

Annex G Consultation Questionnaire

The responses below are from a workshop held by Cowal Community Care Forum August 2012. The 27 people in the audience were a mixture of Forum members, Public partnership Forum members, Councillors and service delivery professionals. It also has additional comments from Cowal Community Care Forum

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

Yes, priority for older people. we have a higher proportion of older people in Cowal than the rest of Scotland

It is a laudable aim and strongly evidenced based.

The idea that there should be minimum disruption to users/patients is excellent.

However it has to be understood that other policy initiatives (that again are evidence based and very positive,) are resulting in big changes visible to users/ patients eg keeping [people at home and reducing hospital beds.

These integration changes will be seen as part of that, and for some will be seen as cost cutting. People are very attached to their hospitals which are very visible and tangible. Care services in the community are not as visible and are seen to be subject to tightening criteria, increased charges and a lot of changes of providers as Councils outsource.

It is therefore advised that communication and engagement strategy with good educative materials are created with budget streams that ensure people know what is happening to their local services and governance structures and why.

They need to feel well represented on those structures and to have a voice. At the moment they do not and the pathways through representative structures are not deemed to work well.

The role of the Scottish Health Council needs to be considered as it currently supports the NHS but will need to increase its role and also support these new structures

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

Holistic approach, preventative and educative, 'little bit of help' identified in RCOP agenda

- Transport is a huge issue – community transport specifically
- Isolation is a big issue
- Need to link transport with other services eg befriending
- Who will take ownership?
- How does the Change Fund, Reshaping Care for Older People fit in?

- There should be no mixed messages regarding health
- That health improvement messages are carried forward is important
- Localised services like defibrillators need to be taken forward

Information an underpinning Information strategy is not there, mentioned but it is a key foundation. This greatly weakens any future developments and needs legislation and strong guidance to ensure all areas have a sound information base for planning, so the public and professionals know what services are on the ground and choice is fostered, and that patient/client records can be developed and shared preferably electronically with proper safeguards in place. There are too many barriers allowed to remain that are preventing user friendly information systems and records to be put in place. That is to the detriment of professionals trying to provide person centred services and users and carers trying to seek support or treatments and chose services . It is hugely inefficient.

There is a worry that it will become unclear what will remain a free health service and what will shift to being a care service. There may be many shifts and grey areas and more services that will cost. This could cause huge problems if not overtly, clearly dealt with early on.

A word that does not appear is Wellbeing. An enhanced sense of wellbeing is an outcome. If services are to be preventative and to encourage people to seek help early we need to focus on wellbeing and health improvement messages. Currently services can make people feel a 'nuisance rather than encourage them to seek to feel well.

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

However, from the Third Sector point of view, we find existing structures inflexible and unresponsive so wonder how the issues will be solved that will make this integrated one better. Community Planning is an excellent structure that has not

lived up to its promise.

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 need to invest in getting some good user focused outcome measures, spreading the good ones that we already have, monitoring and evaluation tools that are user friendly, empowering and can feed into those higher level indicators

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 potential is there but it will depend crucially on how it will work. The public can feel very disempowered despite what are meant to be accountable structures.

At the moment it can feel like a ping pong between the local level and Scottish Government and the Third Sector, users and carers caught inbetween. It needs to be ensured that is dealt with and there is clear accountability and clear multiple pathways to ensure accountability. .

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

Yes No

Not applicable to Argyll and Bute, we are very fortunate to have a coterminous CHP and Council and hope we can retain that advantageous position

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

Yes No

Yes to a large extent, but;

ensure robust public involvement that is supported and funded. A little money will go a long way.

Ensure that there are community development skills around the table as the new model is multidisciplinary working, community involvement, the mutual NHS and co production. This needs community development and change management skills.

Support eg Scottish Health Council and a facilitator add skills, experience and expertise that is needed.

Senior Health Board official (exCHP) , Council ex member from social services, elected Council members, Doctors representatives, Nurses representatives, health professional representatives, health service union representative, COSLA , Voluntary sector, independent sector need to be there. .

- If it happens too quickly it may go wrong
- Link existing and new structures
- The importance of an implementation plan is paramount
- Involvement of all services – integration, close working
- Clear pathways are put in place
- One point of contact for transport
- Recognising what works and what doesn't
- Consult with the public to find out what needs to change
- Transparency
- Changes made in other areas that may impact the health and social

- care integration need to be watched carefully
- Keep the right number of clinicians in the new model,
- Have a good balance of staff

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

Proof of the pudding.....

- This is a very big issue. More robust, clear and publically published mechanisms are needed; a variety of ways of gathering user feedback and lay involvement in inspection and monitoring. There are gaps in monitoring and action especially where there are a range of providers. Clear lines of responsibility must be there, and more dissemination and adoption of good practice.
- Empowered staff and communities can do a lot, but bureaucratic structures can make it very hard to be flexible, innovate, change, respond to user needs. The more 'tight' and efficient' a service the less time anyone has for planning, innovating and change management. If you want a flexible responsive system there must be time for all sectors to be able to meet together and plan then implement change.
- Equality monitoring is weak and needs to be more robust.
- Statistical information on service delivery and outcomes are poor.
- Better ways of identifying outcomes for clients, especially very frail older people are needed.

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

In principle yes but should depend on whether they will meet set standards for the

adult health and social care.

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

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

There are myriad cases of individuals whose care is not good because of a lack of flexibility and responsiveness. The Third Sector has been evidencing this for years. These proposals are a welcome response to that.

The Third Sector has for a long time operated some very good bottom up responsive services that have never been mainstreamed as a model of working nor as a range of core services in every area.

This legislation gives a chance to bring those in, link up with the health improvement agenda as it crosses over with RCOP and Change Fund agendas, and hope to shift the way services are delivered to a truly needs led, flexible, responsive set of services.

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

Budgets should be decided by Government and devolved to HSCP to make decisions and for the locality planning groups to have a say.

This would allow local aspirations to be achieved.

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

He/She must be clearly accountable to the HSCP

One person should not have the final say on the budget, it is the partnership. It must be robustly ensured that works clearly and well and that one person nor group of people hold too much power. Structures often end up not being truly accountable and can remain driven by a dominant partner.

The new structures, whatever they are, should have solid induction, training and initial facilitation to ensure a new ethos, principles and new ways of working are thoroughly embedded, otherwise old mindsets and ways of working will prevail. New structures carry with them training and induction needs.

Often structures are circumvented by a lack of willingness of all levels to fully engage with a new model. Attention must be paid to getting 'buy in' at all levels and to the identification of any issues or blocks that might prevent shifts from taking place.

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

Yes No

We have concerns about this question. We don't think the accountable officer

should be in control but should be there to administer the wishes of the HSCP.

They should be independent, they do not have to be from a health or social care background.

There is a danger that old practices will be perpetuated. It may be that some fresh thinking would be good regarding officers, chairs, public representation.

Crucially a community development approach is needed to implement a model. That for many professionals is a big departure from what they are use to.

In Cowal we have had strong public representation in service redesign and have learned a lot about the difficulties of this. The devil is in the detail and the day to day redesign processes. The direction of travel is very good, but more analysis of how to make this work better, guidance, training etc is needed. Crucially ways of working together and sharing professional expertise and negotiating need attention.

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

Local determination but give strong good practice guidelines, framework and regulation

- Rural problems are different from other areas of Scotland
- Travel and cost associated need to be taken into account at all times and all stages of planning and service delivery

- Remote communities have unique issues wrt travel and services
- Local nurse practitioners would reduce travel. The location of staff needs to be addressed.
- Creative ways of consulting and involving the public are needed. There is little consideration of this, little investment and little understanding of how to get user feedback among many service providers.

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

Needs to be strong as possible and GPs etc should be forced to be involved

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?

- Integrate IT,
- co locate,
- all need to be empowered to be involved
- Training and development to follow the visualised plan for communities and professionals/staff involved
- All staff should have training in the planning process
- Time away from duties to be trained. training built in – the ability to develop flexible responsive needs led services is a major training need.

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

Involve them

How is it envisaged that these new structures will fit in with existing Council structures and Community planning structures? We already have so many meetings and working groups it is hard to see how yet another one will fit it. A lot of duplication and overlap exists. This is a major issue as all are overloaded with meetings some of which do not work very well. Careful thought needs to go into what already exists, where this will sit and what else is needed or what could be adapted/improved.

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

A lot, principle of devolving as much as possible But must be within strong framework of guidance on standards and equity of outcomes across Scotland. Must also be well regulated and monitored.

Despite what are meant to be accountable structures through elected representatives, interface arrangements with the third sector etc, local communities have very little power or say or ability to influence decision making. How will this be dealt with to ensure real co production? Will there be induction and training to ensure everyone has the same ethos, principles, methods of working and understanding of how to jointly work together?

There must be investment in ensuring proper accountability at all levels.

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

This would not work for remote rural areas. . Need to think about what people perceive as a community also and remote rural area size.

Involve as many local people as possible. This has resource implications to ensure it works properly

Do you have any further comments regarding the consultation proposals?

Devolve down and involve as many people as possible, put resources into this to ensure it is meaningful and supported.

Public partnership forums are a good starting point for public involvement and accountability but build on this

Create a structure so that everyone can be involved if they would like to be and create a dynamic relationship between communities and their health and social care providers.

Active involvement from the ground up rather than just consultation processes. Fostering that takes skills that all should be trained in, some resources and support eg Scottish Health Council, community development staff.

We already have join patient experience and public partnership forums and virtual community that anyone can feed into at any point – some good starts with NHS patient feedback website. Build on this.

Time is critical, hard to rearrange commitments, management of change key.

PROACTIVE engagement with hard to reach people needed. We need to go to them, not expect they will come to us.

Depends on how you sell it to people, explain the importance. Hold coffee

mornings and provide incentives! People have to feel ownership towards the process and feel they are a part of it. Major change is a chance to build that dynamic relationship.

Lack of trust is huge and must be overcome. Explain that it is not all about cost cutting.

The absolutely crucial question of good information for the public and for professionals is not addressed, it is just mentioned. It needs a whole strategy itself. It is patchy in Scotland but good joined up information is lacking in Argyll and Bute and indeed is poor within Health and Council never mind between. This is a huge issue that the Government have never lead on and has not been systematically tackled at Health Board or Council levels either. It is a glaring gap in so many ways from lack of information to plan well, e patient records that can be shared etc etc.

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

The EQIA covers many of the issues.

The impact on women of these policies is high and will be detrimental if the community support systems do not work in future. Given the tightening of criteria for support this is a real worry. The downward push on wages and hours to deliver care is a real threat.

It is unclear what will remain a free health service and what will shift to being a care service. There may be many shifts and grey areas and more services that will cost.

It is surprising that low literacy levels are seen as no impact as there is a lack of information for the public in general and few ways of communicating to people are used other than the written word. Therefore people with low literacy are at a double disadvantage. The information is often lacking and when it is available it is

usually written. The system will be more complex in some ways. This is therefore seen as a potential impact that needs mitigated.

Rural areas must not be disadvantaged and it is requested that solid rural proofing of any legislation takes place to ensure no negative impacts.

Do you have any comments regarding the partial BRIA? (see Annex E)

Comments

QUESTION - 11

We operate a Community Transport organisation that covers Cowal and Bute. The question of access is of particular importance to us as we can see first-hand the difficulties people face on a daily basis. There is a definite transport issue in Scotland and in particular Argyll. The elderly specifically are finding it difficult to access health and social care services. There are a number of driving factors here.

1. The elderly population is increasing, living longer and becoming frailer as a result. This puts more pressure on the underfunded third sector which has traditionally plugged the gaps.
2. Council funding has been cut for most Third Sector groups at a time when demand and costs are increasing.
3. Government and local policy is promoting the idea that people live in their own homes rather than residential care. This is very popular with residents and is deemed more cost effective, it does however throw up various transport issues. The basics such as food shopping, getting to doctor's appointments, collecting prescriptions and accessing health and social care systems becomes a real problem as the elderly become unable to drive through age, illness or financial constraints.
4. The Patient Transport Service is cutting back its spending by enforcing its criteria. This is leaving people who have traditionally used the PTS to get to hospital unable to actually get to their appointments. Argyll in particular has become a retirement village with people moving into the area. When they move they leave their support network of family and friends. With the housing crisis people are literally becoming stuck in rural areas unable to move to somewhere more suitable.
5. The concessionary scheme along-side Dial'a'Bus schemes are useless to those who need door to door transport. If you are ill, disabled, elderly or live in a rural area there is a high chance you will need door to door transport.

Example 1. An elderly resident in Glendaruel needed to get to Dunoon General Hospital. She is on a Transport route but does not qualify for Patient transport. The issue here is that the bus leaves so early in the morning and comes back so late in the afternoon/evening that she doesn't feel up to sitting in the hospital for all the

hours of the day. When asked what she would do if we could not provide transport she replied that she would most likely cancel the appointment. I do not doubt that many elderly residents in Argyll find the whole issue of transport a barrier to basic medical care. It could only be guessed at the extra financial burden put on the NHS and Social services as conditions go un-diagnosed and/or treated. This resident is fairly mobile in comparison to those who have mobility issues or are disabled.

Example 2. Social services have classified food shopping as a 'domestic' service creating a problem for those who need transport to shop and more specifically those who are housebound. The third sector is currently plugging this gap. We have up to 10 clients a week that ask us to do their shopping for them and numerous clients every week that require transport to do their own shopping.

Example 3. Prescriptions are now free of charge in Scotland. It is unfortunate that there is no delivery service. We now have numerous clients that need us to deliver their medication on a weekly or monthly basis.

Example 4. A lady who recently died spoke to one of our escorts a while ago, she mentioned that she used to get a taxi to church every Sunday. As she became frailer and ultimately wheelchair bound she commented that she could no longer get a taxi to come and take her to church. This is not an uncommon occurrence it seems. It is understandable why this happens, taxi drivers are running a business and it is most likely not cost effective for one to spend the time it takes with a very elderly wheelchair bound client. There is also a higher duty of care for those who are elderly and/or disabled, for some this is too much responsibility.

Example 5. There is no wheelchair accessible taxi on Bute, we have had a few requests now for transport. As we do not have a vehicle on Bute every day this has meant bringing a vehicle over from Dunoon to transport a client a mile or two on the island.

I could continue writing this for the rest of the day but I have already written over a page. The solution to all these problems and many more, and I understand I am biased working in CT, is Community Transport. It is cheap, effective and flexible. A strong unified CT network is desired by the Patient Transport Service so that they can direct those who do not meet their criteria. It is needed by the residents as the problems mentioned above are only going to get worse over time. CT has a very strong economic argument, it allows money to come into the area in the form of pensions, DLA payments, attendance allowance and Doctors surgery income and allows the area residents to spend their money locally improving the local economy which is suffering. Some would ask what the point of a great health and social care system is if people cannot access it. At the moment we are lagging behind England and Wales where these issues have been identified. Last year councils in England and Wales received £20 million and a large sustainability fund for CT. With a little will a CT network could be set up in Argyll for a fraction of that cost. Very little would be needed as CT can be made hugely sustainable through a number of income generators.