveness and the extent to which they can respond to stresses. This should be monitored.

**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?

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Yes  No

Comments This is a speculative question on which SDF has no view at this time.

**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?

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Yes  No

Comments This would seem appropriate – the budgets controlled through ADPs may be one area which lends itself to inclusion. However, the consequences of this would have to be considered. Budgets around housing and other key services can impact on the prevention and treatment of, and recovery from, problem drug use and should be considered in this light

### 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?

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Yes  No

Comments They could. The question arises, though, whether they will do so in each area of Scotland and what mechanisms will highlight areas where they are not working in this way and what can be done. This is far less clear at this stage,

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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

Comments There may be lessons to be learned from work under the auspices of ADPs in Scotland. SDF may be willing to help identify this if this was thought useful.

**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?

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Yes  No

Comments This is a speculative question on which SDF has no view at this time, However, it can be stated that there are forces which would mean there was a temptation to only pool this money and not other funds. Also, if all the money in different Government funding sources is to be pooled the question arises why this money is given to Local Authorities or Heath Boards and not direct to the management of integrated service structures or the Joint Accountable Officer..

### 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?

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Yes  No

Comments This is a speculative question on which SDF has no view at this time,

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

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Yes  No

Comments

## 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 There is a balance to be achieved between local and national control. Local areas may appreciate a template suggested from the Scottish Government

**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 There should be a duty of consultation with others including local voluntary sector services and service users. It is hard to imagine that GPs offer some unique insight and whether they have the time resources to be involved in a significant way. If the view is that they are 'closer to the ground' this may be so but there are others who would be suitably qualified. Many people in great need of health and other services have little or no contact with a GP.

**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 The consultation document has several weaknesses including that it does not justify why this should be an objective or what benefits it would bring.

Community Planning is to be reviewed and this may be better dealt with there, GP services generally have consistently been highlighted by problem drug users as having poor attitudes and service to drug users. It is hard to imagine that they offer the key to improving services to this vulnerable group.

**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 Community Planning is to be reviewed and this may be better dealt with there, GP services generally have consistently been highlighted by problem drug users as having poor attitudes and service to drug users. It is hard to

imagine that they offer the key to improving services to this vulnerable group.

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

Comments

**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

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

Comments

**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