

**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

Comments

**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

**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

**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

## Consultation Questionnaire

### The case for change

#### **Question 1**

Yes

Where will the resources come from?

### Outline of proposed reforms

#### **Question 2**

Yes

Protect health professional roles. At present we are part of an integrated team and our professional role has become very diluted while we perform other roles as well as our specialist ones. Eg <sup>our</sup> mental health nurses in community carrying out care management role.

Accountability for nurses is severely compromised for example, social work staff can hold 'unmet need' cases but this has a huge impact on nurses who have a duty to care and a registration to protect. We cannot leave a patient with 'unmet need'. This has to be addressed.

Care management requires access to resources but often social work state the resources are 'full' and the person is left on a waiting-list. Health staff need to be able to acquire resources without social work telling us how the money (often health money from hospital/ward closures) is spent. How will the role of clinicians and care professionals be strengthened if resources are not available when required?

### National outcomes of adult health and social care

#### **Question 3**

Health does not have the history of financial negotiation at the sharp end. This causes power imbalance in the struggle for resources. If the jointly accountable officer has enough power and is IMPARTIAL, then that could mitigate against that imbalance.

#### **Question 4**

Targets tend to skew performance ie. Priority on delayed discharges, rather than the people in the community who are at risk of hospital admission and becoming a delayed discharge.

### Governance and joint accountability

#### **Question 5**

Yes, at a management level. However, on the frontline, a dissenting professional voice is ignored or made to feel like a troublemaker.

#### **Question 6**

NHS GGC currently covers more than one local authority.

**Question 7**

Not applicable

**Question 8**

Not applicable.

**Question 9**

Not applicable

Integrating budgets and resourcing

**Question 10**

Regarding section 5.7: Carers require training with regards Mental Health (Dementia).

At grassroots level, often care services at home cannot be provided as the service is 'full'. If people cannot be given the appropriate services at home they are often hospitalised. Social work call this 'unmet' need but this is not acceptable to health staff.

**Question 11**

Training is provided by this team for example to homecare with regards dementia and other mental health issues, however, we continue to come up against homecare staff who cannot provide adequate care. How do we resolve this issue? Why does our mental health support worker cope with a patient at home with challenging behaviours and a mainstream careworker is unable to carry out the same duties despite having received further training? One of the possible reasons for this is that we are told by homecare staff continually that they are unable to give the appropriate time that service users/clients need and only minimal service can be provided.

Health are at a disadvantage for organising services, especially in this department as health workers have been instructed to use the IT system currently in place by Social Work. It is complicated to refer someone for services if you are a health professional unless you use this system every day.

Often, service users, have to wait a length of time for services as they are not available and are full to capacity resulting often in hospitalisation and carer breakdown.

Also, day-care resources for patients with dementia are not specialised enough. Often, as Community Psychiatric Nurses, we refer service users to Alzheimer's Scotland, for example and frequently this service is withdrawn as the person is exhibiting severe challenging behaviour, which their service is unable to cope with. This service is not only for the service user but also for the carer who is often very stressed and struggling to cope. These vital services need to be able to cope with the most challenging people if we are going to keep dementia sufferers at home. Carers are invaluable in this process and deserve good quality respite and day-care for their loved ones. This is not the case at ground level. Dementia services should be able to look after ALL sufferers, not just those in the early stages. Alzheimer's Scotland

often state that if the person is not 'benefitting from day-care' then they should not attend. If this service is withdrawn, the service user/client would require other services such as sitter service, which is expensive to the service user/client and not always readily available. This sitter service is usually only for a few hours at a time and not as beneficial as day-care provides longer period of support/respite.

#### **Question 12**

Not applicable to staff at grassroots level.

#### **Question 13**

Our concerns are, that health does not have the history of financial negotiation at the sharp end. This causes a power imbalance in the struggle for resources. If the Jointly Accountable Officer has enough power and is 'impartial' then that could mitigate against that imbalance.

#### **Question 14**

At the level of seniority outlined, it is hoped that this might help to ensure fairness within the service.

#### **Question 15**

We feel that local government should work jointly with each local authority who have an in-depth knowledge of issues and needs in their own area. Eg, some areas are more highly populated, deprived, affluent etc.

#### **Question 16**

We don't think that professional views in these 'consultations' has ever been taken in to consideration. It never seems to change the direction of change in any way - 'lip service' NOT consultation. Too often this is a stage in a process towards change, which has to be done and has no meaning.

#### **Question 17**

Local consultations ie workshops, consultation documents and seminars regarding change, ensuring sufficient notice given of attendance. For example, within our area, there is not always enough time or notice given to participate in local consultations and to rearrange clinical responsibilities.

#### **Question 18**

General consensus from the CPN's in this team was that the GPs and other health professionals are in the best position to participate effectively in locality planning as stated in 7.11.

**Question 19**

The locality planning group would have to work and negotiate with the Health and Social Care Partnerships to provide a method of devolving responsibility and accountability in decision-making.

**Question 20**

This would depend on the area demographics ie. some areas are deprived and others are affluent and other areas are rural and some more densely populated. These demographics need to be discussed fully and agreements reached to make it fair on professionals working there and the population receiving social and health care.