Integration of Adult Health and Social Care in Scotland

Consultation Analysis Report

December 2012

The Scottish Government
Riaghaltas na h-Alba

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EXECUTIVE SUMMARY

Background to the consultation

1. In May 2012, the Scottish Government launched a public consultation to inform recommendations for legislation to support the integration of adult health and social care in Scotland. This report presents the views expressed by respondents to the consultation proposals.

2. Scottish Ministers' proposals for integration of adult health and social care, as described in the consultation document, are based on four key principles:

- Health and social care services should be firmly integrated around the needs of individuals, their carers and other family members;
- There should be strong and consistent clinical and care professional leadership in the planning and provision of services;
- The providers of services should be held to account jointly and effectively for delivering improved outcomes; and
- Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve, rather than the organisations through which they are delivered.

3. The consultation set out six key proposals to achieve integration:

- Community Health Partnerships will be replaced by Health and Social Care Partnerships, which will be the joint and equal responsibility of Health Boards and Local Authorities, and which will work in close partnership with the third and independent sectors and with carer representation. The focus will be on making sure that people have access to the right kind of care, at the right time and in the right place.

- Nationally agreed outcomes will apply across **adult health and social care**. Health and Social Care Partnerships will be jointly accountable, via the Chief Executives of the Health Board and Local Authority, to Ministers, Local Authority Leaders and Health Board Chairs for the delivery of those outcomes. Outcome measures will focus, at first, on improving older people's care and will be included in all Community Planning Partnerships' Single Outcome Agreements.

- Health and Social Care Partnerships will be required to integrate budgets for joint strategic commissioning and delivery of services to support the national outcomes for adult health and social care. Integrated budgets will include, as a minimum, expenditure on community health and adult social care services, and, importantly, expenditure on the use of some acute hospital services. Where money comes from – health or social care, or indeed, housing – will no longer be of consequence to the patient or service user. What will matter instead will be the extent to which Health and Social Care Partnerships achieve the maximum possible benefit for

service users and patients, together and against the backdrop of shared outcomes and integrated budgets.

- A jointly appointed, senior Jointly Accountable Officer in each Health and Social Care Partnership will ensure that partners' joint objectives, including nationally agreed outcomes, are delivered within the integrated budget by the Partnership.

- The role of clinicians, social care professionals and the third and independent sectors in the strategic commissioning of services for adults will be strengthened. Health and Social Care Partnerships will ensure that effective processes are in place for locality service planning led by clinicians and care professionals, with appropriate devolved decision-making and budgetary responsibilities.

- Proportionally, fewer resources – money and staff – will be directed in future towards institutional care, and more resources will be directed towards community provision and capacity building. This will mean creating new and potentially different job opportunities in the community.

4. The purpose of the consultation was to seek people's views about the legislative proposals for the integration of adult health and social care.

Method

5. The consultation period ran from 8 May to 11 September 2012. It was made up of two main elements: the invitation to individuals and organisations to submit written responses to the consultation document itself, and nine public and practitioner consultation events, providing an opportunity for discussion and direct engagement with a wide range of stakeholders.

6. The Scottish Government promoted the consultation on its web site and invited written responses to the consultation paper from all sections of society in Scotland. The consultation paper included 20 questions to which written responses were invited. A total of 315 responses were received. The non-confidential responses[1] have been published on the Scottish Government website.

7. Nine public and practitioner consultation events took place between May and August 2012 in Edinburgh, Glasgow, Dumfries, Perth and Elgin. The target audience included health and social care professionals from statutory and non-statutory organisations; carers; users of health and social care services; and members of the public more widely. Chapter 4 provides a summary of the key themes from the discussions.

8. Around fifty local events including focus groups and meetings were arranged by various organisations and local forums including the Scottish

[1] Responses to the Integration of Adult Health and Social Care in Scotland Consultation http://www.scotland.gov.uk/Publications/2012/10/5025

Health Council, Health Boards, Local Authorities, third sector organisations and carers' groups. The Scottish Government provided input at these local events. In some cases, stakeholders indicated that discussion at local events was used to inform their written responses.

Summary of views from consultation responses

9. Questions were asked under the five main chapter headings of the consultation, covering:

- National outcomes for adult health and social care;
- Governance and accountability;
- Integrated budgets and resourcing;
- Jointly Accountable Officer; and
- Professionally led locality planning and commissioning of services.

10. Most of the questions offered respondents the opportunity to answer 'yes' or 'no'. In addition, respondents were invited to provide a textual response. Most respondents chose not to answer specifically 'yes' or 'no', instead providing a more discursive response reflecting the complexities of their experience and viewpoint. This input provides a richness of insight, which is most helpful to the process of taking forward legislation.

11. The remainder of this section provides a brief summary of key points made in response to the proposals in the consultation.

National outcomes for adult health and social care and scope

12. The majority view supported nationally agreed outcomes to be included in Single Outcome Agreements and for statutory partners to be held jointly and equally accountable for delivery. However, there were differing opinions about the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend the focus to improving integration of all areas of adult health and social care.

13. Those in favour expressed the view that it is sensible to start with the largest group of service users, allowing Health and Social Care Partnerships to incorporate improvements before extending to all adults.

14. Other respondents indicated concerns that, by focusing on 'older people' first, an artificial divide may be created that may have a negative impact on other groups of patients and service users, who did not meet the 'age criteria'.

15. Some respondents appear to have interpreted the proposed scope as being limited to older people. Where this point was raised at discussion events, Scottish Government officials reiterated the point that Ministers intend to legislate for all areas of adult health and social care, allowing integration beyond adult health and social care services, for example including children's services, where there is local agreement to do that.

Governance and accountability

16. Respondents noted that joint accountability requires robust information, clear outcomes, evidenced performance management and public reporting through external scrutiny. Most respondents expressed the view that the proposals should be strengthened with respect to plans for performance management arrangements, and that these should focus on the delivery of outcomes which are clear, balanced and not solely target driven. There was also reference to the importance of involving non-statutory partners in the development of performance management arrangements.

17. Many respondents expressed the view that a Health and Social Care Partnership should be about the synergy between a single council and a single Health Board. Concerns were raised that should a Health and Social Care Partnership span more than one Local Authority area then local issues could be lost in larger partnership considerations, and that it may over-complicate existing structures. Additionally, some respondents felt that experience shows that small partnerships are more effective at delivering the needs of the individual and their communities, and that funding should be devolved more locally.

18. On proposals regarding committee membership, Local Authority respondents asked particularly for flexibility regarding the number of Councillors who could sit on the Health and Social Care Partnership committee. There was a consistent view that accountability should be to the full Council and not the Leader of the Council or its officers.

19. Concerns were raised particularly by stakeholders from the third and independent sectors, carers' representative groups, and public and service users' representative groups that the proposals for accountability arrangements focussed particularly on the statutory partners. The view was expressed that other groups should also be recognised and involved in integrated accountability arrangements.

20. There was also a consistent view that the proposals should be strengthened with respect to assuring effective public participation in the processes of planning services. Public Participation Forums were quoted as an example of a successful means of engaging with the public and building in the views of unpaid carers and service users.

Integrated budgets and resourcing

21. Most respondents expressed the view that the models described within the proposals could successfully deliver the objective to use adult health and social care budgets to best effect for the patient or service user. Preference was given in most responses to the 'body corporate' model. However, some respondents, mainly from Local Authorities, expressed the view that more options should be available, and that decisions regarding which model to use should be made locally.

22. In terms of whether or not Ministers should give direction on minimum categories of spend for inclusion in the integrated budget, there was a general view in favour of Ministerial prescription kept to a minimum spend, to allow for local discretion and flexibility and to accommodate local priorities. A few respondents expressed concerns that, if Ministers prescribe a minimum, only that minimum will be included in the integrated budget.

23. There were mixed views regarding whether or not Health Boards and Local Authorities should be free to choose whether to include the budgets for other Community Health Partnership functions (beyond adult services) within the scope of the Health and Social Care Partnership. The majority of respondents expressed the view that this should be left to local determination. A few respondents suggested a stepped approach, starting with the minimum and when Health and Social Care Partnerships can demonstrate it is working, move to include more services. There were some respondents who expressed the view that Ministers should prescribe the extent of the integrated budget in order to assure consistency of approach. Some respondents also expressed the view that budgets for children's and housing services particularly, should be included within the scope of the integrated budget from the start.

Jointly Accountable Officer

24. Respondents expressed differing views regarding the appointment of Jointly Accountable Officers and expressed a need for further information on the role and remit of the post. Some respondents thought that responsibility for planning and delivery of integrated services should sit with the Chief Executives of Health Boards and Local Authorities, and existing Community Health Partnership General Managers. Others felt that the role would be necessary in order to manage the integrated budget effectively.

25. There was general agreement that if Jointly Accountable Officers are appointed they need to be multi-skilled, experienced, knowledgeable and expert managers, able to operate with autonomy, wield influence and exercise authority within both statutory structures, as well as within the Health and Social Care Partnership. Many respondents expressed the view that the Jointly Accountable Officer post must be senior enough to reflect these requirements.

Professionally led locality planning and commissioning of services

26. The majority of respondents expressed a desire for locality planning arrangements to be developed locally, supported by Scottish Government guidance. A few respondents expressed the view that the Scottish Government should direct locality planning arrangements to ensure consistency across service delivery areas.

27. The proposal 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 and implementing service

provision was welcomed. However, some respondents asked that the duty be strengthened by using the terms ‘involve’ and ‘engage’ rather than ‘consult’. Reference was also made to the need to make specific mention of other clinical staff, health and social care professionals and service users.

28. Respondents expressed the view that, in order to encourage active participation of clinicians and social care professionals in planning service provision, they would need to have a clear understanding of the requirements of their localities. Many respondents added that Health and Social Care Partnerships could be strengthened by setting up joint professional and stakeholder advisory committees to contribute to the development of joint strategic commissioning plans. It was suggested that structured support for stakeholder involvement would be required.

29. Opinions were split regarding locality planning being organised around clusters of GP practices. Whilst many supported this approach in principle, many respondents supported locality planning being developed at the level of ‘natural communities’. There was also a consistent view that the size of localities should be determined locally. There was a mixed view of the level of devolved responsibility for decision-making to localities. The strongest proponents of devolved decision- making came from professional membership organisations, Local Authorities and public representative bodies.

CHAPTER 1: INTRODUCTION

1.1 The Scottish Government launched a public consultation to inform recommendations for legislation to support integration of adult health and social care in Scotland. This report presents the views expressed by respondents to the consultation proposals.

Background to the consultation

1.2 The *Healthcare Quality Strategy for NHS Scotland*[2], published in May 2010, underpins our commitment to deliver the highest quality healthcare services to people in Scotland and, in recent years, we have seen significant improvements in terms of standards and outcomes, with improvements in waiting times, patient safety and delayed discharges from hospital. Our introduction of Scotland's *National Dementia Strategy*[3], our continuing commitment to Free Personal and Nursing Care[4] and our Reshaping Care for Older People[5] programme, all demonstrate our determination to assure innovative, high quality care and support services that improve people's lives. *Caring Together: The Carers Strategy for Scotland*[6] supports unpaid carers, who are themselves essential providers of health and social care, and the *Social Care (Self Directed) (Scotland) Bill*[7] seeks to put greater control into the hands of individuals using care and support services.

1.3 The recent review of Community Planning undertaken by the Scottish Government and the Convention of Scottish Local Authorities identified that effective Community Planning arrangements should be at the core of public service reform to achieve better outcomes for communities. Realising this will require community planning partners and communities to work together to understand local needs and aspirations, and to design and deliver services that meet these needs and aspirations.

1.4 There is recognition, however, across Scotland that we need to go further. Separate – and sometimes disjointed - systems of health and social care can no longer adequately meet the needs and expectations of increasing numbers of people who are living into older age, often with multiple, complex, long-term conditions, and who need joined up, integrated services. Addressing these challenges will demand commitment, innovation, and

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[2] *Healthcare Quality Strategy for NHS Scotland*
http://www.scotland.gov.uk/Publications/2010/05/10102307/0
[3] *National Dementia Strategy*
http://www.scotland.gov.uk/Publications/2010/09/10151751/0
[4] Free Personal and Nursing Care
http://www.scotland.gov.uk/Resource/Doc/305166/0095748.pdf
[5] Reshaping Care for Older People Programme
http://www.jitscotland.org.uk/downloads/1299249359-ReshapingCareProgrammeFinal4March.pdf
[6] *Caring Together: The Carers Strategy for Scotland*
http://www.scotland.gov.uk/Publications/2010/07/23153304/0
[7] *Social Care (Self Directed Support) (Scotland) Bill*
http://www.scottish.parliament.uk/parliamentarybusiness/Bills/48001.aspx

collaboration from everyone involved in planning, managing, delivering, using and supporting health and social care services.

1.5 The Scottish Government, statutory partners in local government and NHS Scotland, and non-statutory partners in the third and independent sectors, agree that better integration is required if we are to ensure the ongoing provision of high quality, appropriate, sustainable services. Integration is not an end in itself – it will only improve the experience of people using services when we all work together to ensure that we are integrating services as an effective means for achieving better outcomes.

1.6 The Scottish Government launched a public consultation on 8 May 2012, to inform recommendations for legislation to support the integration of adult health and social care services in Scotland. The consultation paper was entitled *Integration of Adult Health and Social Care in Scotland: Consultation on Proposals*[8] and stated that the aim of the proposed legislation is to improve people's experience of health and social care services and the outcomes that services achieve, and to ensure that the substantial proportion of Scottish public services spending, that supports these services, is used to the very best effect.

1.7 Four key objectives for integration:

- Health and social care services are firmly integrated around the needs of individuals, their carers and other family members;
- There should be strong and consistent clinical and care professional leadership in the planning and provision of services;
- The providers of services should be held to account jointly and effectively for delivering improved outcomes; and
- Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve, rather than the organisations through which they are delivered.

1.8 The consultation set out six key features of the proposals:

- Community Health Partnerships will be replaced by Health and Social Care Partnerships which will be the joint and equal responsibility of Health Boards and Local Authorities, and which will work in close partnership with the third and independent sectors and with carer representation. The focus will be on making sure that people have access to the right kind of care, at the right time and in the right place.

- Nationally agreed outcomes will apply across **adult health and social care**. Health and Social Care Partnerships will be accountable, via the Chief Executives of the Health Board and Local Authority, to Ministers, Local Authority Leaders and Health Board Chairs for the delivery of those outcomes. These outcome measures will focus, at first, on improving

[8] *Integration of Adult Health and Social Care in Scotland: Consultation on Proposals* http://www.scotland.gov.uk/Publications/2012/05/6469

older people's care and will be included in all Community Planning Partnerships' Single Outcome Agreements.

- Health and Social Care Partnerships will be required to integrate budgets for joint strategic commissioning and delivery of services to support the national outcomes for adult health and social care. Integrated budgets will include, as a minimum, expenditure on community health and adult social care services, and, importantly, expenditure on the use of some acute hospital services. Where money comes from – health or social care, or indeed, housing – will no longer be of consequence to the patient or service user. What will matter instead will be the extent to which partnerships achieve the maximum possible benefit for service users and patients together, against the backdrop of shared outcomes and integrated budgets.

- A jointly appointed, senior Jointly Accountable Officer in each Health and Social Care Partnership will ensure that partners' joint objectives, including nationally agreed outcomes, are delivered within the integrated budget by the Partnerships.

- The role of clinicians, social care professionals and the third and independent sectors in the strategic commissioning of services for adults will be strengthened. Health and Social Care Partnerships will ensure that effective processes are in place for locality service planning led by clinicians and care professionals, with appropriate devolved decision-making and budgetary responsibilities.

- Proportionally, fewer resources – money and staff – will be directed in future towards institutional care, and more resources will be directed towards community provision and capacity building. This will mean creating new and potentially different job opportunities in the community.

Purpose of the consultation

1.9 The purpose of the consultation was to seek people's views about the legislative proposals for the integration of adult health and social care. The consultation included twenty questions covering seven key themes: the case for change; outline of proposed reforms; national outcomes; governance and joint accountability; integrated budgets and resourcing; jointly accountable officer; and professionally led locality planning and commissioning of services.

This report

1.10 The rest of this report sets out to explore responses received to these questions. Chapter 2 describes the method used to capture views to the consultation proposals. Chapter 3 focuses on the views expressed in the written responses and Chapter 4 provides a summary of the discussion at the public and practitioner consultation events.

CHAPTER 2: METHOD

2.1 This chapter outlines the method used for the consultation on the proposals to integrate adult health and social care in Scotland.

Process overview

2.2 The formal consultation took place between 8 May and 11 September 2012. During this period the Scottish Government wanted to encourage a wide and inclusive discussion. This consultation followed a year long process of engagement with stakeholders to develop the proposals. To achieve this there were two main elements to the consultation process:

- The invitation for individuals and organisations to submit written responses to the document *Integration of Adult Health and Social Care in Scotland: Consultation on Proposals*[8]; and
- Nine public and practitioner consultation events.

Written responses

2.3 The Scottish Government promoted the consultation on its web site and invited written responses to the consultation paper from all sections of society in Scotland. In particular, from those groups and organisations with a specific interest in health and social care. A copy of the consultation questionnaire can be found in Annex 2.

2.4 The consultation document and information on the consultation process were available on the Scottish Government web site. This included an Easy Read version of the document. Paper copies including larger print and Braille versions of the consultation document were made available on request.

2.5 The consultation document was distributed to a wide range of stakeholders including Members of the Scottish Parliament (MSPs), Health Boards, Local Authorities, third and independent sector, professional organisation/bodies and equality groups.

2.6 The written responses were submitted directly to the Scottish Government via email and by post. Those responding were given three options regarding confidentiality of their response (confidential; keeping their name but not response confidential; and not confidential). Those who did not fill in any option had their responses treated as confidential. 315 written responses were received by the Scottish Government. The respondents were categorised into individual and organisational or group responses, with 15 categories to describe individual and group role or interest in health and social care (see chapter 3, section 3.2, for a profile of the respondents).

Consultation events

2.7 The Scottish Government held nine public and practitioner events over the summer. There was a mixture of practitioner focused and public events.

2.8 The Scottish Government hosted practitioner events in Edinburgh, Glasgow, Perth, Dumfries and Elgin. These events provided practitioners from the NHS, local government and the third and independent sectors with an opportunity to discuss the integration agenda in more detail and provide valuable feedback in advance of submitting written responses to the consultation.

2.9 The Scottish Health Council hosted public consultation events, on behalf of the Scottish Government, in Edinburgh, Glasgow, Perth and Dumfries. These events provided an opportunity for members of the public to discuss in detail the proposals to integrate adult health and social care and also to provide valuable feedback in advance of submitting written responses to the consultation.

2.10 All of the events started with an overview of the proposals to integrate adult health and social care, presented by the Scottish Government. At the practitioner events this was followed by a panel question and answer session. The panel included representatives from health, local government, third and independent sectors.

2.11 For the public events, facilitated table discussions regarding the consultation proposals were held prior to the panel question and answer session. The facilitators used open questions to stimulate discussion. A copy of the facilitators' questions guide can be found at Annex 4. Participants were given the opportunity to put forward questions to the panel. Chapter 4 provides a summary of the key themes from all the public and practitioner events.

Local information sharing events and meetings

2.12 The Scottish Government contributed to around a further fifty events. This included a variety of conferences, workshops and focus group meetings hosted by a wide range of organisations, including Health Boards, Local Authorities, third sector organisations, carers organisations and public participation forums. Scottish Government officials provided an overview of the proposals and the participants were given the opportunity to ask the Scottish Government officials questions about the proposals. These events provided information and discussion that helped participants inform their response to the consultation, and added informally, and very helpfully, to the ongoing discussion between Scottish Government and partner organisations about the proposals. The views expressed at these local events are not represented in the report.

Data analysis

2.13 The views expressed by the 315 respondents were grouped into themes under each of the twenty questions posed in the consultation document. The views expressed by participants at the public and practitioner events were summarised under key themes from the discussion.

2.14 A computer based system was set up to collate information from the written responses to support the analysis. Both quantitative and qualitative approaches were used to reflect the nature of the consultation questions. The consultation document contained twenty questions aimed at collecting views on the scope for change; national outcomes for adult health and social care; governance and joint accountability; integrated budgets and resourcing; jointly accountable officer; and professionally led locality planning and commissioning of services. The majority of the questions asked directly whether respondents agreed with specific proposals by providing a yes/no tick box option. It should be noted that the response form did not include any 'mixed view' or 'no response' option. The analysis therefore includes quantitative data derived from views where the respondent has made clear whether they agree or disagree with the proposal.

Summary

2.15 This chapter has outlined the methods used in the consultation. The remainder of this report sets out the views of respondents to the consultation, with chapter 3 reporting on the views expressed in the written responses and chapter 4 providing a summary of the discussion at the public and practitioner consultation events.

CHAPTER 3: ANALYSIS OF WRITTEN RESPONSES

3.1 This chapter provides a summary and analysis of the written responses to *Integration of Adult Health and Social Care in Scotland: Consultation on Proposals*[8]. The chapter begins with an overview of who responded to the public consultation, what the main themes were from these responses and then reports on the views of respondents around each of the proposal themes set out in chapters 1 to 7 of the consultation document.

The respondents

3.2 315 written responses were received from a wide range of sources (49 from individuals and 266 from groups or organisations), see Table 3.1.

Table 3.1: Respondent profile

Type	No. of responses
Health Board (including Special Health Boards)	21
Other NHS organisation	9
General Practitioner	4
Local Authority	27
Other statutory organisation	10
Third sector care provider	24
Independent/private care provider	4
Representative organisation for professional group	37
Representative organisation for staff group	5
Education/academic group	4
Representative group for patients/care users	17
Representative group for carers	6
Patient/service user	11
Carer	1
Other	117
Multiple Categories	18

All Health Boards and Local Authorities responded to the consultation either as an individual organisation or as a joint Health Board and Local Authority response.

Overview of the written responses to the consultation

3.3 Most of the questions offered respondents the opportunity to answer 'yes' or 'no' via a tick box option. In addition, respondents were invited to provide a textual response. Most respondents chose not to use the tick box option to answer specifically 'yes' or 'no', instead providing a more discursive response reflecting the complexities of their experience and viewpoint. This input provides a richness of insight, which is most helpful to the process of taking forward legislation.

3.4 The remainder of this chapter provides an overview of the textual responses. As the majority of respondents chose not to use the 'yes' or 'no' tick box option, statistical analysis has not been reflected within the summary of the views expressed by respondents for each of the questions. Where respondents have stated agreement or disagreement within their comments, we have reflected this. A breakdown of those who used the tick box option to indicate a 'yes' or 'no' answer and the number who left this blank, including a breakdown of categories, can be found at Annex 1.

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?

3.5 There were conflicting opinions regarding whether Health and Social Care Partnerships should initially focus on promoting outcomes for older people. Those in favour expressed the view that it is sensible to begin with outcomes for older people first as they are the largest users of the service. A recurrent view, often referring to personal experience, was that focusing on one group would allow partnerships to capitalise on lessons learned. This would allow partnerships to incorporate improvements before extending the integrated approach to other services. Many of these respondents also expressed the view that there should be a condition attached that the definition for 'older people' should relate to the stage and state of health rather than chronological age.

3.6 Among those who agreed with question 1, there was sometimes a view that the scope was too big. There were concerns raised that working with such a large group would be time consuming and may lead to delayed outcomes due to lack of resource. A few responses highlighted the importance of learning from past experience. Also, the view was expressed that starting with a large group might make it more difficult to change approach if difficulties arose.

3.7 For those who did not agree with this approach, there was a commonly held view that focusing on outcomes for 'older people' first would create an artificial divide that will have a negative impact on groups who do not meet the required 'age criteria'. Examples quoted were the needs of younger disabled people, those with mental health problems and those diagnosed with Parkinson's Disease at a young age. Many respondents stated concerns that if outcomes are targeted at 'older people's' services, resources will be directed to areas that are being monitored which will lead to poor services elsewhere. There were also concerns raised that assumptions might be made that the service is 'fit for purpose' across all adult services. Any extension to the focus of integration would need to take into account specific needs of other groups, for example people with learning difficulties, as 'older people's' services might not meet their specific needs.

3.8 Among those who did not agree with the approach, there was generally the view that integration should include all adult services from the start and that this should be clearly defined in the legislation. Some respondents expressed the view that integration should go further and include children and young people's services. According to this view, a whole system approach is required to ensure that there is no disruption to people using the services.

3.9 Among those who did not agree, some respondents working in rural areas made the point that focusing on 'older people's' outcomes first would be very difficult when dealing with a sparsely populated rural area. The services for rural areas are more likely to benefit from 'hubs' or 'one stop shops' to successfully deliver an integrated service. Limiting the scope could lead to people in rural areas not receiving the service they need.

3.10 Nearly all respondents, both from those who agreed and disagreed with the approach, expressed the view that if legislation focuses on outcomes for 'older people' first there would, as a minimum, need to be clear guidelines and timescales for the extension to other adult services. Without this, there is a risk of unnecessary delays and people left not receiving the services they need.

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?

Partnership working

3.11 Among those who answered yes to this question, many respondents expressed the view that the focus should be more on partnership working to achieve common outcomes at both strategic and operational level. A few respondents commented on the importance of leadership at each level for health, social care, third and independent sectors.

3.12 A few respondents referred to the framework as being a positive step in achieving a reduction in the rate of hospital admissions for older people. In addition, there was reference made to the need for effective partnership working to achieve this aim.

Additions to the proposals

3.13 Several respondents who answered no to question 2 expressed the view that housing, criminal justice, and children and young people's services should be included from the outset. The point was made that criminal justice social work is an adult social care service, which has critical relationships with those in the new Health and Social Care Partnerships including services relating to addiction and mental health.

3.14 Many expressed the view that housing should be included as a partner in the decision-making and implementation. Housing was viewed as critical to

keeping people in the community. In addition, several respondents made the point that integration should be used as an opportunity to work with a wider range of partners, including leisure and transport.

3.15 A consistent view was that the proposals should clarify how integration will be implemented and who will be involved. A few respondents made reference to the lack of detail regarding what hospital services would look like in the new structure.

3.16 Several respondents expressed the view that preventative interventions could be lost under integrated arrangements. A few respondents raised the point that an early health improvement intervention (with a younger age group) would support prevention. This would lead to less reliance on health services as people grow older.

3.17 A consistent view, particularly from third sector organisations, was the need to develop a set of guiding principles based on equality and human rights. The point was made that legislation needs to consider how this Bill will link with the *Social Care (Self Directed Support) (Scotland) Bill*[7]. Legislation should govern and guide practitioners throughout implementation. A key principle should be supporting older people to live in the community for as long as possible.

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 and for support to carers. 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?

Measuring success

3.18 A few respondents raised concerns regarding how joint responsibility could be achieved between two separate partners. Nationally agreed outcomes are likely to be different for different population groups, which could lead to local variations. There needs to be recognition that this approach will take time to develop as staff will need to get used to a new way of working.

3.19 There was sometimes the view expressed that accountability does not go far enough. Statutory bodies need to be accountable to local communities.

3.20 A few respondents expressed the view that measuring outcomes might be difficult as current community information technology systems do not provide integrated data. There was support, primarily from carers networks,

that the Caldicott principles[9] should be used when collecting, transferring or generally working with personal information. There was an NHS view that at a national level there is a need to simplify the legislation surrounding data sharing to provide a simple and clear framework for the provision of integrated services.

3.21 The majority of respondents agreed that national outcomes should be set by the Scottish Government but there should be flexibility to allow partnerships to focus on local priorities. A few respondents commented that the Scottish Government needs to develop a monitoring framework and a process for reporting and inspection.

3.22 There was a recurrent view, mainly from NHS staff, that they could only agree with the proposal in part. The reason given was issues regarding the different organisational structures. It was suggested that national agreement would be required where there is more than one Local Authority per Health Board. Different Local Authorities seeking to adopt different approaches and/or priorities whilst working with one Health Board could confuse staff and result in delays. There was also a view that the legal framework may not allow a mechanism through which Health and Social Care Partnerships could report. Instead there was the suggestion that Health and Social Care Partnerships should be allowed to report back through their own organisation.

Involving non-statutory partners

3.23 From those who agreed with question 3, some expressed concerns that the law will not go far enough to make the desired change. There was also the view that there needs to be further consideration regarding how to ensure involvement of General Practitioners.

3.24 A few respondents added that third sector organisations, services users and carers should have an equal role in developing outcomes. In addition, legislation and policy should include the right to advocacy for service users and carers.

3.25 Among those who answered no to question 3, a few respondents expressed the view that this proposal will be difficult because bodies reporting to two completely separate and culturally different organisations may create confusion and structural problems, which may make it difficult to ensure accountability. A few individual responses expressed the view that this will only work if there is a reciprocal duty for GPs to be involved.

[9] Caldicott Principles
http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1195733746440

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

3.26 The majority of respondents expressed the view that nationally agreed outcomes for adult health and social care should be included within all local SOAs provided this was done appropriately. There needs to be consistency between all partners. Outcomes should be owned by health and social care and must involve those working with patients. Respondents suggested that outcomes should be based on local need and welcomed some flexibility to deliver on local priorities.

3.27 Several respondents made the point that service users, carers and third sector organisations should be involved in service design and delivery.

3.28 There was a consistent view, mainly from the NHS sector, that more consideration would need to be made regarding how to streamline and improve performance. Some respondents made reference to linking into other performance targets such as HEAT to support benchmarking.

3.29 A few respondents expressed the view that the Scottish Government should have powers to update and/or add outcomes if insufficient progress is being made.

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?

Support mechanisms for joint accountability

3.30 Several respondents expressed the view that joint accountability is not enough on its own to deliver this agenda. The agenda needs to be supported through robust information, clear outcomes, evidenced performance management and public reporting through external scrutiny. The point was made that historical precedent would suggest that clear accountability, joint or otherwise, does not necessarily lead to delivery.

3.31 Many of the views expressed by a wide range of stakeholders including NHS sector, Local Authorities and third sector, state that the proposals may result in tensions between national and local government and the Health Board and their partner Local Authorities. These tensions will be particularly acute where there are competing organisational or political priorities. Respondents suggested two mechanisms for alleviating these concerns. The first is that a clear national system of dispute resolution is devised. The second is that different accountabilities than those proposed within the consultation should underpin the proposals. Respondents suggested that this could be achieved through;

- NHS structures, to Scottish Ministers and the Scottish Parliament;
- Current Community Health Partnership style arrangements; and
- Community planning arrangements.

Local democratic accountability

3.32 Several views, mainly from Local Authority respondents, made the point that the proposals would reduce local democratic accountability for social care and distance these services from the local government scrutiny arrangements that are currently in place. A consistent view from respondents points to the principle of council sovereignty and the view that accountability needs to be to the full Council, not its officers or a small number of elected members.

The involvement of non-statutory partners

3.33 A wide range of stakeholders from the third and independent sectors, carer, public and user groups felt that the arrangements for accountability were dominated by statutory partners. They want to see a space for these groups to be recognised and involved in the accountability arrangements. Respondents referred to two general ideas about how this might be taken into account:

- For users, carers and the public there is a need for clear and quick information to be released. This should not only be in statistical returns, as these can be complex and difficult to understand, but clear and concise information that is up to date. The proposals need to provide for clear routes by which non-statutory partners can then respond to this information and influence decision-making and service planning; and
- A number of service providers highlighted the need for non-statutory partners to be formally embedded within strategic commissioning and locality planning arrangements. The Change Fund[10] arrangements serve as a useful example of this and could be built upon within the legislation.

Proportionate influence and multi-partnership areas

3.34 Several respondents from a wide range of stakeholders including NHS sector, Local Authorities and third sector, noted that more thought will have to be given to areas where there are multiple partnerships within a single Health Board area and consideration will be required to address these complexities. From a Health and Social Care Partnership perspective, greater consideration is required in relation to how they will be able to exert a proportional influence over the decision-making of a Health Board, which has multiple considerations, and from a service perspective the impact on hosted or pan partnership service delivery, also needs further consideration.

[10] The Change Fund http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/change-fund-plans/

Culture change

3.35 Several respondents, largely from the third sector, noted that these arrangements on their own will not address the significant cultural shift that needs to occur, and expressed concern that a medical model of service provision and decision-making may prevail over more social or care models of support.

Other points

3.36 A few respondents made the following additional comments:

- The arrangements will not address the divide between primary and secondary care;
- Health and Social Care Partnerships should have a duty placed on them emphasising clinical effectiveness and quality;
- Need for greater clarity about how these proposals address the current "cluttered landscape";
- The Minister for Local Government should also be accountable for health and social care delivery;
- Health and Social Care Partnerships should be accountable through Community Councils; and
- For small Health Boards with a single co-terminus Local Authority there is a need to look carefully at the number of committees and layers of bureaucracy that is prescribed.

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

3.37 Several respondents, mainly from public representatives, carers, health professionals and the third sector, expressed the view that a Health and Social Care Partnership should be about the synergy between a single Council and a single Health Board. Concerns were raised that should a Health and Social Care Partnership span more than one Local Authority area then local issues could be lost in larger partnership considerations, and that it would over-complicate existing structures. Additionally, some respondents felt that experience shows that small partnerships are more effective at delivering the needs of the individual and their communities, and that funding would be devolved more locally.

Clear guidance

3.38 Some of the respondents expressed the view that for this to be made a reality the Scottish Government would have to provide significant guidance. This would need to detail how the lines of accountability to two Councils would work within a Health and Social Care Partnership, to assure local democratic accountability and how the integrated budgets would work across two Councils. Some responses were sceptical that these assurances could be delivered within the broader framework of proposals.

Local flexibility

3.39 Quite a lot of respondents, including those who agreed and disagreed with question 6, commented that the legislation should provide flexibility to establish a Health and Social Care Partnership that covers more than one Local Authority. Some of these respondents went on to say that if partnerships wanted to use the legislation then the decision should be based on a clear evidence base that the arrangements would lead to improved outcomes for communities and a more effective use of resource.

Other points

3.40 Among those who disagreed, some organisations and individuals expressed a desire for partnerships to mirror Health Boards rather than Local Authorities. Some also made the point that this should not be an opportunity for public bodies to just save money at the expense of local decision-making.

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

Membership of the committee

3.41 Nearly all of the respondents expressed the view that the proposed committee arrangements are not appropriate. A commonly held view was that there should be additional representation on the Health and Social Care Partnership. Respondents suggested a range of members including:

- GPs;
- Secondary Care Professionals;
- Health Professionals in general;
- Chair of Community Planning;
- Independent sector;
- Complementary Health Practitioners;
- Housing representative;
- Independent contractors;
- Primary Care representative;
- Special Health Boards;
- Healthcare scientists;
- Health Board and Local Authority Chief Executives;
- Nurses;
- Allied Health Professionals;
- NHS staff side representative;
- Local Authority staff side and trade union representative;
- Pharmacists;
- NHS executive directors;
- Public Health representative;
- Geriatricians;
- Children and Young people representative;
- People with learning difficulties;

- People with disabilities;
- Finance experts; and
- Governance experts.

Committee membership

3.42 Nearly all of Local Authority responses and some other stakeholders asked for flexibility on the numbers of Councillors who can sit on the Health and Social Care Partnership committee. The larger Councils felt that they would need significantly more than the minimum of three noted in the proposals and this would outstrip the numbers of non-executive directors available to Health Boards. A few of these responses intimated that the number of non-executive directors available should not determine the maximum number of elected member representatives.

3.43 A recurring view from statutory partners and Community Health and Care Partnerships was the importance of allowing the Leader of the Council and the Health Board Chair to sit on the Health and Social Care Partnership committee.

Voting on the committee

3.44 The majority of respondents expressed the view that voting rights should be extended to either additional members of the committee (such as those noted above) or those categorised as 'non-voting' in the proposals. There was particularly strong support for voting rights to be extended to the representatives of the third sector, users, the public and carers. Respondents noted that voting was required to ensure meaningful representation, accountability to the public and equity in the relationship with statutory partners. Many respondents felt it was a backwards step from the current arrangements where these partners have voting rights on Community Health Partnership committees.

3.45 A few of the statutory partner respondents voiced their support for the voting proposals outlined in the consultation.

Third Sector, Users, Carers and the Public

3.46 Beyond voting, several respondents, mainly third and independent sector organisations and individuals, felt that the proposals should be strengthened with regard to embedding these stakeholders in the wider service planning process. Respondents for all categories noted the benefits of having strong representation from these stakeholders. Public Participation Forums were referred to as a good example to build public engagement in processes and the importance of building in the views of unpaid carers and service users was also noted. A few of the respondents felt that the proposals are dominated by statutory partners and a genuine attempt must be made to ensure it is not just tokenistic representation.

Clear role for non-statutory partner representatives

3.47 A few individuals and several organisational responses commented on the processes for finding representatives from non-statutory partners. There was a strong feeling that better ways of identifying and supporting representatives were needed and these proposals offered an opportunity to formalise this. There is a need to ensure that they are truly representative, they have a clear remit, are able to influence decision-making of the Health and Social Care Partnership committee and that areas of good practice are not lost. These issues are often compounded in rural areas where there are less people to get involved.

Accountability for decision-making

3.48 Some of the statutory partners raised a concern that the consultation implied that the Jointly Accountable Officer would be making autonomous decisions. They note that responsibility needs to rest with the Health and Social Care Partnership itself, not the individual officer.

Clinical Director

3.49 A few NHS sector responses raised concerns regarding a single clinical director being able to represent the range of clinical specialism and sub-specialism, the different roles and responsibilities of staff groups and the acute and primary sectors.

Other points

3.50 Some organisations and individuals made the additional following points:

- The proposals might amount to a 'third provider' who will be least able to deliver better outcomes;
- Professional and clinical governance needs to be considered;
- Additional non-voting membership should be determined locally;
- There needs to be a supra-partnership agenda around the strategic development of acute budgets;
- Decisions should be made on the basis of consensus and not a deciding vote;
- A rotating chair may cause conflict and hinder progress, highlighting the divide between organisations rather than providing consistency;
- A rotating chair should last for longer than a year;
- The proposals need to take into account other statutory Council roles (Head of Paid Service, Section 95 Officers, Chief Social Work Officer, Mental Health Officers); and
- The role of Councillors, who also sit on the Health Board, needs to be taken into account.

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?

3.51 Many respondents, represented across the range of stakeholders including NHS sector, Local Authorities, individuals, representative groups and third and independent sector organisations, noted that there was not enough information about the performance management arrangements to make an assessment of their efficacy.

External scrutiny

3.52 Several respondents from a wide range of stakeholders including NHS sector, third sector and user groups, noted the central role that external scrutiny will need to play to ensure that performance management is robust. There was consideration in a good proportion of these responses that the scrutiny landscape itself should be more integrated to reflect the new arrangements. There was concern that without this, existing structures may become overly complex and burdensome.

Outcomes focus

3.53 Some respondents, mainly Local Authority and health representatives, commented that performance management arrangements should focus on the delivery of outcomes. These need to be clear and understandable and balanced, not solely target driven. The point was made a number of times that the public will judge the effectiveness of the proposals not on the performance management system but its ability to improve outcomes and take effective action against Health and Social Care Partnerships that fail to deliver. A few respondents also asked that any outcomes or measures replace existing targets rather than add to an 'already burdensome reporting regime'.

3.54 Quite a lot of the respondents noted the importance of involving non-statutory partners in the development of the performance management arrangements. It is essential that users experience is at the heart of the system as it is they who will know if the Health and Social Care Partnership is delivering successful outcomes. There was a clear sense that the reporting of the performance management system needed to be understandable and timely, allowing non-statutory partners to feedback and support improvements. A specific measure on capacity building for co-production and integrated working with the third sector was proposed.

3.55 Some of the Councils expressed the view that performance management should not lead to eroding local democratic accountability and processes by involving central government and national agencies in the delivery of social care.

Improvement and benchmarking

3.56 A variety of different stakeholders including NHS sector, Local Authorities, third sector and criminal justice authorities, suggested that an improvement network or mechanism to share best practice would be essential in delivering better outcomes and supporting Health and Social Care Partnerships. Clear and comparative data between Health and Social Care Partnerships was seen as essential in driving this process.

3.57 A few respondents noted that a robust system of dealing with complaints is just as important as a performance management system in providing assurance to the public.

Other points

3.58 Among those who disagreed, some organisations and individuals made the following additional points:

- The Mental Welfare Commission should be included in the list of external scrutiny bodies;
- The Cabinet Secretary and the Council Leader should be the ultimate arbiters if there were a dispute;
- The implications for the transitions from children's to adult services should be considered;
- There should be measures for patient safety;
- The GP contract and Quality and Outcomes Framework should be considered to ensure GPs play an active role;
- Data systems must be joined up and reliable;
- The performance management system should take account of, and measure the cultural shift; and
- There needs to be outcome measures for other areas of joint delivery.

Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other Community Health Partnership functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Prescription/flexibility of scope of services

3.59 Most of the comments advise that this should be left to local determination and decision-making. This is essential to allow the development of innovative responses to local problems and service delivery issues and to ensure that cost effective integrated arrangements are put in place. Respondents advised that there is significant integrated working between different areas of service already and a prescribed limit on integration would inevitably cut across these arrangements.

3.60 Several respondents, mainly NHS sector and third and independent sector organisations, felt that the Scottish Government should prescribe the

extent of services that Health and Social Care Partnerships should include in the integrated arrangements. They argue that to attain the national consistency that Ministers seek and avoid variations of service provision, all Health and Social Care Partnerships need to integrate the same services. Some respondents go further and note that the Scottish Government should prescribe the services included within the integrated budget, but these services should stretch far wider than adult services.

Measured approach

3.61 Several respondents from a broad range of stakeholders including the NHS sector, mental health services, third sector and community forums expressed the view that Health and Social Care Partnerships should be required to take a stepped approach to including areas of service provision focussing on outcomes. Health and Social Care Partnerships should be required to demonstrate that they have integrated effectively for adult services and improved outcomes for older people, and then be allowed to include other areas. This would provide consistency but allow progressive and successful partnerships to increase their scope, in an organised way. Statutory and non-statutory stakeholders could then be involved in the consultation and development of outcomes for the other areas as they are included.

Other services

3.62 A few respondents questioned the consequences for services that are not included within the integrated arrangements. They asked how the consistency and quality of service provision would be maintained as focus shifted to those services included within integrated arrangements and what governance arrangements would need to be put in place. These considerations were particularly important for children's and housing services, and a variety of views were expressed as to whether these services should be included from the start.

Other points

3.63 Among those who disagreed, some organisations and individuals made the following additional points:

- The Scottish Government needs to provide guidance about what services should be included within the scope and what services are not included;
- Health and Social Care Partnerships need clear lines of professional accountability and governance for services within and out-with scope; and
- The totality of the integrated service needs to be able to deliver Self Directed Support.

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?

Models

3.64 Nearly all of the respondents felt that the models described could deliver the objective to use joint resources in a better way. Where a preference was expressed, it was for a 'body corporate'. There was some suggestion that further models existed or could be developed but there was no detail provided.

3.65 Of the statutory agencies, the majority of Health Boards agreed that the models described provide a mechanism to deliver the integration objective. A couple of the Health Boards expressed the view that delegation to a body corporate required structural change. Nearly all of the Local Authorities were also in agreement that the models described could be used to deliver the objective. Respondents who answered negatively thought there should be more than two option models to choose from and that the choice should be a local one.

Scope of the integrated budget

3.66 Several respondents expressed the view that clarity was required on what elements of hospital budgets, particularly acute, would be included in the scope of the integrated budgets with many respondents feeling it must be a substantial part in order to shift the balance of care. Concern was expressed about the practicalities of allocating acute resources across several partnership areas where there was no single co-terminus Local Authority. There was also a concern raised that acute services could remain a dominant partner. Some respondents suggested that it should not just be spend on older people because the hospital resource element of the integrated budget will be required for all adults in need of these services.

3.67 Many respondents indicated that the two options described ("Delegation to the Health and Social Care Partnership, established as a Body Corporate" and "Delegation between Partners") raised more questions than answers and respondents were keen to have further guidance on this.

Technical issues

3.68 Several respondents expressed concerns regarding a number of technical accounting issues. The most common one was around the different VAT arrangements between the Health Boards and Local Authorities. Others were Section 95 Officer status, reporting and audit arrangements, procurement, capital budgets, charging, dealing with overspends and a need to align budget cycles. A few respondents raised concerns over the current

data sharing arrangements and suggested these needed to be tackled at a national level, along with unifying information technology systems.

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?

Shared experience

3.69 Respondents listed a wide range of examples of their experience of making flexible use of resources across health and social care. These ranged from participation in national projects (Reshaping Care for Older People[5], Integrated Resource Framework[11], the Change Fund[10]) to differing scales of local projects and initiatives.

3.70 Several respondents suggested that data sharing issues and related joining up of information technology systems should be addressed as part of the integration agenda.

'Resources lose identity'

3.71 Most of the respondents agreed that resources should lose their identity but there were some concerns about what this would mean for accountability. Some statutory bodies were worried that they retain the requirement to account for their resources and need to be able to identify how, and on what, the money has been spent. This was not thought to be a deal breaker though, and most people raising this felt that further guidance would be helpful.

3.72 The need for further guidance and clarification was a recurring theme, with many respondents feeling the proposals were not yet clear on the mechanisms for integrating resources or technical solutions to achieve this. Some respondents were aware of the finance work streams[12] that were already in place and expected these groups to provide further information in due course.

3.73 There was a range of views as to what should be included in an integrated budget but most thought hospital services should be in (with the provisos mentioned above) while some felt housing budgets should also be included. Examples of different client group or diagnosis specific budgets were also mentioned, in the main by groups with an interest in those clients or conditions. Concerns were also raised from these groups that bigger services would be protected at the expense of some of the smaller more niche budget lines. In that vein, concerns were expressed that service users must not be

[11] Integrated Resource Framework http://www.shiftingthebalance.scot.nhs.uk/initiatives/sbc-initiatives/integrated-resource-framework/

[12] Working Groups supporting the Integration of Adult Health and Social Care Bill http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/IntegrationBillWorkingGroup

disadvantaged by the proposals and that front line services should be protected.

Shifting resources

3.74 Several respondents suggested that shifting resources would (and probably should) lead to disinvestment decisions. Respondents thought that this would inevitably lead to money being taken out of certain parts of the system. One respondent suggested that a clear scoring mechanism and process should be established to justify disinvestment decisions. Several respondents were keen that joint decisions on resources put an end to unilateral decisions being made that impacted on another part of the care system and others made a similar point that there is a need to put an end to cost shunting.

3.75 Several respondents commented that due to changing demographics the proposals would not be enough to close the funding gap. While initial allocations into integrated budgets should reflect existing recurrent expenditure, respondents reflected that radical service redesign is required. A few suggested that integrated budgets were fine in theory but would be difficult to put into practice. In that context it was suggested that leadership, ownership and enthusiasm would be key to making the vision a reality, adding that professional behaviours and cultures would need to change.

3.76 Wholesale structural changes were not wanted and some respondents felt that budgets should sit within Health Boards or Local Authorities for joint use. Others thought that resources should be devolved to locality levels. Several respondents felt it important that money should follow the individual. GP involvement was a common theme, with some respondents wondering whether there was an opportunity through the GP contract to try to encourage greater involvement by GPs. Most respondents mentioning GPs thought that their involvement in planning services was vital, alongside other care professionals and care service users and carers themselves. Several respondents felt that the third sector was more reactive to change and whole system working than the statutory sectors.

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?

Ministerial direction

3.77 Ministerial prescription was welcomed by most of the respondents but should be kept to a minimum and allow for local discretion and flexibility and to be able to accommodate local priorities. There were some worries that in prescribing a minimum then that might lead to only the minimum budget being included. Generally, respondents sought more clarity before being able to make a more informed judgement. Particular clarity was wanted on what might constitute ‘minimum categories’.

3.78 All except two Health Boards answering this question agreed with it, although one added that the minimum must be sufficient. One Board felt it should be left entirely to local decision while another acknowledged that a minimum scope would be helpful but should be guidance only. The overwhelming majority of Local Authorities answered positively and most added that the prescription should be a minimum. A minority felt it should be left to local discretion.

Self-directed support and charging

3.79 Respondents, mainly from Local Authorities and third and independent sectors, expressed the view that clarity was required, when the resource lost its "identity". Self Directed Support would still only be available for social care and not from the NHS. Many respondents suggested that consideration should be given to extending Self Directed Support to health services. The point was raised that health services are considered a 'universal' and generally free service while social care is targeted, subject to eligibility criteria and means tested for charging purposes.

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?

Description of Jointly Accountable Officer

3.80 There is a difference of opinion over whether Jointly Accountable Officer posts are necessary, or indeed appropriate. Respondents, mainly from statutory partners, Unions and professional representative organisations raised questions about how viable the role is. Respondents in agreement with question 13 were mainly from Community Health Partnerships and third and independent sector. However, there is broad consensus that if we are to have them, post holders will need to be multi-skilled, experienced, knowledgeable and expert managers, able to operate with autonomy, wield influence and exercise authority within both statutory structures, and within the Health and Social Care Partnership binding them.

3.81 Broadly, respondents recognise that the context in which a Jointly Accountable Officer should operate successfully needs support mechanisms which complement the Jointly Accountable Officer's role and duties; financial and democratic accountability arrangements which are clear and transparent; but also an appreciation of respective organisational cultures, values, behaviours and attitudes; and how to reconcile inevitable differences in these. Respondents view the Jointly Accountable Officer's perspective on this as important in resolving tensions without resorting to procedure or sanction – for example if the Chief Executives to whom the Jointly Accountable Officer will report don't agree, or if there are budgetary tensions between partners. There is agreement that developing the right leadership skills will be important if the

Jointly Accountable Officer is to succeed in this, though again some uncertainty was expressed about how arrangements will work in practice.

3.82 Many respondents made the point that the Jointly Accountable Officer post will not of itself shift either investment or the balance of care. Some would see the new Health and Social Care Partnership as a truer, more corporate, model for integrating budgets. Concern about the Jointly Accountable Officer having limited capacity to take important decisions about spending at an appropriately senior level also seemed to be an issue. Some respondents questioned whether indeed an additional post is needed in an already complex financial environment, with established sets of accountabilities relating to individual budgets. Many thought that the focus should be on integrating the money (e.g. by "ring fencing" it) rather than establishing a single point for its accountability.

3.83 A few respondents perceive the shift in investment to be achieved as a direct indicator of, or proxy for, the elusive systemic "shift in the balance of care". If that systemic shift is to happen, they argue more details are needed first about the level of acute funding, how acute funds are factored in and what financial controls and accountability the Jointly Accountable Officer will exercise over them.

Other points

3.84 Several respondents raised additional points about how Jointly Accountable Officers would use financial authority.

- Uncertainty thus far about Jointly Accountable Officers, how they will be identified, what skill sets they will require and what capacity and capability they will have to lead;
- Some uncertainty about Jointly Accountable Officers being responsible for a very large budget;
- A perceived potential for Jointly Accountable Officers to exercise bias in favour of one or other system, causing tensions and undermining decision-making mechanisms in one, other or both structures;
- The need for clarity about where the post holder will fit within the overall Health and Social Care Partnership governance structure;
- The need for clarity about the actual role occupied by the Jointly Accountable Officer, without causing disruption to current structures and post holders; and
- Uncertainty about how to create the right conditions for the Jointly Accountable Officer to work autonomously, to secure appropriate financial accountability for expenditure or a shared budget in relation to the Health and Social Care Partnership, while simultaneously being accountable to the Chief Executives of both statutory organisations.

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

Jointly Accountable Officer post

3.85 Several respondents were clear that this post needed to be senior enough to gain the confidence of Health Board and Local Authority, of the workforce and of the community that they would be accountable for. It was noted that in bringing the two Partners together, there would be considerable differences both in terms of culture and behaviour; in terms and conditions, in expectation of outcomes; and that only a post of sufficient seniority would be able to deliver them.

3.86 Among those who agreed with question 14, some respondents expressed the view that only at a very senior level would the individual be able to command the integration of the budget from both Partners and then direct how that budget should be spent in terms of outcomes. This was felt to be particularly the case if a Jointly Accountable Officer and Health and Social Care Partnerships, crossed Local Authority boundaries and the Jointly Accountable Officer would need to be able to manage the diverse requirements of outcomes across these boundaries.

3.87 Among those who agreed with question 14, some respondents noted that although they felt that this post was at an appropriate level of seniority, there were concerns over how it would work with existing statutory posts. It was felt that further guidance needed to be made explicitly on how this role would work with the Chief Social Work Officer and the Section 95 Officer, whose roles have a legal status. This would remove any ambiguity over encroachment of duties, duplication of effort, and undermining the responsibilities of existing workforces and individuals already in post.

3.88 Many respondents expressed the view that the seniority of this post should not be prescribed centrally and should reflect the size and nature of its community, and thus the scope of the Health and Social Care Partnership. They felt that the only way that this could be achieved was by determining the seniority of this post using a local perspective. It was understood that in some situations this might lead to the necessity of this post being scrutinised, or by this post being hosted by a specific Partner, but that this situation should be managed by each Health and Social Care Partnership reflecting local requirements.

Jointly Accountable Officer requires impartiality

3.89 Among those who agreed with question 14, many expressed the view that the Jointly Accountable Officer, in working with and being accountable to the two Partners, would need to be completely impartial in both areas of health and social care. This post would need to be seen to be working in the interests of the Health and Social Care Partnership as a whole. This would endow the role with the independence to make difficult decisions. For example, shift of resources between areas, and challenge the Partners to

work broadly with external partners, such as housing. It was felt that it would be useful if the individual either had experience of working with Health Boards or Local Authority committees, or that a programme of training and peer support could be developed to aid the individual's understanding of the complexities and perspectives of these two Partners.

Local determination of the role with Scottish Government guidance

3.90 Among those who agreed with question 14, concerns were raised by several respondents that in line with the rest of the development of this policy, the role of the Jointly Accountable Officer should firstly be driven by the needs of the community the post would serve. It was noted that the Health and Social Care Partnerships across Scotland would serve very different communities, be that rural or densely populated, or with differing demographic profiles, and that the creation of the Jointly Accountable Officer post should be done so by taking into account the local conditions at the community level. It was suggested that to further enhance this, the individual could be employed from the local level so that there was an understanding of the issues and complexities of the communities that the post served. However, it was recognised that this would lead to inconsistencies in the scale and remuneration of this post, but that was deemed to be acceptable. It was felt that guidance would be needed to ensure consistency of the delivery of outcomes and that this should be driven by the Scottish Government.

Performance management

3.91 Among those respondents who agreed with question 14, mainly third and independent sector organisations and individuals, it was suggested by a few respondents that the development of this post should be done in a manner which is structured around robust, clear lines of accountability, both up toward the Chief Executives of the Partnership and down to the workforce and the community. They also advised that this could be extended to a clear line of budget delegation which would then maintain good governance and transparency in the system.

3.92 Among those who agreed with question 14, several respondents felt that although they agreed with the seniority of the post and the responsibilities that this post would be endowed with, they would want to see a robust framework of performance management which the individual could be measured by. The concerns lay in the fact that the decisions that the Jointly Accountable Officer would make would have an impact on the communities that the Health and Social Care Partnership would serve. They wanted to ensure that the individual would be held to account for the outcomes of these decisions at the earliest opportunity should the services be seen to be weak or failing the community that they were set up to serve.

3.93 Some respondents advised that they were unable to reply to this question as they felt there was not enough information or clarity on the responsibilities and competencies of the role. It was envisaged that this role would be very influential, and this would need to be fully understood before

the role was prescribed. In addition to this, it was felt that until the Health and Social Care Partnership structure had been set up, the Jointly Accountable Officer role would have no framework for development and therefore should not be developed in isolation from the Health and Social Care Partnership structure, it would need to flow from this.

3.94 Several respondents raised questions over how this post would be reconciled with pre-existing statutory posts in Local Authorities, such as the role of the Section 95 Officer and the Chief Social Work Officer, and corresponding posts in the NHS sector. They felt that the creation of this post, if at the wrong scale, could make for situations of division and conflict. It would be important to understand who would have the final decision-making role and how that final decision would be reached.

3.95 It was felt by some respondents that this role should not be necessary as these responsibilities should sit with the Chief Executives and Community Health Partnership General Managers, who should work together in a joined up manner across the Health and Social Care Partnership. The emphasis should be on supporting these existing roles, empowering them to work together in a more joined up manner, rather than creating a new role which will be expensive and add a further layer of bureaucracy.

3.96 Several respondents felt that the level and range of responsibilities and decisions that this post would be charged with would be too much for one individual. They felt that a better system of transparency and accountability would be created if the powers of this role were taken by a committee. It was felt that this would also remove the issues of reconciliation of this post with existing statutory posts, and that the decisions coming out of a committee discussion would be more robust.

Other points

3.97 Among those who expressed the view that they were unable to answer question 14, respondents raised the following additional points:

- That one individual would have too much control over the budget;
- Wanted to see a structure in place for the removal of a Jointly Accountable Officer if not performing as required;
- The creation of 32 of these posts would be a considerable expense on the public purse;
- These posts should be considered as fixed term appointments until the Health and Social Care Partnership is working efficiently;
- If left to local determination the post could be open to too wide an interpretation, would need a generic job description;
- Requires guidance where the Partners were not co-terminus;
- Envisage difficulty in the recruiting of 32 highly skilled and talented individuals;
- There is a need to consider whether this post could be created by the merging of existing posts; and

- The title of the role should more accurately reflect the role e.g. Joint Director of Finance.

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?

3.98 Many respondents expressed the view that the best way of meeting local concerns and conditions is to allow locality planning to be developed locally. The point was made that only through the understanding of local conditions could an effective locality planning service be developed and provided through working with service providers and users.

3.99 Quite a lot of respondents built on the above theme, recommending that although they would support locality planning to be determined locally, they would like the Scottish Government to provide guidance. A few respondents felt that the issuance of guidance would ensure a level of consistency of engagement and involvement of all stakeholders, including carers and patient associations, in locality planning committees.

3.100 Alongside the provision of guidance, some respondents advised that they would like locally determined locality groups to have their performance managed by a more senior body. They advised that this could sit at either the Jointly Accountable Officer, Health and Social Care Partnership or Scottish Government level and would need to be included in the guidance that would be drawn up.

3.101 Several respondents from the third and independent sector organisations suggested that the Scottish Government direct locality planning arrangements. This would avoid the potential for variation and inequalities in service delivery across different localities.

3.102 Some respondents requested that alongside the Scottish Government directing locality planning arrangements, these directions should also include an equal emphasis on the involvement of the third sector and service users at the decision-making level.

3.103 A few of the responses stated that more work is required to describe how locality planning arrangements can effectively contribute to the delivery and planning of services that have a low prevalence. It was suggested that central guidance would be necessary to ensure service quality is enhanced.

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?

3.104 A range of stakeholders from all the representative groups of health, social care, and the third and independent sectors agreed that the duty was strong enough.

3.105 On the other hand, many respondents, mainly from health and third and independent sector organisations, with equal variation across the stakeholder groups, advised that they felt the duty needed to be stronger. They advised that the word 'consult' stakeholders should be replaced with 'involve' and 'engage'. They also felt that the duty should make specific mention of not only GPs, but also of other clinical staff, health and social care professionals and service users.

GP contracts

3.106 Several respondents, from Local Authorities and the third and independent sector, expressed the view that it would be difficult to envisage the outcomes of this activity until there was further clarity on the possible changes that were being considered with regard to the GP contract.

Question 17: What practical steps/change would help to enable clinicians and social care professionals to get involved with and drive planning at a local level?

Peer support and local circumstances

3.107 Several third sector organisations and public partnership representatives recommended that local planning for services would be best understood in the local areas and that an understanding of local conditions could only be developed at a local level. Therefore they recommended that mechanisms to encourage the involvement of professionals in service development should be locally determined.

3.108 Several respondents from the health, third and independent sectors raised the issue of rural working as compared to those professionals working in highly populated areas. It was felt that those working in more rural areas would require a stronger peer network, which would enable them to promote good practice and strategic planning at the community level, which would be particular to the conditions of rural areas.

Joint strategic commissioning plans

3.109 Many respondents from all sectors felt that to encourage the active participation of clinicians and social care professionals in the provision of services, they would need to have a clear understanding of the requirements

of their localities. Working together, they would then develop a joint strategy in the planning of services and the commissioning of those services for their specific locality conditions.

Advisory committee on joint commissioning

3.110 Several respondents from all sectors built on the theme of joint strategic commissioning plans and recommended that localities should set up joint professional and stakeholder advisory committees. These commissioning plans would then be developed from the evidence gathered from this committee, enabling the locality to strategically plan the commissioning of services in an evidenced and, thus effective manner.

Capacity to be involved

3.111 Several respondents, including GP representative groups, carer associations and individuals, expressed the view that although they strongly supported the involvement of all stakeholders in driving planning at a local level, there needed to be a structure developed which supported their participation in these meetings. For GPs, they advised that they should have protected time in their contract to allow them to be available. Medical and clinical representative groups suggested that there should be a system of training to allow professional backfill for when GPs and other professionals would be participating in the steering groups. Carer groups and individuals requested that they would need carer support or respite care to allow them to participate in this.

Managerial structure and workforce training

3.112 Some respondents expressed the view that the best way to encourage participation of professionals in planning at the local level was to have a strong message from the top. They advised that to make this happen there should be strong leadership with clear lines of accountability and governance both going up to management and down to the workforce. They further advised that to develop a collaborative joint workforce to deliver locality planning, there would be a need for a strong training scheme particularly on the theme of working with the public.

Integrated information technology systems

3.113 A few respondents recommended that to encourage and support clinical and social care professionals to work together in a joint manner required an information technology system and back office that was fully integrated, reliable and modern.

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

GP contract

3.114 There was a mix of opinions regarding how locality planning should be organised. Many agreed that locality planning should be organised around clusters of GP practices. It was suggested that to support this, GP practices should be encouraged to manage their patient lists into more local catchment areas rather than the existing wide range of registered populations. A few respondents noted that, although they supported this proposal, it should not be at the absolute exclusion of other primary care contractors, rather that these professionals should work together to provide services to communities.

3.115 A few respondents raised the point that although they supported the proposal in principle, they felt they would be unable to answer this question until they knew the outcomes of the new GP contract. This issue was also raised in response to question 16.

Locality planning organised around communities

3.116 Several respondents did not favour locality planning being organised around clusters of GPs. Instead they expressed the view that locality planning should be arranged around the community. They noted that the locality group would be most effective for the service user if it reflected and involved the people and organisations of that community, and complemented existing services and structures. Developed in this way, they would better serve their communities. Some respondents added that although what works well in one area might not naturally fit another area, there was a need for a level of consistency and that this should be directed through the provision of guidance. Consideration should be given to how localities interact with each other to best plan and deliver services.

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

3.117 Several public representative groups and rural based Local Authorities and third and independent service providers advised that they would not support the devolution of decision-making and responsibilities from Health and Social Care Partnerships to locality planning groups. They felt that in order for communities to receive a consistently high level of quality service, these activities should remain at the partnership level where they can be held to account.

3.118 Several respondents across the stakeholder categories expressed a consistent view that the Health and Social Care Partnership should work with its locality planning groups and consider what was achievable by each Group. Thus devolution being driven from the Health and Social Care Partnership level. This would allow for different rates of devolvement of activities and

would allow for some local determination in the provision of services at the locality level. Using this method, it was felt that the Health and Social Care Partnership could then remain accountable for both service provision and overall performance of its locality planning groups.

3.119 In comparison to the above theme, many respondents advised that locality planning groups should be empowered to drive the devolution of responsibilities and decision-making from the Health and Social Care Partnership to the community level whilst remaining accountable to the Health and Social Care Partnership for performance and service delivery. This would allow locality planning groups to adapt their services to fulfil the local needs of their communities whilst maintaining standards and consistency of service provision.

3.120 Several professional membership organisations, Local Authorities and public representative bodies and individuals advised that they wanted these decisions and responsibilities (particularly the spend of the budget), to sit at the locality planning group level. They reported that only at this level would the outcomes of those responsibilities accurately reflect the needs and conditions of that local community. It was suggested that this proposal could go further, that locality planning groups could work with the Jointly Accountable Officer and include some level of devolved authority, so being fully responsible for their own community.

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?

Population range

3.121 Several representative bodies for the professional, third and independent sectors felt that the range quoted was too small. There was a concern raised that having a community so narrowly focussed would make it difficult for the commissioning of services for specific health conditions. They recommended that to be able to obtain adequate provision for this and to achieve a critical mass of expertise and experience in a locality – particularly in rural areas, a population count needed to be nearer to 50,000. There was also a suggestion that to complement this, there should be no more than 2-3 localities per Health and Social Care Partnership thus having the spread of expertise where required.

Locally determined

3.122 There was a consistent view across the respondents that this should be locally determined. There were suggestions that the Partnership could be embedded within the Community Planning Partnership so tying in service provision at the locality level within the wider public service landscape. Throughout this theme there was recognition that there would be some guidance required to steer localities through the complexities of the needs of

mixed socio-economic communities, or communities of different geographies where population sizes differed significantly.

3.123 Several respondents felt that these figures were arbitrary, and that a better way to determine a community and its needs was through the geographical structures of communities, for example, by towns or council boundaries. They felt that this would better capture the range of communities across Scotland.

3.124 Some respondents felt that it would be a better use of locality planning groups if they were organised along boundaries of socio-economic makeup. This would then allow the locality planning groups to plan services and their budget using the parameters of need and thus address the direct concerns of their local community.

CHAPTER 4: DISCUSSION OF THE CONSULTATION EVENTS

4.1 A series of public and practitioner events took place between May and August 2012 in Edinburgh[13], Glasgow[14], Dumfries[15], Perth[16] and Elgin[17]. The target audience included health and social care professionals from statutory and non-statutory organisations; carers; user of health and social care services; and members of the public more widely. The rest of this chapter provides a summary of the key themes discussed.

Public Events

Streamline services

4.2 Participants expressed the view that Health Boards and Local Authorities need to work with the third sector in sharing information, avoiding duplication and delay in user access to services. The idea of a 'one stop shop' with good signposting to refer people to the appropriate services was mentioned several times as a positive way forward.

4.3 Many participants commented on the possible benefits of integration. Some felt that an integrated service may provide greater consistency of services and improve accountability. A joint service could provide more opportunity for patients and service users to be involved in decisions relating to their own care. Participants hoped that by working in partnership, integration may lead to changes in attitude of NHS sector, third sector and Local Authorities and eliminate the "blame culture".

Overcoming barriers

4.4 Most of the participants supported a move towards integrated adult health and social care services but thought there were a number of barriers to overcome. Discussions included reference to a lack of resources, different organisational cultures and staffing issues. Some participants felt that the impact of welfare reform could put additional pressure on services with the potential of funding being withdrawn from one area of health and social care to fund another area. Different organisational cultures would need to be overcome. There was recognition that there are existing different staff terms

[13] Edinburgh Practitioner and Public Events
http://www.scotland.gov.uk/Resource/0040/00403222.pdf
http://www.scotland.gov.uk/Resource/0040/00403223.pdf
[14] Glasgow Practitioner and Public Events
http://www.scotland.gov.uk/Resource/0040/00402635.pdf
http://www.scotland.gov.uk/Resource/0040/00402640.pdf
[15] Dumfries Practitioner and Public Events
http://www.scotland.gov.uk/Resource/0040/00403594.pdf
http://www.scotland.gov.uk/Resource/0040/00403595.pdf
[16] Perth Practitioner and Public Events
http://www.scotland.gov.uk/Resource/0040/00402645.pdf
http://www.scotland.gov.uk/Resource/0040/00402641.pdf
[17] Elgin Practitioner and Public Event
http://www.scotland.gov.uk/Resource/0040/00402646.pdf

and conditions. Participants expressed the view that these barriers could be overcome by including staff training and the introduction of robust and meaningful processes for dealing with disagreements and disputes. There was also reference made to the importance of learning from integration projects that have been set up in other parts of the country.

4.5 Participants at the practitioner events also discussed the different cultures of the NHS sector and Local Authorities. There was recognition that a culture change and desire for integration needs to happen. Good leadership was mentioned as essential to the success of managing the change process. Staff will need to be supported.

4.6 Training and development of staff was highlighted many times. Participants expressed the view that training should be high priority, particularly if there is less emphasis on acute services and more on community based care in the future. If staff resources are to be reapportioned from acute to community care services, then there will be a need for refresher training.

Information technology

4.7 Participants expressed the view that current information technology systems, which are not currently designed to support integration, could act as a barrier. Information technology needs to be joined up for single shared assessments to take place.

4.8 Information technology was also discussed at the practitioner events. The current systems were viewed as obstructing clear patient pathways due to difficulties in the sharing of information and data governance. Participants expressed a desire for a single patient record and an improved ability to share information between professionals.

Public involvement

4.9 A recurring view at all the events was the importance of public involvement. There was recognition that Public Partnership Forums (PPF) had played an important role in representing the views of the public and were an excellent source of local expertise and knowledge. Many agreed that it would be important for PPFs to plan how best to support health and social care integration. Participants also expressed the view that meaningful engagement means involving service users and carers throughout the process of planning and developing services.

4.10 Among those who attended the practitioner events, there was also the view that robust public involvement is required.

Practitioner Events

Scope

4.11 Participants recognised the demographic pressures that we are experiencing and the need to improve outcomes for older people. However, some participants expressed the view that there is a need to look to the wider society and include children. Participants asked for clarity regarding the initial focus on 'older people'. Specifically what is meant by 'older people' and whether this means there will be an 'age criteria' attached.

4.12 There was differing opinion about the level of prescription that should be written into the legislation. Some argued that the Scottish Government should provide central focus, whereas others favoured local solutions.

Governance

4.13 Participants expressed the view that the consultation proposals require more detail regarding who will be in charge and who will be held accountable. There was reference made to the need for a balance between delivering on outcomes for both Ministers and Local Councillors and for the outcomes themselves to still be tangible.

4.14 Human Resource issues were seen as a barrier to working in joint teams. This creates a need to streamline the governance to counteract this. The specific barriers mentioned were: two sets of terms and conditions; two salary scales; issues over information technology and information governance; and external scrutiny arrangements.

Locality planning

4.15 Participants expressed the view that this should be left to local determination. Reference was made to the need for communities to be in charge of their own services and localities of different geographies, and structures need to have flexibility to request services which best meet their demand.

ANNEX 1

Breakdown of 'yes', 'no' and 'neither' yes or no responses

Table 1

Question no.	Yes		No		Neither	
	No.	%	No.	%	No.	%
1	115	36	37	12	163	52
2	58	18	72	23	185	59
3	97	31	30	10	188	60
4	149	47	6	2	160	51
5	67	21	48	15	200	63
6	108	34	34	11	173	55
7	42	13	76	24	197	62
8	58	18	51	16	206	65
9	112	36	23	7	180	57
10	81	26	41	13	193	61
11	101	32	29	9	185	59
12	75	24	35	11	205	65
13	59	19	50	16	206	65
14	89	28	24	8	202	64
15	46	15	53	17	213	69
16	68	22	58	18	189	60
18	29	9	75	24	211	67
20	21	7	77	24	217	69

Tables 1.2 to 1.18 provide a breakdown of 'yes', 'no' and 'neither' yes or no responses by category of respondents. A 'multiple categories' reference was added as some respondents classed themselves as covering more than one of the given categories.

The 'other' category included medical groups, child protection resources, membership groups (e.g. allied health professionals), third sector representative organisations, housing, community health partnerships and joint responses from statutory partners.

Table 1.1: Q1 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	8	38	3	14	10	48	21
Other NHS	2	22	1	11	6	67	9
General Practitioner	0	0	1	25	3	75	4
Local Authority	10	37	3	11	14	52	27
Other statutory	5	50	0	0	5	50	10
Third sector care provider	7	29	7	29	10	42	24
Independent/private care provider	3	75	0	0	1	25	4
Rep organisation for professional group	20	54	2	5	15	40	37
Rep organisation for staff group	1	20	0	0	4	80	5
Education/academic	1	25	0	0	3	75	4
Rep group for patients/care users	7	41	3	18	7	41	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	5	46	0	0	6	54	11
Carer	0	0	0	0	1	100	1
Other	39	33	13	11	65	56	117
Multiple categories	7	39	4	22	7	39	18

Table 1.2: Q2 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	6	29	4	19	11	52	21
Other NHS	1	11	0	0	8	89	9
General Practitioner	0	0	2	50	2	50	4
Local Authority	3	11	11	41	13	48	27
Other statutory	3	30	2	20	5	50	10
Third sector care provider	5	21	8	33	11	46	24
Independent/private care provider	2	50	1	25	1	25	4
Rep organisation for professional group	9	24	12	32	16	43	37
Rep organisation for staff group	0	0	0	0	5	100	5
Education/academic	1	25	2	50	1	25	4
Rep group for patients/care users	6	35	3	18	8	47	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	4	36	2	18	5	45	11
Carer	0	0	0	0	1	100	1
Other	14	12	22	19	81	69	117
Multiple categories	4	22	3	17	11	61	18

NB Percentages may not total 100% exactly due to rounding.

Table 1.3: Q3 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	9	43	1	5	11	52	21
Other NHS	3	33	0	0	6	67	9
General Practitioner	0	0	2	50	2	50	4
Local Authority	12	44	2	7	13	48	27
Other statutory	4	40	1	10	5	50	10
Third sector care provider	7	29	6	25	11	46	24
Independent/private care provider	0	0	1	25	3	75	4
Rep organisation for professional group	16	43	3	8	18	49	37
Rep organisation for staff group	1	20	0	0	4	80	5
Education/academic	0	0	1	25	3	75	4
Rep group for patients/care users	6	35	3	18	8	47	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	6	54	0	0	5	45	11
Carer	0	0	0	0	1	100	1
Other	26	22	7	6	84	72	117
Multiple categories	7	39	3	17	8	44	18

Table 1.4: Q4 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	12	57	0	0	9	43	21
Other NHS	3	33	0	0	6	67	9
General Practitioner	1	25	0	0	3	75	4
Local Authority	14	52	3	11	10	37	27
Other statutory	5	50	0	0	5	50	10
Third sector care provider	14	58	1	4	9	37	24
Independent/private care provider	3	75	0	0	1	25	4
Rep organisation for professional group	20	54	0	0	17	46	37
Rep organisation for staff group	3	60	0	0	2	40	5
Education/academic	0	0	1	25	3	75	4
Rep group for patients/care users	10	59	0	0	7	41	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	5	45	0	0	6	54	11
Carer	0	0	0	0	1	100	1
Other	48	41	1	1	68	58	117
Multiple categories	11	61	0	0	7	39	18

NB Percentages may not total 100% exactly due to rounding.

Table 1.5: Q5 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	6	29	2	10	13	62	21
Other NHS	0	0	0	0	9	100	9
General Practitioner	1	25	1	25	2	50	4
Local Authority	1	4	13	48	13	48	27
Other statutory	3	30	0	0	7	70	10
Third sector care provider	6	25	6	25	12	50	24
Independent/private care provider	1	25	0	0	3	75	4
Rep organisation for professional group	12	32	4	11	21	57	37
Rep for staff group	1	20	1	20	3	60	5
Education/academic	0	0	1	25	3	75	4
Rep group for patients/care users	4	24	5	29	8	47	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	5	45	0	0	6	54	11
Carer	0	0	0	0	1	100	1
Other	22	19	12	10	83	71	117
Multiple categories	5	28	3	17	10	56	18

Table 1.6: Q6 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	10	48	1	5	10	48	21
Other NHS	1	11	0	0	8	89	9
General Practitioner	1	25	1	25	2	50	4
Local Authority	10	37	3	11	14	52	27
Other statutory	4	40	0	0	6	60	10
Third sector care provider	10	42	2	8	12	50	24
Independent/private care provider	2	50	0	0	2	50	4
Rep organisation for professional group	16	43	6	16	15	40	37
Rep organisation for staff group	1	20	0	0	4	80	5
Education/academic	1	25	2	50	1	25	4
Rep group for patients/care users	7	41	3	18	7	41	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	4	36	3	27	4	36	11
Carer	0	0	0	0	1	100	1
Other	34	29	11	9	72	62	117
Multiple categories	7	39	2	11	9	50	18

NB Percentages may not total 100% exactly due to rounding.

Table 1.7: Q7 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	4	19	3	14	14	67	21
Other NHS	0	0	0	0	9	100	9
General Practitioner	1	25	1	25	2	50	4
Local Authority	3	11	15	56	9	33	27
Other statutory	2	20	1	10	7	70	10
Third sector care provider	2	8	7	29	15	62	24
Independent/private care provider	1	25	1	25	2	50	4
Rep organisation for professional group	6	16	12	32	19	51	37
Rep organisation for staff group	1	20	0	0	4	80	5
Education/academic	0	0	1	25	3	75	4
Rep group for patients/care users	2	12	5	29	10	59	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	5	46	0	0	6	54	11
Carer	0	0	0	0	1	100	1
Other	13	11	21	18	83	71	117
Multiple categories	2	11	9	50	7	39	18

Table 1.8: Q8 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	6	29	3	14	12	57	21
Other NHS	1	11	0	0	8	89	9
General Practitioner	0	0	1	25	3	75	4
Local Authority	6	22	7	26	14	52	27
Other statutory	3	30	0	0	7	70	10
Third sector care provider	3	12	7	29	14	58	24
Independent/private care provider	1	25	1	25	2	50	4
Rep organisation for professional group	10	27	9	24	18	49	37
Rep organisation for staff group	2	40	0	0	3	60	5
Education/academic	0	0	1	25	3	75	4
Rep group for patients/care users	3	18	5	29	9	53	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	3	27	2	18	6	54	11
Carer	0	0	0	0	1	100	1
Other	17	14	12	10	88	75	117
Multiple categories	3	17	3	17	12	67	18

NB Percentages may not total 100% exactly due to rounding.

Table 1.9: Q9 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	11	52	1	5	9	43	21
Other NHS	2	22	1	11	6	67	9
General Practitioner	1	25	1	25	2	50	4
Local Authority	16	59	1	4	10	37	27
Other statutory	3	30	0	0	7	70	10
Third sector care provider	8	33	2	8	14	58	24
Independent/private care provider	0	0	2	50	2	50	4
Rep organisation for professional group	16	43	3	8	18	49	37
Rep organisation for staff group	0	0	0	0	5	100	5
Education/academic	2	50	0	0	2	50	4
Rep group for patients/care users	7	41	0	0	10	59	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	4	36	1	9	6	54	11
Carer	0	0	0	0	1	100	1
Other	36	31	8	7	73	62	117
Multiple categories	6	33	3	17	9	50	18

Table 1.10: Q10 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	7	33	2	10	12	57	21
Other NHS	1	11	0	0	8	89	9
General Practitioner	1	25	1	25	2	50	4
Local Authority	8	30	9	33	10	37	27
Other statutory	4	40	0	0	6	60	10
Third sector care provider	4	17	5	21	15	62	24
Independent/private care provider	1	25	0	0	3	75	4
Rep organisation for professional group	14	38	5	14	18	49	37
Rep organisation for staff group	1	20	0	0	4	80	5
Education/academic	0	0	1	25	3	75	4
Rep group for patients/care users	4	24	3	18	10	59	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	5	45	1	9	5	46	11
Carer	0	0	0	0	1	100	1
Other	25	21	12	10	80	68	117
Multiple categories	6	33	2	11	10	56	18

NB Percentages may not total 100% exactly due to rounding.

Table 1.11: Q11 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	8	38	1	5	12	57	21
Other NHS	1	11	0	0	8	89	9
General Practitioner	2	50	0	0	2	50	4
Local Authority	15	56	0	0	12	44	27
Other statutory	3	30	1	10	6	60	10
Third sector care provider	13	54	1	4	10	42	24
Independent/private care provider	1	25	1	25	2	50	4
Rep organisation for professional group	15	40	7	19	15	40	37
Rep organisation for staff group	0	0	0	0	5	100	5
Education/academic	0	0	3	75	1	25	4
Rep group for patients/care users	5	29	3	18	9	53	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	5	46	1	9	5	46	11
Carer	0	0	0	0	1	100	1
Other	28	24	9	8	80	68	117
Multiple categories	5	28	2	11	11	61	18

Table 1.12: Q12 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	8	38	2	10	11	52	21
Other NHS	0	0	0	0	9	100	9
General Practitioner	1	25	0	0	3	75	4
Local Authority	13	48	2	7	12	44	27
Other statutory	2	20	0	0	8	80	10
Third sector care provider	5	21	5	21	14	58	24
Independent/private care provider	1	25	0	0	3	75	4
Rep organisation for professional group	6	16	10	27	21	57	37
Rep organisation for staff group	0	0	0	0	5	100	5
Education/academic	2	50	1	25	1	25	4
Rep group for patients/care users	4	24	4	24	9	53	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	4	36	1	9	6	54	11
Carer	0	0	0	0	1	100	1
Other	23	20	10	8	84	72	117
Multiple categories	6	33	0	0	12	67	18

NB Percentages may not total 100% exactly due to rounding.

Table 1.13: Q13 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	5	24	6	29	10	48	21
Other NHS	1	11	1	11	7	78	9
General Practitioner	0	0	1	25	3	75	4
Local Authority	3	11	12	44	12	44	27
Other statutory	3	30	0	0	7	70	10
Third sector care provider	2	8	4	17	18	75	24
Independent/private care provider	0	0	1	25	3	75	4
Rep organisation for professional group	8	22	9	24	20	54	37
Rep organisation for staff group	1	20	0	0	4	80	5
Education/academic	0	0	0	0	4	100	4
Rep group for patients/care users	5	29	2	12	10	59	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	2	18	2	18	7	64	11
Carer	0	0	0	0	1	100	1
Other	23	20	10	8	84	72	117
Multiple categories	6	33	2	11	10	56	18

Table 1.14: Q14 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	13	62	3	14	5	24	21
Other NHS	1	11	1	11	7	78	9
General Practitioner	1	25	0	0	3	75	4
Local Authority	6	22	7	26	14	52	27
Other statutory	3	30	0	0	7	70	10
Third sector care provider	6	25	0	0	18	75	24
Independent/private care provider	2	50	0	0	2	50	4
Rep organisation for professional group	13	35	3	8	21	57	37
Rep organisation for staff group	1	20	0	0	4	80	5
Education/academic	1	25	0	0	3	75	4
Rep group for patients/care users	6	35	1	6	10	59	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	5	46	0	0	6	54	11
Carer	0	0	0	0	1	100	1
Other	27	23	7	6	83	71	117
Multiple categories	4	22	2	11	12	67	18

NB Percentages may not total 100% exactly due to rounding.

Table 1.15: Q15 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	5	24	5	24	11	52	21
Other NHS	0	0	1	11	8	89	9
General Practitioner	0	0	1	25	3	75	4
Local Authority	3	11	13	48	11	41	27
Other statutory	0	0	1	10	9	90	10
Third sector care provider	8	33	1	4	15	62	24
Independent/private care provider	2	50	0	0	2	50	4
Rep organisation for professional group	6	16	8	22	23	62	37
Rep organisation for staff group	0	0	1	20	4	80	5
Education/academic	0	0	1	25	3	75	4
Rep group for patients/care users	4	24	2	12	11	65	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	4	36	1	9	6	54	11
Carer	0	0	0	0	1	100	1
Other	10	8	16	14	91	78	117
Multiple categories	4	22	2	11	12	67	18

Table 1.16: Q16 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	9	46	5	24	7	33	21
Other NHS	2	22	0	0	7	78	9
General Practitioner	0	0	1	25	3	75	4
Local Authority	10	37	4	15	13	48	27
Other statutory	3	30	0	0	7	70	10
Third sector care provider	3	12	10	42	11	46	24
Independent/private care provider	1	25	1	25	2	50	4
Rep organisation for professional group	6	16	11	30	20	54	37
Rep organisation for staff group	1	20	0	0	4	80	5
Education/academic	1	25	0	0	3	75	4
Rep group for patients/care users	3	18	5	29	9	53	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	2	18	1	9	8	73	11
Carer	0	0	0	0	1	100	1
Other	23	20	15	13	79	68	117
Multiple categories	4	22	5	28	9	50	18

NB Percentages may not total 100% exactly due to rounding

Table 1.17: Q18 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	2	10	8	38	11	52	21
Other NHS	0	0	0	0	9	100	9
General Practitioner	1	25	1	25	2	50	4
Local Authority	1	4	13	48	13	48	27
Other statutory	1	10	0	0	9	90	10
Third sector care provider	2	8	7	29	15	62	24
Independent/private care provider	0	0	2	50	2	50	4
Rep organisation for professional group	5	14	9	24	23	62	37
Rep organisation for staff group	0	0	0	0	5	100	5
Education/academic	1	25	0	0	3	75	4
Rep group for patients/care users	3	18	4	24	10	59	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	3	27	2	18	6	54	11
Carer	0	0	0	0	1	100	1
Other	7	6	25	21	85	73	117
Multiple categories	3	17	4	22	11	61	18

Table 1.18: Q20 responses by category of respondent

Category	Yes		No		Neither		Total
	No.	%	No.	%	No.	%	
NHS Health Board	2	10	6	29	13	62	21
Other NHS	0	0	1	11	8	89	9
General Practitioner	1	25	1	25	2	50	4
Local Authority	1	4	15	56	11	41	27
Other statutory	0	0	1	10	9	90	10
Third sector care provider	1	4	7	29	16	67	24
Independent/private care provider	1	25	1	25	2	50	4
Rep organisation for professional group	2	5	11	30	24	65	37
Rep organisation for staff group	0	0	0	0	5	100	5
Education/academic	2	50	0	0	2	50	4
Rep group for patients/care users	3	18	4	24	10	59	17
Rep group for carers	0	0	0	0	6	100	6
Patient/service user	0	0	5	46	6	54	11
Carer	0	0	0	0	1	100	1
Other	6	5	21	18	90	77	117
Multiple categories	2	11	4	22	12	67	18

NB Percentages may not total 100% exactly due to rounding

ANNEX 2

Consultation Questionnaire

The case for change

Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

Yes ☐ No ☐

Comments

Outline of proposed reforms

Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

Yes ☐ No ☐

Comments

National outcomes for adult health and social care

Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

Yes ☐ No ☐

Comments

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

Yes ☐ No ☐

Comments

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 ☐

Comments

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

Yes ☐ No ☐

Comments

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

Yes ☐ No ☐

Comments

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 ☐

Comments

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 ☐

Comments

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 ☐

Comments

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

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 ☐

Comments

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 ☐

Comments

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

Yes ☐ 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 ☐

Comments

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 ☐

Comments

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

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 ☐

Comments

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

Comments

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

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

ANNEX 3

Respondent List (non-confidential responses only)

Individuals

- Ann J A McCarthy
- Brian Polding
- Dorothy Potter
- Duncan Martin
- Helen Moss
- Ian Wallace
- J Cowan
- Janet Shankland
- Jennifer Gray
- John H Owens
- Mark Hodgkinson
- Maureen Summers
- Michael Maas-Lowit
- Mr Brown
- Mrs E McGuiness
- Nicholas Walker
- Nigel Wanless
- Patricia Susan Miller
- Philip Wilson
- Robert Park
- Ruth Buchanan
- Sam Riddell
- Terence Hegarty
- William Rogerson

13 anonymous responses were received.

Organisations

NHS Board (including Special Boards)

- NHS 24
- NHS Ayrshire and Arran
- NHS Boards Chief Executives' Group
- NHS Education for Scotland
- NHS Fife
- NHS Forth Valley
- NHS Grampian
- NHS Greater Glasgow and Clyde
- NHS Health Scotland
- NHS Highland
- NHS Lanarkshire

- NHS Tayside
- NHS Western Isles
- Scottish Ambulance Service
- The State Hospitals Board for Scotland

Other NHS Organisations

- Association of CHPs
- Ayrshire and Arran Local Medical Committee/GP Sub-Committee
- Glasgow City Three Public Partnerships Forums
- NHS Greater Glasgow and Clyde, Area Nursing and Midwifery Committee
- North Ayrshire Public Partnership Forum
- Scottish Health Council

Local Authority

- Aberdeen City Council
- Aberdeenshire Council
- Angus Council
- Comhairle nan Eilean Siar
- Dundee City Council
- East Ayrshire Council
- East Dunbartonshire Council
- East Lothian Council
- East Renfrewshire Council
- Falkirk Council
- Fife Council
- Glasgow City Council
- Highland Council
- Midlothian Council
- Moray Council
- North Ayrshire Council
- Perth and Kinross Council
- Renfrewshire Council
- Seniors Together – South Lanarkshire Council
- South Ayrshire Council
- South Ayrshire Council Alcohol and Drug Partnership
- South Lanarkshire Council
- Stirling Council

Other Statutory Organisations

- Association of Directors of Social Work (ADSW)
- Community Justice Authorities
- COSLA
- Fife Society for the Blind
- Joint Response from Healthcare Improvement Scotland and the Care Inspectorate

- Information Commissioner's Office
- Merchiston Community Council
- Scotland's Commissioner for Children and Young People
- Scottish Borders Community Health and Care Partnership
- Scottish Children's Reporter Administration
- Scottish Public Services Ombudsman
- Scottish Social Services Council (SSSC)
- Strathclyde Partnership for Transport
- The Scottish Human Rights Commission

Third Sector Care Provider Organisation

- Action on Hearing Loss Scotland
- Altrum
- Alzheimer Scotland
- Arden House Projects
- British Red Cross
- Camphill Scotland
- Chest, Heart and Stroke Scotland
- Circle
- Cornerstone
- ELCAP
- Fife Elderly Forum
- Lead Scotland
- Mental Health Aberdeen
- Minority Ethnic Carers of Older People Project (MECOPP)
- Quarriers
- Royal National Institute of Blind People (RNIB) Scotland
- Scottish Association for Mental Health (SAMH)
- The Coalition of Carers in Scotland

Independent/private care provider organisation

- Bandrum Nursing Home/Fife Branch of Scottish Care
- Bupa Care Services
- Celesio UK

Representative organisation for professional group

- British Dental Association
- British Geriatrics Society (Scotland)
- Division of Clinical Psychologists Scotland
- East Lothian Local Practitioner Forum
- Fife Local Medical Committee
- Glasgow Local Medical Committee Ltd
- Guild of Healthcare Pharmacists
- Heads of Older People's Psychology Services (HOOPPS)
- Lothian Area Healthcare Science Committee

- Lothian Occupational Therapy Professional Advisory Group
- NHS Ayrshire and Arran – Division of Psychiatry
- NHS Greater Glasgow and Clyde Mental Health Services Senior Nurse Group
- NHS Lothian Allied Health Professional Committee
- Psychological Services – NHS Lanarkshire
- Queen's Nursing Institute Scotland
- Royal College of Midwives Scotland
- Royal College of Nursing
- Royal College of Psychiatrists in Scotland
- Royal College of Speech and Language Therapists
- Scottish Directors of Public Health Group
- Scottish Medicines and Scientific Advisory Committee (SMASAC)
- SOLACE Scotland
- Solar
- Sopra Group Ltd.
- The National Pharmacy Association Ltd.
- The Royal College of Surgeons of Edinburgh
- United Kingdom Homecare Association
- West of Scotland Nursing, Midwifery and Allied Health Professionals Consultant Network

Representative organisations for staff group e.g. trade union

- Allied Health Professions Clinical Area Forum
- BMA Scotland
- Inverclyde CHCP Joint Staff Partnership Forum
- Royal College of General Practitioners
- Society of Radiographers
- UNISON

Education/academic group

- Royal College of Paediatrics and Child Health

Representative group for patients/care users

- Age Scotland
- Enable Scotland
- East Renfrewshire Public Partnership Forum
- Fife Independent Disability Network
- Learning Disability Alliance Scotland
- Muir Maxwell Trust
- Midlothian Public Partnership for Health
- MS Society
- The Consultation and Advocacy Promotion Service (CAPS)
- South Edinburgh Health Forum

Representative group for carers

- Carers Scotland
- The Princess Royal Trust for Carers in Scotland

Patients/service users

- Aberdeen Health and Social Care Partnership
- Hospital Patients Council, NHS Ayrshire and Arran
- Largo Area Community Council
- Moray Public Participation Forum
- Prostate Cancer UK

Multiple category organisations

- Aberdeenshire Community Planning Partnership
- Angus Council and NHS Tayside
- Chartered Society of Physiotherapy Scotland
- City of Edinburgh Council and NHS Lothian, Edinburgh CHP
- College of Occupational Therapists
- Cowal Community Care Forum
- Dundee City Council and NHS Tayside Joint Response
- Lothian Centre for Inclusive Living
- Mental Health Services Public Reference Group for NHS Ayrshire and Arran
- National Osteoporosis Society
- Parkinson's UK
- Sexual Health and Bloodborne Virus Framework Third Sector Network

Other

- Aberdeenshire Alcohol and Drug Partnership
- AHPs, East Lothian Council
- Alliance Boots
- Area Clinical, NHS Dumfries and Galloway
- Audit Scotland
- Ayrshire and Arran Data Sharing Partnership
- Borders Public Partnership Forum
- Breast Cancer Care
- British Acupuncture Council
- Children and Young People's Health Support Group/Child Health Commissioners' Group
- Citizens Advice Scotland
- Coalition of Care and Support Providers
- Community Pharmacy Scotland
- Dumfries and Galloway Strategic Partnership (the Community Planning Partnership)
- East Renfrewshire Community Health and Care Partnership
- Edinburgh Voluntary Organisations Council

- Forfar Gold Forum
- Glasgow Housing Association
- Independent Living in Scotland
- Joint Response: Association of Local Authority Chief Housing Officers; Chartered Institute of Housing in Scotland; Scottish Federation of Housing Associations; Glasgow West of Scotland Forum of Housing Associations; Housing Support Enabling Unit; Care and Repair Scotland
- Joint Response: Chief Executives and Senior Officers of NHS Forth Valley; and Clackmannanshire, Falkirk and Stirling Councils
- Joint Response: Falkirk and District Association for Mental Health Members; Falkirk Service Users and Carers Reference Group; and Falkirk Senior Citizen's Group
- Joint Response: NHS Shetland and Shetland Islands Council
- Joint Response: NHS Tayside, Perth and Kinross Council
- Long Term Conditions Alliance Scotland
- MacMillan Cancer Support
- McCarthy and Stone Retirement Lifestyles Ltd
- Midlothian Voluntary Sector Forum
- NHS Greater Glasgow and Clyde, Rehabilitation and Enablement Mental Health (Paisley)
- North Lanarkshire Public Partnership Forum
- People First (Scotland)
- Royal College of Physicians of Edinburgh
- Self Directed Support Scotland (SDSS)
- Service User and Carer Reference Group – North Ayrshire
- Scottish Borders Elder Voice
- Scottish Community Care Benchmarking Network
- Scottish Consortium for Learning Disability
- Scottish Council on Deafness
- Scottish Council for Single Homeless
- Scottish Council for Voluntary Organisations
- Scottish Drugs Forum
- Scottish Independent Advocacy Alliance
- Scottish Independent Hospitals Association
- Scottish National Party, Glasgow City Council
- Scottish NHS Chairs Group
- Scottish Public Health Specialists Network
- Social Care Ideas Factory (representatives from Loretto Housing Association, Neighbourhood Networks, Crossreach, Enable Glasgow, Alzheimer's Scotland, British Red Cross)
- Society of Personnel and Development Scotland
- South Ayrshire Public Partnership Forum
- The Neurological Alliance of Scotland
- Voluntary Action East Ayrshire
- Volunteer Centre Edinburgh
- West Dunbartonshire Community Health and Care Partnership
- West Lothian Community Health and Care Partnership
- WithScotland

Annex 4

Public Events – Facilitators' guide for discussion group session

The Scottish Government will give a presentation on adult health and social care integration and after this the round table discussions will begin. This will be followed by a question and answer with the panel. The Chair of the event will set out the purpose of the discussions and also state that if anyone wants to ask any questions afterwards they can or, alternatively, they can request for a facilitator to ask the question on their behalf.

Discussion Group Session

Brief introductions around the table

1. What does good adult health and social care integration mean to you?

2. In your view what would be the benefits of integrated health and social care?

3. What would be the barriers to integrated health and social care?

4. How could these barriers be overcome?

5. How should the public, patients, carers and service users be involved in the health and social care partnership after integration?

Are there any questions that people would like the facilitators to ask the panel? [Take a note of these and ask them during the Q & A session]

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