

## 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

We consider that the model developed and working in East Renfrewshire provides a proven model for new integrated partnerships. East Renfrewshire CHCP was established with an ambitious agenda. The purpose of the CHCP is to:

- manage ALL local NHS and social care services, i.e. fully integrated provision;
- improve the health of its population and close the inequalities gap;
- play a major role in community planning;
- achieve better specialist care for its population;
- achieve strong local accountability through the formal roles for lead councillors and the engagement and involvement of its community; and
- drive NHS and local authority planning processes.

Based on the East Renfrewshire CHCP experience, whilst recognising the need for new partnerships to build towards success incrementally, we are cautious about the initial focus being set too narrow. This could perversely serve to limit local aspirations and lead to fragmentation.

As we move towards more of a focus on early intervention and prevention, the importance of the new integrated health and care partnership being fully comprehensive and embedded within the community planning partnership cannot be under estimated. As a fully integrated CHCP, our Health Improvement Team

has provided support and encouragement to the wider Council and community planning partners in their public health role .

A fully integrated partnership arrangement makes it easier for the Chief Social Work Officer to carry out their proper officer role without having their responsibility fragmented across the council.

We would suggest that there should be some flexibility for local areas to develop the model of integration that best meets their local needs and circumstances. In East Renfrewshire we are well placed to exceed the proposals and to dis-integrate could potentially present a number of difficulties.

## 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

Clearly we are of the view that the proposal would be more comprehensive if it concluded children and family services, health improvement and criminal justice. We have in place many of the elements outlined in the framework

- East Renfrewshire CHCP is a concurrent partnership it operates as a sub committee of both East Renfrewshire Council and NHS Greater Glasgow and Clyde
- East Renfrewshire CHCP and is accountable to both organisations for its performance. This is reported to the Scottish Government through the SOA and for HEAT by NHSGGC.
- The CHCP Director is jointly appointed and accountable to both the East Renfrewshire Council and NHSGGC Chief Executives
- Through care group planning and commissioning the CHCP has shifted resource from institutional to community provision and is working to increase community capacity building.
- Clinical and social care professionals and public partnership representatives are members of the CHCP Committee currently with voting rights although these have not been formally used. Representatives of all these groups along with third and independent sector are part of care group planning arrangements

When East Renfrewshire CHCP was established, the Council and NHS partners agreed that it would bring together NHS and local authority responsibilities to form an integrated partnership but in a way that retained clear individual agency accountability for statutory functions, resources and employment issues. It is a partnership organisation not a separate, new entity. We believe the model developed and working in East Renfrewshire provides a proven model on which to base the new partnerships

However we would look for clarification on the partnership status of 'distinct bodies corporate' – does this mean they will be a separate entity rather than joint Council and NHS arrangement? We believe that the setting up of a separate organisation may actually discourage partnership working, with the new organisation being seen as separate from the Council and NHS rather than a core part of both organisations therefore we would strongly advise against a separate organisation.

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**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?

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Yes  No

When East Renfrewshire CHCP was established, the CHCP Committee became a formal part of the community planning structures. The CHCP Director represents the NHS at community planning meetings and leads the NHS contribution to the SOA, making this a very simple and efficient process. We consider it vital that this 'golden thread' is retained and strengthened by these new proposals.

Whilst there are separate performance management mechanisms in place for NHS and local authorities, it is important to note that both ERC and NHSGGC are signatories to East Renfrewshire's Single Outcome Agreement which provides both the overarching context for partnership working in East Renfrewshire and is the cornerstone of the relationship between the Scottish Government and East Renfrewshire Community Planning Partnership not solely the Local Authority. We endorse the strengthening of this approach.

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

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Yes  No

At a service level East Renfrewshire CHCP has found it difficult to reconcile and service the varying and multiple performance reporting requirements of the partner organisations and the Scottish Government. As CHCP our performance on HEAT and other SOA target has consistently been very good, however in our experience the overemphasis on targets has led to unintended consequences on outcomes in the system e.g. the target of 4 hour A&E waits has led to increased hospital admissions when our preferred outcome would be that they returned home

is with appropriate supports. We have contributed to the development of National Outcome Measures and believe that this will be a successful approach and agree that these should be included in the Single outcome agreement. However we should emphasis that the National outcomes should truly be outcome measures, not detailed activity measures as is often the case for HEAT targets. This would allow local partnerships to determine the best way to improve outcomes in their local areas. Local Partnerships as part of the SOA process should also be able to set indicator targets that reflect the needs and challenges in their local communities.

### **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

Achieving strong local accountability through the formal roles for lead councillors and the engagement and involvement of its community is part of the core purpose of East Renfrewshire CHCP. East Renfrewshire CHCP is a concurrent partnership body, wherein a subcommittee of East Renfrewshire Council and a sub committee of NHSGGC meet in the same place and at the same time. Through this arrangement the CHCP Committee is therefore accountable to the Council and the NHS Board. Each of the partner organisations reports to Scottish Government on performance through the Community planning process with a direct line of accountability for the NHS. To date this model of governance has worked well.

The Director of the CHCP is accountable to both partner Chief Executives and to the CHCP Committee. The Local Authority Chief Executive is accountable to the full Council and the NHS Chief Executive to the Board. Each of the partner organisations reports to Scottish Government on performance through the Community planning process with a direct line of accountability for the NHS.

Our view is that whilst the overall principles of joint accountability in the consultation document are sound, the specific proposals are not workable in terms of the legal framework for councils in Scotland. No councillor including the leader can take a formal decision making role in isolation. All accountability is through the Council (or a committee of the Council). Whilst it is reasonable to expect the leader and board chair to represent their organisations, this is different from an accountability role with an expectation that they can instruct action.

The proposal also confuses the role of the accountable officer for delivery and the role of the committee for strategic decision making. The proposal could be interpreted as giving the accountable officer a level of delegated authority well in excess of any other officer in the public sector. The accountable officer will need a very clear reporting line to the committee. The committee should have responsibility for setting the strategic direction and then scrutinising performance and the accountable officer responsible for ensuring delivery of the agreed programme of work.

We cannot see the advantage of the complex tripartite arrangements in the proposals and do not believe that they fully reflect the role of the council leader. Also the potential loss of the Council leader on the CHCP Committee as a result of these proposals would be a disadvantage. The proposed joint accountability arrangements seem overly complex and unworkable. For example, if a joint meeting between the minister, leader and board chair is required each year, this will involve a large number of meetings. We feel that a risk based by exception model whereby the various parties meet if required to jointly consider how to improve performance would be more appropriate.

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

Yes  No

East Renfrewshire CHCP was formed to create a single integrated mechanism for service delivery when previously services had been split across health board areas resulting in very different models and access to health care within the same local authority area. The scale of the CHCP and the principle of being co-terminus was important to the partners' vision of modern and integrated community health and social care services focused on natural localities.

We have found this successful in terms of outcomes for local people and local accountability and ownership.

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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

East Renfrewshire CHCP committee has five elected members from the Council and two members of the NHS Board, along with clinical, staff, public representatives and the Director of the CHCP. The 5 elected members of the Council, including the leader, acts a committee of the Council that meets concurrently with the other members who act as a sub committee of the NHS Board.

The five elected members represent the political balance of the Council and are very involved in the work of the Committee ensuring that it is an important part of the Council's governance structure. The Chair of the CHCP is an elected member who is on the Cabinet as the Covenor of the CHCP and is also a Board Member of NHSGGC. He is therefore accountable to both organisations.

To date the balance of the Committee has worked well at the meetings there is no distinction between social care and health papers, the majority of papers have both a health and care dimension and all members contribute equally to both health and care agendas irrespective of their role in Council or NHS with the overriding driver being outcomes for local people.

We would be extremely reluctant to see any reduction in local accountability and ownership, which is delivered through the active work of the five elected members on the Committee. We agree that Health Boards and Local Authorities should be held jointly and equally accountable however we are concerned about the potential limit of three elected members and the impact of this on our existing successful governance structures. Whilst we acknowledge that this may present some difficulties for NHSGGC, we feel that partnerships should be given local discretion



in terms of membership.

In our experience the balance of membership between the partners, whilst the subject of discussion when the original scheme of establishment, was drawn up has not proven to be a real issue. Since the CHCP commenced any matters of concern have been thoroughly discussed and a consensus reached rather than moving to a vote. (The CHCP has only voted once about the location of meetings and members would regard moving to regular votes as an indication that the partnership is not working). Over the years we have built significant levels of trust and understanding between the partner organisation representatives. We would not wish the proposals for the new partnership governance to unsettle this. The potential loss of the Council leader on the CHCP Committee as a result of these proposals would also be a disadvantage.

We understand the rationale for the revised governance structure but locally this will result in a loss of voting rights for the Public Partnership Forum (PPF). Our PPF has evolved and developed over the time of the CHCP and is a useful body for testing all proposed service changes and increasing public engagement, we would wish to build on this role and function in the new partnership arrangements, in line with the policy direction of co-production.

**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 consider that we have robust local performance management arrangements. East Renfrewshire CHCP takes regular performance reports to the CHCP Committee. This is an area of interest to all committee members including public partnership representatives and officers are generally asked a number of searching questions about the report. The Director, and through her, the Senior Management team have objectives set and agreed by both partner organisations and are held personally accountable for their work performance. Each six

months an Organisational Performance Review is held at which the two Chief Executives, supported by members of their performance management teams, review the CHCP's performance with the CHCP senior management team. Any areas of weakness identified are addressed through an agreed action plan which is regularly scrutinised by the Chief Executives and reported to the CHCP Committee. In addition the CHCP is externally scrutinised by bodies such as the Care Inspectorate. East Renfrewshire's CHCP performance has consistently found to be good and in areas excellent.

We believe that public reporting of progress towards agreed national outcome is the best way of ensuring accountability. The section on performance management seems a little unclear to us, particularly in relation to existing scrutiny mechanisms and governance arrangements.

**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

East Renfrewshire CHCP is responsible for all social care and local health care delivery and has the budget for the full range of these services. We would wish to continue with this, as we have a successful track record and believe that any reduction in the scope of the new partnership could impact adversely on outcomes, therefore we endorse the proposal to give flexibility to local partners to determine the scope of local partnership arrangements, including the opportunity to include all health and social care functions. A number of very successful partnerships, like ourselves, already operate with this model and they must be allowed to continue.

**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

1. East Renfrewshire CHCP manages aligned health and care budgets as detailed in Question 11. We are attracted by the idea of resources losing their badge and the ability to focus money on the needs of local residents.

2. We consider that it is helpful for the partnership to oversee local health and care budgets including budgetary mechanism to move resources from acute hospitals into the community. Whilst there are some complexities and bureaucratic difficulties, there are areas where modifications to current arrangements would deliver more effectiveness and transparency, and with commitment from both partner organisations the issues can be reviewed and remedied. They should however be regarded as marginal in comparison to the scale of the consultation proposals. Essentially current arrangements within East Renfrewshire CHCP operate well and subject to their modification and development may not require the extent of change as suggested within the consultation to achieve the objectives of the consultation.

**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

East Renfrewshire CHCP is allocated funding on an agreed basis for the defined range of functions, by the Council and NHSGGC. Those budget allocations are based on synchronised planning processes and a transparent approach to addressing identified pressures and issues. The CHCP Committee sets budgets for its activities within the overall allocation. The CHCP Health and social care budgets are not pooled but aligned, allowing a clear track of expenditure to the allocating body. The scheme of establishment and subsequent financial agreements allows for a process to be agreed for virement between these budgets provided this is justified, reported for approval to the Council Cabinet and notified to NHSGGC. Through constructive partnership working it has not been necessary to utilise this facility. In addition East Renfrewshire Council and NHSGGC have worked together through different capital planning processes to agree investment in two major capital projects for Barrhead and Eastwood Heath and Care Centres.

The CHCP Finance Business Partner manages both budgets meeting regularly with Council and NHS Finance Managers and parties a member of both finance management teams. Regular budget meetings held with CHCP Heads of Service and their management teams incorporate discussions on both NHS and Council budget allocations, allowing a view across the full extent of their aligned budget.

There are some complexities within the current set-up however as the NHS and Council operate different financial systems and reporting cycles, and follow different procurement and vat rules. As the budgets are held within the separate systems of the allocating body this necessitates cross-charging between the NHS and Council, and along with management of Resource Transfer funding can be argued an inefficient use of finance team resource. We would welcome opportunities for streamlining this.

The annual planning cycle is synchronised across the CHCP, however separate budgeting processes exist within NHS and Council. While the CHCP Management team takes a view across the full budget, there has not always been the same opportunity to influence spending pressures equally. An example of this would be the funding of incremental progression within staffing budgets. The Council's payroll budget is worked up from current payroll records each year and fully recognises incremental uplifts for all staff groups, however within the NHS budget an allocation is made across the Board area for incremental drift that does not always fully fund the level of increase experienced. Opportunities to recognise spending pressures consistently across the CHCP budget would provide a more coherent approach.

While the overall financial position is monitored and reported to CHCP Committee, separate monitoring and reporting arrangements exist for NHS and Council. Within each of these separate reporting arrangements, variances across care groups are reported however the net expenditure position is the focus.

**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

Our Scheme of Establishment sets out in exact detail the services and budgets delegated by the partners to the CHCP. This process was very helpful in agreeing setting parameters for the CHCP's responsibilities, from this experience we would support clarity at the outset. Subsequently the range of NHS services managed locally has increased with changes agreed through negotiation and joint planning across NHSGGC, therefore we would recommend that any direction

is not embedded in the legislation but in the supporting guidance. However we would ask for greater clarity re the acute hospital resource and that there be a transparent, consistent, robust and workable approach to its allocation and the how local partnerships are enabled to shift the balance of care

### 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

In our current arrangements the level of delegated authority to the Director is set out in the financial regulations of the partner organisations and Scheme of Establishment. Whilst we agree in principle to the proposals, more work needs to be done of the financial authority of the accountable officer and the role of the committee requires to be taken into consideration. Whilst it is appropriate for the accountable officer to make operational decisions based on the best interest of the patients/ residents, it may not be appropriate for the accountable officer to make strategic decisions to refocus significant amounts of money without reference to the committee, especially if this would change the strategic direction, previously agreed by the committee.

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

Yes  No

In our current arrangements the CHCP Director is employed by East Renfrewshire Council and is a Director of the Council. She has a secondary contract to NHS GGC. She acts as a full part of the Senior Management Teams of both partner organisations and is able to carry out a corporate role for either organisation e.g. leading on the Council's strategy for older people and the NHS GGC learning disability review. From our experience this is a very effective arrangement and along with the joint accountability and integrated senior management team is critical to the success of the Partnership. This level of seniority will be crucial to the new partnerships considering the role the joint accountable officer is expected to play.

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**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?

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Yes  No

In East Renfrewshire we have begun to develop proposals to redesign our older people's and rehabilitation services around clusters of GPs and a number of natural communities. However we are unclear as to what is meant by locality commissioning of services and how this relates to self directed support, strategic commissioning and procurement. We would look for further clarification on this matter in guidance.

**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?

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Yes  No

We are committed to genuine GP and professional engagement and believe that all professionals including independent contractors have a role to play in delivering the best service locally. Placing this within a duty will ensure that this is undertaken.

Locally capacity, time and finance have been barriers in the engagement of clinicians, and specifically GPs. We have financed GP involvement in our Reshaping Care for Older People's agenda, but it is difficult to ensure that all contractors are actively engaged. We would expect that if independent contractor involvement is made a duty that this would be appropriately resourced.

**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?

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In terms of our experience, capacity, time and finance have been barriers to the engagement of clinicians. We would suggest that planning at local level focus on the patient/customer pathway and outcomes for meaningful engagement.

In addition to funding for clinical involvement there is a need for additional resourcing; organisational development; and training and education for partners' and partnership management and front line staff.

**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 believe that there needs to be the right balance of practice and resident population for service delivery. In East Renfrewshire we have begun to develop proposals to redesign our older people's and rehabilitation services around clusters of GPs and a number of natural communities. It should be noted that 15,000 of our 90,000 residents have GPs outwith East Renfrewshire and that there is a health centre in our geographic area which is currently part of South Glasgow CHP as the majority of its patients are from that area. We would suggest that due to these complexities that there is need for local flexibility to determine the most appropriate locality arrangements

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

We believe that locality planning is useful for operational planning but not suitable for agreeing strategic directions. Clarification of the matters raised in question 15 will help us form a view.

From our experience of strategic commissioning for Reshaping Care for Older People we would note that this is resource intensive for a variety of organisations and that independent and third sector organisations do not have the capacity or the resource to sustain this on a locality basis.

Equally we have a strong relationship with our Public Partnership Forum and we envisage their role will be paramount to the successful delivery of the proposals and in line with the principles of co-production. Duplicating strategic planning processes at a locality level will pose difficulties for their volunteer base.

**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

In East Renfrewshire, we are currently working to three cluster areas with population sizes of approximately 25,000-35,000 but again would suggest that this is left to the determination of local partnerships and their knowledge of natural communities.

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

In East Renfrewshire we can demonstrate six years of commitment and leadership from NHSGGC and East Renfrewshire Councillors to embed an integrated CHCP in East Renfrewshire. The results have been improved outcomes for local people. There is concern that this success could be lost if the guidance from Scottish Government affected the current arrangements in East Renfrewshire and would propose that local areas who have demonstrated a significant commitment to this agenda and can evidence the characteristics of successful integration are given flexibility so they can implement and continue in a method that fits with their own circumstances.

**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