

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 would suggest that the rationale for change is not that clearly articulated in the proposals particularly given the significant progress made by local authorities, working in partnership with NHS colleagues, to reduce delayed discharge and unplanned emergencies to hospital.

A focus on outcomes however is a positive one. Restricting it initially only to older people, whilst making this transition more manageable, will mean however that there may be some potentially competing performance management arrangements for Partnerships.

To follow an outcomes approach will require a considerable cultural shift for staff in the Partnership and training and development will be needed across all disciplines.

Structural change, whilst it may facilitate this changed focus, may also divert attention so it would be hoped that transition arrangements will be flexible and adaptive to local circumstances to minimise this risk.

From a local perspective we see a need to integrate all adult services from the outset.

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

The Framework for Integration as set out in 2.6 provides a key set of principles. There are several areas where the practicality of establishing this new Partnership is unclear. This is particularly so in relation to the acute sector and housing. We would also welcome more emphasis on working with communities and the co-production of locally relevant services.

The impact on Children's Services is not considered.

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

Joint and equal accountability for performance against National Outcomes is welcomed as this will reinforce the need to utilise joint resources in pursuit of joint or shared outcomes.

The difficulty of measuring and therefore agreeing performance against these outcomes is significant however and it is hoped that there will be support and recognition of that during the transition phase.

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

The inclusion of the National Outcomes in the SOA would bring the involvement of other Partners into the achievement/delivery of these outcomes and the new duty on all partners to engage in the delivery of the SOA is welcomed.

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

It is acknowledged that it will be difficult to find the right balance between local and

national accountability for Health and Social Care but any arrangements should add value and provide support for the implementation of change required by services. These proposed arrangements, given that concerns exist regarding the potential democratic deficit which could exist at local level, could create political tensions which may not facilitate this change agenda. We believe that in Moray, accountability should be to the full Community Planning Board.

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

Yes No

Although the opportunity and flexibility to do this should be there nationally, we have very robust arrangements in place locally and would want to develop these further. We would however want to remain open to establishing specific arrangements with neighbouring Authorities where there are clear benefits to sharing or combining services.

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

Yes No potentially

The Committee structure proposed could potentially provide governance of local Health and Social Care services. The question really is will it provide good quality governance and promote local accountability and decision making.

The structure proposed introduces the concept of non-voting members to the Committee structure and, whilst this provides an opportunity for increased professional and community participation, the relationship and dynamic of these stakeholders with the voting members will bring an added dimension to decision making which is as yet unknown. The balance between non-voting and voting members may need further consideration, as would the balance between professional representations.

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

The contribution of stakeholders should mean that the Committee contains a level of expertise and skill to examine delivery failures.

If meetings are transparent and open to the public then Committees should be able

to generate public confidence. For example, added transparency can be secured through the webcasting of committee meetings, which is also important for those who have less mobility and therefore restricted to attending meetings.. However, confidence can only be sustained by positive actions and the test of the Committees will be their ability to lead positive change locally.

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

Local flexibility is welcomed.

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

The model described could successfully deliver the objective required by the Government. It could equally fail to deliver it. No structure can guarantee success.

The delivery of cost effective positive outcomes for Health and Social Care does rely upon effective partnership working between individuals and this can be, and should be facilitated by these changed arrangements. However, a focus on structural change can divert attention and disrupt local working arrangements.

The most important factor will be the degree of autonomy that Partnerships have to make the decisions that release value and support innovation and creativity in Health and Social Care. We would be anxious though to see the Self Directed Support Bill along with the integration of health and social care services reflecting the need for community health services being made available through SDS and therefore being complementary/compatible in this respect.

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

Moray has a well established Moray Alcohol and Drug Partnership which offers targeted support from an integrated team of health and social work professionals.

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

Direction on spend would be welcomed. There will be a need to determine the level of inclusion of acute sector spend in order to facilitate the shift in the balance of care.

There needs to be a recognition of the constraints currently placed on services as a result of limited and reducing budgets. Ministers will need to take into account the implications of setting minimum spend levels on other service areas where no minimum levels are established.

Further guidance from Government in terms of efficiency expectations, budget setting and financial regulations would be helpful.

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 We feel unable to tick either box – detail unclear

We are unclear from the detail of what is contained within the proposals.

Certainly, the Jointly Accountable Officer will have the function, role and responsibility to lead the Partnership in achieving the objectives set. Governance arrangements should also ensure accountability for this post and also describe the decision making process.

Ultimately, it will be how well the Jointly Accountable Officer works with the governing committee and leaders which will enable this responsibility to be properly discharged. As stated earlier, we would want to see governance ultimately resting with the Community Planning Board.

The accountabilities and responsibilities of this post holder in relation to the section 95 officer need to be more clearly defined.

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

Yes No

The level of responsibility of the Jointly Accountable Officer seems recognised by their proposed seniority.

The qualifications, skill or experience of the Jointly Accountable Officer could be more fully described.

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 planning should be done locally.

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 We feel unable to tick either box – detail unclear

Although this is not clear from the detail contained within the proposals, this duty, combined with the requirements of non-voting professional members of the Committee, would appear to be sufficient.

We would also like to see such a duty for consultation of service users.

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?

The involvement and indeed responsibilities of local professionals in planning,

delivering and reviewing local provision should be embedded in the quality strategy of each Partnership. We would also stress that it is important to emphasise that it should not only be professionals who drive planning at a local level – the need to empower local communities to co-produce services should be integral.

A requirement for such a strategy may be helpful in due course.

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

The model of locality planning should be left to local Partnerships.

GP clusters do not necessarily reflect local geographic or demographic factors that are as important in terms of planning and delivering local services.

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

It should be determined locally in partnership and kept under review..

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

As above, for local decision.

Do you have any further comments regarding the consultation proposals?

The Moray Council conducted a SWOT analysis of the proposals for Elected Members and senior officers were in attendance. A transcription of this analysis is shown in Annex G (i).

The Moray Council is supportive of change to the structure of Health and Social Care in order to deliver better outcomes for Moray.

There is some caution attached to the proposals, particularly in relation to the impact on staff and evolving partnership arrangements locally, and therefore we would have concerns if there was not the opportunity to build on what already works well in Moray. We would also not want to see more layers of bureaucracy in the emerging arrangements as the emphasis should be on the direct delivery of

services to the public.

There will be a need to clarify the strategic landscape as a consequence of these proposals, both in relation to the Community Planning Partnership (currently subject to national review) and specific job roles and Moray Council would like to see these issues addressed alongside these proposed changes.

The challenges of professionals and organisations working together in a new way is one that is welcomed but The Moray Council believes that this process of change comes with risks and that these must be openly and transparently discussed on all sides for the proposals to be effectively implemented.

We do believe however that the full potential benefits will not accrue until we have proper integration across a whole range of services.

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

none

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

none

STRENGTHS

- Pooling of resources, £, systems, ICT, property.
- Pooling/sharing of data (patient/service user)
- Shared / single outcome focus
- “one bottom to kick”
- Seamless provision of services
- “one stop” – better ‘customer care’
- Improved accountability and scrutiny. Transparency
- Reduced bureaucracy
- Increase and broaden staff skills (cross training)
- Breakdown professional barriers
- Opportunity to ‘consult’ with Health minister
- Democratic accountability across Health and Care
- Heightened profile of social care profession
- Reduced delayed discharges
- Inclusion of GPs, SW, Practitioners input “people who are doing the job”

OPPORTUNITIES (Items already covered in “strengths” have been omitted)

- “Money goes to where there is need”
- More preventative work should be possible
- To create better, more sustainable services
- Build on Moray’s progress
- “A person at the centre”
- Joint accountability for actions and outcomes
- Create structure which enables or supports the already existing staff willingness to work together.
- To make better use of the third sector
- To engage with the clinicians
- Create shared vision
- For staff to ‘move on’ – early retirement
- To work closely with community hospitals, care homes
- For community involvement in scrutiny
- New job opportunities
- Reduce duplication
- Opportunities for community ownership
- Local/National conversation between Minister and the Board of the Partnership
- Local need responsiveness
- Develop opportunities in schools to understand the Health and Care needs of the population and to understand employment opportunities
- Information channels made open and appropriate
- Look at generational issues, that is the need to engage young people now in thinking about demands of an ageing population

THREATS

- Gap between NHS Moray and Grampian in terms of priorities
- Non-Executive Directors on the Health & Social Partnership Committee – how can they wholly and fairly serve Moray when they have obligations and loyalties at Grampian level
- NHS acute spend – some overlaps with older peoples’ health needs – how does the money flow?
- Elected Members on Health & Social Care Partnership Committee. What will political effective be on Health delivery
- Could public see Jointly Accountable Officer as unaccountable because they are not elected?
- Need for clarity of relationship between Chief Social Work Officer and the new Jointly Accountable Officer
- Impact of more change on staff morale
- Inadequate “buy-in” from staff
- Impact on out of hours medical service
- GPs might not embrace or welcome the changes
- Threat that Social Work/Care training spend reduced
- Reduced profile for Social Work?
- Home/community not always best
- Inadequate public involvement in shaping the changes and services
- That the annual public meeting would be inadequate scrutiny, not sufficiently robust
- Relative reward for Jointly Accountable Officers and Chief Executives needs to be given attention
- Excess power in hand of Jointly Accountable Officer
- Some Elected Members feel Community Planning Partnership should lead.
- Costs of the restructure have not been accurately or realistically assessed.
- That other (non older people, non home/community) services might be reduced
- That those services not integrated continue to function less efficiently
- That the whole restructure does not adequately address the shortfall between demand and resource availability

WEAKNESSES

- More bureaucracy potentially
- Erosion of professional identities
- Place of hospitals not clear in proposals
- Protection of current employees' terms and conditions
- Creates alternative SILOs (Health and Care and Housing for example)
- How to ensure fair disclosure of assets and fair disaggregation / contribution
- Governance too pre-occupied with single issues to manage full remit
- That relationship and respective responsibilities of the Community Planning Partnership and Health & Social Care Partnership not clear, leading to reduced effectiveness and reduced focus.