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 X☐ No ☐

Comments
On balance, for the reasons highlighted in the consultation paper, this maybe a practical and helpful approach. It would, of course, not be without some considerable difficulties which need to be addressed. Foremost is the one of definition. Is this to be defined solely by age? As stated in para 1.12 of the document, people with disabilities have requirements across all age groups but there is no suggestion as to how this problem is to be addressed by focussing initially on older people's services. Is the definition to be set in the local Partnership Agreements or will this be defined in Regulations?.
In a recent survey of people with learning disability in receipt of packages of support costing in excess of £1200 a week the Commission found a high number of people – in excess of 150 – who were 65 or older. Many others will be turning 65 in the next year or two. It is rare that a person first receiving a community care assessment and related package of support once they have turned 65 would command such financial input into their community care. If Older People's Services are to be defined by age alone will the money for such support follow the individual? If not, will, for instance, a person receiving a support package in respect of their learning disability receive additional support should they develop dementia or other age related disorder requiring community health and social care support?

An underlying problem in focussing initially on services to older people is that it perpetuates a discriminatory approach to funding the support needs of older people relative to other "care groups" which currently exists - at a time when there will be joint accountability for the commissioning of such services. It will not be solely an issue of local democratic choice that such anomalies evolve and continue. There is an argument that such distinctions should end and that the focus should be on levels of care and support required – such as 1:1, residential care, waking night staff, on-call night staff - not whether a person has a mental illness, learning disability, physical impairment or dementia. The Equality Impact Assessment states that public sector equality duties require the Scottish Government to pay "due regard" to the need to eliminate discrimination and advance equality of opportunity and there is the real danger that by focussing on older people initially, Health Boards and local authorities may be seen as failing in this duty.

If the initial focus is to be on older people's services, there should be close national attention paid to how, in future, the question of parity between different categories of people with support needs is to be achieved. Arguably, joint integrated budgets overseen by a single accountable officer working within local partnership agreements drafted to meet nationally agreed outcomes within the national performance network, offers the real possibility of addressing this difficult area of public policy.;

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 X☐ No ☐

Comments
We feel an important omission in the proposed Health and Integration Outcomes is the fact that the delivery of all outcomes should be ECHR compliant and that all outcomes should ensure the protection of adults vulnerable and at risk as a result of their mental illness, learning disability or other related condition.
The Commission feels it is important to maintain the actual and apparent independence of certain local authority functions such as those of Mental Health Officers; the responsibilities of the Chief Social Work Officer under the AWI Act as well as local authority responsibilities in respect of such matters as investigating concerns re welfare and finances of individuals under the MH and AWI Acts and having to make an application for guardianship when needed and it is not being done by anyone else.
There is a danger in losing this structural independence, something commented on quite clearly and strongly in the Millan Committee Report. Clinical decisions taken and the subsequent care plans to be put in place have to take account of the rights of the individuals involved. Local authorities have inherited this responsibility under a number of pieces of legislation; responsibilities which have been strengthened under the Scottish Parliament with the passage of the AWI Act, the MH Act and the Adult Support and Protection Acts. Any inroads into this structural independence must be established in such a way so as to insure that those staff charged with assessing whether interventions require statutory authority are managed separately from those making the clinical decisions. Someone occupying a bed they are assessed as no longer needing from a medical standpoint who lacks capacity and is objecting to the care plan which includes moving him into a care home ,cannot simply be moved by social care or health staff whether the service is integrated or not. (Approximately 900 guardianship applications were taken out in the past

year for people with dementia.) If, as we believe should remain the case, these applications and/or statutory MHO reports attached to the applications continue to be the responsibility of local authorities, this budget cannot be considered part of older people's services.

In many ways these proposals are akin to what might be called a hybrid of the previous "Joint Future" agenda. This did not deliver for many reasons but could be summed up by lack of commitment from all levels of both the organisations. An example might be the low numbers of Single Shared Assessments completed by NHS staff, or the delay in allocation of an assessment of a hospital patient not being tracked by Eddison. The culture of both organisations requires to change at a much faster pace than ever before, to achieve better outcomes regardless of which service is responsible. the

MWC strongly supports the principle that more resources should be directed towards community provision and capacity building as could be achieved under Section 26 Mental Health Care & Treatment (S) Act 2003.

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 X☐ No ☐

Comments
MWC would support a jointly owned and agreed outcomes-led approach to adult health and social care reform with the added provisos discussed above.

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 X☐ No ☐

Comments

Yes. Nationally agreed outcomes should be included within local SOA, with the additions stated above. We support the fact that decision making authority for delivering outcomes will rest with the Health & Social Care Partnerships without the need to "refer back up the line".
We have some concern that moving from 34 CHP's to 32 H&SCP's may not be sufficient to significantly streamline arrangements, although it would be a helpful move in the right direction.

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 X☐ No ☐

Comments
We are not clear to what extent local partnership agreements will be able to establish their own priorities and how local issues are to be resolved within the national framework, especially where health and local authority priorities as currently established diverge to a significant extent.

Hopefully, the outlined arrangements for joint accountability to local authority leaders and Ministers will provide the right balance although a management protocol must be agreed to avoid the Jointly Accountable Senior Officer from being placed in a stalemate position by his/her Chief Executives. We look forward to seeing the exact level of authority delegated to these officers.

It will also be important to ensure that the targets for performance are structured to avoid conflicting priorities or situations where there is a shift in the balance of care from one area to another without the necessary equivalent shift in resources. This has to be clearly planned out in the work of national outcomes/HEAT/and SOA work groups so there is no negative impact on delivered outcomes to service users.

In 4.20 there should be an additional body noted in the external scrutiny partners to reflect the work of the Mental Welfare Commission (MWC) in reviewing quality of service and outcomes achieved for individuals with mental illness, learning disability or related conditions.

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

Yes X☐ No ☐

Comments
Yes, in some instances this may well make sense. However, it may be that in other areas this will result in the HSCP's becoming too large which risks them losing democratic accountability.

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

Yes X☐ No ☐

Comments
These proposals seem reasonable although we would refer you to the comments we made in response to question 2.. It will be essential to support this group with competent professional advisers and patient/service user representation. Pathways of care should be clear and precise and any resulting efficiency savings should be reinvested in achieving the service outcomes. There must be clearly established protocols for resolving clinical disputes between health and social care staff on individual cases.

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 X☐ No ☐

Comments
The performance management arrangements may be reasonable but risk being over-engineered and complex which could reduce their effectiveness.

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 X☐ No ☐

Comments
The question of including the remit for other CHP functions should be a

matter for each Partnership.

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 X☐ No ☐

Comments
The key to the success of this proposal is the extent to which local stakeholders both inform and buy into the local Partnership Agreements. The delegated authority of the Jointly Accountable Officer will be crucial but it will be essential that they are in receipt of the right information of both a quantitative and qualitative nature from those involved in commissioning services (which includes those assessing the support needs of individuals.). One indicator of the success of this will be the extent to which the services delivered lose their “social” or “health” care identity. At a time of change, it has been known for some staff to navigate away from embracing strategic/cultural change by hiding behind professional smokescreens, this should be anticipated and avoided. Some of the remedial work required to facilitate this change would be for the parties to re-commit to the principles of Single Shared Assessment by all groups within the HSCP, although there should be greater clarity nationally as to the definition of what constitutes a Single Shared Assessment.

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 ☐

Comments
Not applicable

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 X☐ No ☐

Comments
Direction on the minimum categories of expenditure would be essential. Getting the detail right will be very difficult. Such secondary legislation, however, should be subject to widespread consultation to ensure the widest buy-in.

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 X☐ No ☐

Comments
The ability of the Jointly Accountable Officer to overcome difficulties in service delivery will be strengthened by the commitments in the Partnership and Service Level Agreements. The support required from the host partner should not be underestimated in the initial stages. The shift in financial investment should also be supported by an organisational cultural shift which needs the support of senior managers from both organisations as well as from those staff more directly involved in implementing the change in respect of the care and support of individuals.

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

Yes X☐ 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 X☐

Comments
Guidance might be safer given the differences between urban/ rural/ island authorities and health boards. National objectives need to continue which should be matched by the local targets in improving health and social care. Locality planning should be retained by locally elected bodies.

Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals from both the local authority and the NHS, 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 X☐ No ☐

Comments
Yes the duty is strong enough. Consultation on service provision planning should allow transparency and opt-in to the consultation by all stakeholders should be obligatory. The bridge between locally perceived strategic priorities and those nationally agreed may well prove difficult at times, especially where local anomalies in terms of the provision of services in a disproportionate way in respect of certain categories of people (e.g older people or people with ASD) will need to be addressed.

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
Local operational teams could be given the opportunity to have joint “away” days akin to the protected time training to consider the efficiency, effectiveness and fairness of current and/or proposed priorities for service provision.. A regular element to this should be through reviewing use of (or lack of) SSA. All unmet need should be recorded. The teams need not be jointly located but they must operate on a MDT modus operandi.

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 X☐

Comments
The planning should be around the local authority catchment areas which would be larger than clusters of GP practices. GPs will be key, but not central players in the joint delivery of services. This would allow greater scope for pathways and resources to be commissioned affording economies of scale, etc. The GP's status as independent contractors might be a barrier to the holistic nature of better outcomes for service users through integrated service delivery.

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

Comments
As indicated different solutions might be found in different areas, so locality planning groups should be accountable. National guidance and, possibly direction, may be necessary to ensure equity of provision across all service user groups. This will require SMART management techniques to be transparently applied to ensure outcomes are met.

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
Same as Q 18.

Do you have any further comments regarding the consultation proposals?

Comments

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

CommentsThe EQIA does not take into account the needs to ensure that any policy and structural changes do not create or perpetuate any effectively discriminatory practices which impact upon certain categories of service users.

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

Comments