ANNEX 1(D)

PROPOSALS FOR PRESCRIBED INFORMATION TO BE INCLUDED IN THE INTEGRATION SCHEME RELATING TO THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

CONSULTATION QUESTIONS

1. Do you agree with the prescribed matters to be included in the Integration Scheme?

Yes √

No ☐

2. If no, please explain why:

3. Are there any additional matters that should be included within the regulations?

Yes ☐

No √

4. If yes, please suggest:

Health service managers should be added as a group to be consulted.

5. Are there any further comments you would like to offer on these draft Regulations?

The structure of the scheme as currently written suggests that risk, information sharing, complaints and staff development are seen as separate entities. While we acknowledge that each of these areas requires specific attention to ensure that it is appropriately developed in the new organisation, these areas will come together within the framework of care and clinical governance which must take an overview of all of the areas when the organisation becomes fully operational. The CHPs will be dissolved as we move into integration. In relation to the clinical governance the Clinical Directors have a statutory responsibility for Clinical Governance within their CHPs for which they report to the Chair of the CHP. We need to ensure that accountability of care and clinical governance is clearly described in the regulations.

ANNEX 2(D)

PROPOSALS FOR PRESCRIBED FUNCTIONS THAT MUST BE DELEGATED BY LOCAL AUTHORITIES RELATING TO THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

CONSULTATION QUESTIONS

1. Do you agree with the list of Local Authority functions included here which must be delegated?

Yes [√]

No [ ]

2. If no, please explain why:

3. Are there any further comments you would like to offer on these draft regulations?

No further comment.

ANNEX 3(D)

PROPOSALS FOR REGULATIONS PRESCRIBING FUNCTIONS THAT MAY OR THAT MUST BE DELEGATED BY A HEALTH BOARD UNDER THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

CONSULTATION QUESTIONS

1. Do you agree with the list of functions (Schedule 1) that may be delegated?

Yes ☐

No ☑ √

If no, please explain why:

We believe that Children Services should be included in the Integrated organisation as these services are currently very well integrated. There is a risk of the service becoming less well integrated with the change in structure.

The strategic planning of unplanned and emergency care should be extended beyond secondary care to explicitly include the planning of emergency aspects of general practice in daytime hours.

Given the strategic planning responsibilities of the Health and Social Care partnership very serious consideration should be given to Public Health being located within the Health and Social Care Partnership.

There needs to be more clarity around the meaning of "strategic planning" at the particular level of health and social care integration. If the organisation is truly to take responsibility for the strategic planning of unplanned and emergency services, the resources associated with these services require to be at the disposal of the health and social care partnership. This would not alter the operational management responsibilities which are anticipated to continue with acute services.

Schedule 1 defines the services that "may" be delegated. From this it is clear that the power to enter into a GMS contract remains with the Board as does education, research and Section 22 of the Mental Health (Care and Treatment)(Scotland) Act 2003 which gives a responsibility to the Health Board to maintain a list of approved medical practitioners.

Death certification may be delegated. This is worthy of reflection given that it will be easier to co-ordinate the planning and implementation of death certification across the whole of the health services. Perhaps operational responsibility rather than strategic responsibility is what should be delegated to the Partnership. The provision of regional and national health services are also deemed inappropriate for delegation to the new organisation. This will provide challenges for some mental health and learning disability services, particularly around forensic, LD and adult mental illness as well as perinatal mental health and eating disorders care and should be reconsidered in the regulations.

Clinicians working in these services currently work across a number of organisational boundaries. As the clinical pathways are in place a change in structure may have no material effect on services however the views of the specialist services should be sought.

Cont/d…..

Cont'd …

We agree that the GP out of hours' services should sit within the Health and Social Care Partnership to enable the development of services focused on people remaining in their own homes.

In terms of mental health the 'must' is described as CMHTs – integration should include all mental health services – ie include. Having some mental health services within integration and some outside would be disruptive and unhelpful.

In terms of LD the 'must' is also described as CLDTs – the same argument applies here as it does in mental health all of LD including inpatient services should be included in integration

Pharmaceutical services can and should be included within the new organisation as should general, dental and ophthalmic services and the budgets allocated to these. However, the pharmaceutical budget should remain at Health Board level to enable planning, equity and safe delivery of these services across the Health Board.

2. Do you agree with the list of services (Schedule 2) that must be delegated as set out in regulations?

Yes ☐

No ☑ √

If no (i.e. you do not think they include or exclude the right services for Integration Authorities), please explain why:

There is real concern within Care of the Elderly specialists that the use of the term "care of older people services" causes confusion. The service provided by Geriatricians, is demarcated by patient attributes and not by age. The boundary between adult medicine and medicine for the older adult is very blurred. Any attempt to create an inflexible distinction between the two has the potential to do a great disservice to individual patients and introduce inequity of service and access.

There are several mental health services which work on a regional network basis with clinicians and patients moving between the different levels of intensity. Patient care is dictated by agreed clinical pathways which also flow across primary, secondary and tertiary interventions.

It is important that these services remain integrated within the Board level mental health services to enable the current care pathways and Managed Clinical Networks to continue to support the safe and effective delivery of care.

Finally the prescribed functions relate to "persons of at least 18 years of age". Mental Health and Learning Disability Services treat people under the age of 18. These services should continue to be part of the Mental Health and Learning Disabilities Services in the new organisation.

3. Are you clear what is meant by the services listed in Schedule 2 (as described in Annex A)?

Yes	
No	√

If not, we would welcome your feedback below to ensure we can provide the best description possible of these services, where they may not be applied consistently in practice.

Clinical colleagues within the Health Service continue to lack clarity about which services may and must be delegated as well as the definition of strategic planning for a range of services.

4. Are there any further comments you would like to offer on these draft regulations?

ANNEX 4(D)

The Scottish Government
Riaghaltas na h-Alba

PROPOSALS FOR NATIONAL HEALTH AND WELLBEING OUTCOMES RELATING TO THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

CONSULTATION QUESTIONS

1. Do you agree with the prescribed National Health and Wellbeing Outcomes?

Yes ☐

No √

If no, please explain why:

There are aspirations. It will be extremely difficult to develop measurable indicators by which to measure performance.

Outcome 7 needs redefined to state that "people who use Health and Social Care Services are safe from harm as a result of a service intervention or lack thereof".

Specific comments on individual outcomes are noted below:

- Outcome 1: How would we measure whether service users are taking more personal responsibility for their health outwith uptake of specific services like smoking cessation? Health and wellbeing are linked but not synonymous. Are we aiming to measure health or quality of life or both? Measuring quality of life is complex. What meaningful data would we extract by attempting to operationalise this outcome?
- Outcome 2: this is reasonable and measurable.
- Outcome 3: A 'positive' experience should not be taken to mean that service user satisfaction with a service is synonymous with delivery of a good and appropriate service to meet that person's needs. It would be preferable to change this outcome to:
  People who use health and social care services are treated in a person-centred way and have their dignity respected.
  This outcome will probably depend on some sort of service user satisfaction measures which are not particularly reliable/robust.
- Outcome 4: This outcome is aspirational and measurement will be very challenging. As in (1) – how is it intended that services measure quality of life?
- Outcome 5: This should be a central objective of integration. Presumably measurement of these indices will be a development of existing metrics so should be possible to operationalise.
- Outcome 6: The health and wellbeing of unpaid carers will be affected by variables outwith the scope of integration – eg their financial circumstances. If this outcome is to be meaningful it will need to be operationalised around specific measurables such as access to respite care.
- Outcome 7: This is essential and measurable; development of these measures should be relatively straightforward building on existing guidelines and processes across health and social care.
- Outcome 8: This outcome should support clinical and care governance by ensuring that staff have access to adequate CPD. It would be a more robust outcome if it read:

    People who work in health and social care services are supported through continuing professional development and professional supervision/ mentorship to ………etc.

2. Do you agree that they cover the right areas?

Yes ☑ √

No ☐

3. If not, which additional areas do you think should be covered by the Outcomes?

4. Do you think that the National Health and Wellbeing Outcomes will be understood by users of services, as well as those planning and delivering them?

Yes ☑ √

No ☐

5. If not , why not?

6. Are there any further comments you would like to offer on these draft Regulations?

No further comments.

ANNEX 5(D)

The Scottish Government
Riaghaltas na h-Alba

PROPOSALS FOR INTERPRETATION OF WHAT IS MEANT BY THE TERMS HEALTH AND SOCIAL CARE PROFESSIONALS RELATING TO THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

CONSULTATION QUESTIONS

1. Do you agree that the groups listed in section 2 of the draft regulations prescribe what 'health professional' means for the purposes of the Act?

Yes ☐

No ☑ √

2. If you answered 'no', please explain why:

Health care managers, although not formally registered as care professionals, must be consulted.

3. Do you agree that identifying Social Workers and Social Service Workers through registration with the Scottish Social Services Commission is the most appropriate way of defining Social Care Professionals, for the purposes of the Act?

Yes ☑ √

No ☐

4. If you answered 'no', what other methods of identifying professional would you see as appropriate?

5. Are there any further comments you would like to offer on these draft Regulations?

No further comment.

ANNEX 6(D)

PRESCRIBED FUNCTIONS CONFERRED ON A LOCAL AUTHORITY OFFICER RELATING TO THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

CONSULTATION QUESTIONS

1. Do you believe that the draft Regulations will effectively achieve the policy intention of the Act?

Yes [√]

No [ ]

2. If not, which part of the draft Regulations do you believe may not effectively achieve the policy intention of the Act, and why?

> The policy aim is the right one however delivery will only happen through change of working practices, behaviours and through this as we move into a new system of truly integrated working. This will take a significant period of time to deliver (2-3 years). This timescale is not being reflected in communication to the public.
>
> The regulations, while necessary, will result in additional bureaucracy which may have the effect of slowing down the rate of change. This must be guarded against.

3. Are there any further comments you would like to offer on these draft Regulations?