Community Planning under the Community Empowerment (Scotland) Act 2015: Consultation on Draft Guidance

Healthcare Improvement Scotland response

Healthcare Improvement Scotland drives improvement in the quality of health and social care for all people in Scotland. Our work supports the 2020 vision for Scotland where people are able to live longer healthier lives at home, or in a homely setting.

We work with health and social care providers to drive improvement in the care people receive by:

- empowering people to have an informed voice in managing their own care and shaping how services are designed and delivered
- using the best available evidence to provide national clinical standards, guidance and advice for health and social care providers to use.
- providing programmes of world-class improvement support to help services improve, and
- delivering scrutiny activity which is fair but challenging and leads to improvements in the care that people receive.

We work in partnership with those delivering care including integration authorities, third sector organisations, the independent care sector, housing organisations and NHS boards to make improvements in health and care services which are cost effective and sustainable.

Our detailed responses on the questions set out in the consultation document are provided below. These include a number of references to the work of the Scottish Health Council, which is part of Healthcare Improvement Scotland. Reference is also made to the Improvement Hub, which we have created in response to the integration of health and social care services across Scotland, to support Health and Social Care Partnerships and NHS boards to improve the quality of health and social care services.
Q1: The guidance identifies a series of principles for effective community planning. Do you agree with them? Should there be any others?

We broadly agree with the identified principles for effective community planning. In relation to ‘Effective performance management’ we would highlight that the way in which this is put into practice is important and certain approaches can in fact undermine the principles behind it.

The Economic and Social Research Council funded research into the Meaningful and Measurable use of personal outcomes data strongly suggests that qualitative data and stories should be given equal weight with quantitative data in any effective system for managing the performance of human systems.

We therefore very much welcome the recommendation that performance management frameworks should ‘include a blend of performance evidence’ which combines data with ‘experiences of local communities and service users’. The guidance also suggests that ‘the CPP may consider it appropriate to supplement this with other information, including…qualitative evidence’. We think that there is scope for and benefit in this being strengthened and more explicitly endorsed, as well as recognition of the potential pitfalls of traditional performance management approaches.

The implementation of a robust process to ensure that community views are gathered to support performance management is crucial. The Scottish Health Council can offer support to how community and patient experience is best captured so that equal weight is given to users views and in line with the principle of the Our Voice framework (see information below under question 5).

Q2: The draft guidance sets out common long-term performance expectations for all CPPs and community planning partners. Each CPP will adopt its own approach towards meeting these expectations, reflecting local conditions and priorities. Even so, do you think there are common short- or medium-term performance expectations which every CPP and partner should be expected to meet? If so, what are they?

We welcomed that the performance expectations includes ‘a deep rooted commitment to continuous improvement’ . The guidance includes detail on performance management but we are concerned that there is little in relation to quality improvement and what is understood by this for CPPs. Will CPPs develop their own model of continuous improvement? It is important to have a shared understanding of what is meant by this for CPPs, how they might approach this and demonstrate how and where improvements are being made. Generally there is a
good deal of discussion about what they will improve but the capacity to implement improvement is unclear. There is a risk that improvement will be viewed as an ‘add on’ rather than being ‘deep rooted’.

While we recognise the importance of flexibility around local approaches to meeting performance expectations, and support this, there may be merit in establishing mechanisms for CPPs across regions to share challenges and best practice, in order to support improvement.

Healthcare Improvement Scotland’s Improvement Hub is a resource to support those who are delivering integrated health and social care across Scotland to improve aspects of care delivery services and to support the development of infrastructures and cultures which enable the work of improvement. This includes work, for example on personal outcomes, which may be of interest to CPPs.

Q3: The 2015 Act requires CPPs to keep under review the question of whether it is making progress in the achievement of each local outcome in their LOIP and locality plan(s). CPPs must from time to time review their LOIP and locality plan(s) under review, and to revise them where appropriate. Even with this, do you think the statutory guidance should require CPPs to review and if necessary revise their plans after a specific period of time in every case? If so, what should that specific period be?

Yes

Please explain why.

We do not have a strong view on what the specific period of time for review / revision of Local Outcomes Improvement Plans and locality plans, however would suggest that ‘from time to time’ is too vague and that a timeframe should be specified.

It is perhaps, however, more important to consider how to ensure that the review / revision of plans is meaningful and leads to improvement. Is there scope for this work to link to existing reporting mechanisms for CPPs? It is also important to be clear on what exactly is being reviewed and how, and for this to be meaningful and transparent for stakeholders and communities.

Q4: What should the statutory guidance state as the latest date by which CPPs must publish progress reports on their local outcomes improvement plans and locality plans?

4 months  6 months  Other
If other please provide timescale. Please explain why.

Again, we do not have a strong view on the timescale for publication of progress reports on local outcomes improvement plans and locality plans, but would suggest that in order to provide meaningful data this would need to be at least 6 months.

We welcome that CPPs will be required to publish annual progress reports which include an assessment of how they have participated with community bodies. The Scottish Health Council has experience of assessing how well NHS Boards have involved individuals and local communities in developing services through its annual Participation Standard assessment process and can share further details of an established system that works well. Our experience demonstrates that there is merit in building independent community verification into that process; again the Scottish Health Council can provide further information.

It is also recommended that new and innovative ways of reporting, including capturing public feedback, are considered rather than solely relying on an annual report which may not be suited to all parts of the community.

Q5. Do you have any other comments about the draft Guidance?

As noted above, there is a range of experience which the Scottish Health Council has in relation to community participation and engagement, which is offered via a local office in every NHS Board area. We would suggest therefore that there is scope for this to be recognised as the Guidance is finalised and implemented.

In addition, the Scottish Health Council, alongside other partner organisations, is implementing Our Voice which was announced by the Cabinet Secretary for Health & Wellbeing in 2014. Our Voice is based on a vision where people who use health and care services, carers and the public will be enabled to engage purposefully with health and social care providers to continuously improve and transform services. People will be provided with feedback on the impact of their engagement, or a demonstration of how their views have been considered. Our Voice will operate at three levels covering individual involvement, community involvement and national involvement. Given the spread of Our Voice across health and social care (and including Community Planning Partnerships), there would merit in referencing this work in the Guidance.

We would also wish to comment in relation to the language used in the guidance. The document uses a range of terms, such as participation and co-production, which in our experience can be interpreted differently. It is important therefore to ensure a
shared understanding of what is meant by these – particularly in the context of integration - and therefore perhaps worth explaining this further in the guidance. The Scottish Community Development Centre has done work to define what is meant by these and their National Standards for Community Engagement may be worth referencing.

Q6. We propose that the draft regulation for locality planning should set one criterion only, which is a maximum population permissible for a locality. Do you agree? What are your reasons?

N/A

Q7: The draft regulation sets a maximum population size for localities subject to locality planning of 30,000 residents. It also proposes an exception which allows a CPP to designate a local authority electoral ward as a locality even where its population exceeds 30,000 residents. Are there circumstances in which these criteria would prevent a CPP from applying a reasonable approach to locality planning? What difference would it make to how localities were identified for the purposes of locality planning in the CPP area(s) in which you have an interest, if the maximum population size were set at (a) 25,000 residents or (b) 20,000 residents?

We would wish to highlight one potential issue in relation to using council wards as the locality. In this case, it would be important for the CPP to demonstrate that its interventions are targeted at specific areas of deprivation, rather than a broad brush attempt to renew one council ward. This last approach has been controversially used in the past, e.g. renewing play areas across a council ward, rather than focussing on targeted interventions for the most deprived areas within that ward.

Q8: Do you have any other comments about the draft Regulation?

No

Q9: Are there any equality issues we should be aware of in respect of local outcomes improvement plans and locality plans?

We would not highlight any specific issues but make the general point that this will depend largely on how representative they are of their communities, through community engagement processes in their development, and also how transparent and accessible they are made to a range of groups. Would Equality Impact Assessments be a useful mechanism for ‘testing’ this?