

PUBLIC BODIES (JOINT WORKING) (SCOTLAND) BILL

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the Public Bodies (Joint Working) (Scotland) Bill introduced in the Scottish Parliament on 28 May 2013. It has been prepared by the Scottish Government to satisfy Rule 9.3.3 of the Parliament's Standing Orders. The contents are entirely the responsibility of the Scottish Government and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 32–EN.

POLICY OVERVIEW

2. The Bill provides the framework which will support improvement of the quality and consistency of health and social care services through the integration of health and social care in Scotland. This framework permits integration of other local authority services with health services. The Scottish Ministers intend to use the framework to integrate adult health and social care services as a minimum, and for statutory partners to decide locally whether to include other functions in their integrated arrangements. The policy ambition for integrating health and social care services is to improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.

“...effective services must be designed with and for people and communities – not delivered ‘top-down’ for administrative convenience.

“This complexity [in public service delivery in Scotland] is reflected in inadequate strategic coordination between public service organisations that work routinely to different objectives, with separate budgets and processes for accountability.

“Points of authority and control are dispersed widely among varied public bodies, making joint working and reform difficult. Collaboration often relies on the persistence and flexibility of individual front-line workers and leaders.”

The Christie Commission Report
Commission on the future delivery of public services, June 2011

3. There is a great deal to be proud of in terms of health and social care provision in Scotland. The Healthcare Quality Strategy for NHS Scotland¹ underpins the Scottish Government's commitment to deliver the highest quality healthcare services to people in Scotland and, in recent years, Scotland has seen significant improvements in terms of standards and outcomes, with improvements in waiting times, patient safety and delayed discharge from hospital. The Scottish Government's introduction of a Dementia Strategy², continuing commitment to Free Personal and Nursing Care and Reshaping Care for Older People³ programme, which is supported by the Change Fund for older people's services, all demonstrate determination to assure innovative, high quality care and support services that improve people's lives. The Scottish Government's Carers' Strategy⁴ supports unpaid carers, who are themselves essential providers of health and social care, and the Social Care (Self-directed Support) (Scotland) Act 2013⁵ seeks to put greater control into the hands of individuals using care and support services.

4. Nevertheless, there is widespread recognition across Scotland that reform needs 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, stamina and collaboration from all of us who are involved, in different ways, in planning, managing, delivering, using and supporting health and social care services.

5. The Scottish Government, its statutory partners in local government and NHS Scotland, and its non-statutory partners in the third and independent sectors, agree that better integration of health and social care services is required in order to ensure the on-going 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 partner organisations work together to ensure that services are being integrated as an effective means for achieving better outcomes.

6. When referring to “integrated health and social care”, what is meant is that services should be planned and delivered seamlessly from the perspective of the patient, service user or carer, and that systems for managing services should actively support such seamlessness.

7. There has been very significant progress in improving pathways of care in recent years. The Joint Futures policy, Community Health Partnerships and the work of the Joint Improvement Team have also contributed to development of partnership working across health and social care. Nevertheless, many clinicians, care professionals and managers in health and social care currently describe two key disconnects in Scotland's system of health and social care. The first disconnect is found within the NHS, between primary care (GPs, community nurses,

¹ The Healthcare Quality Strategy for NHS Scotland

<http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf>

² Scotland's National Dementia Strategy <http://www.scotland.gov.uk/Publications/2010/09/10151751/17>

³ Reshaping Care for Older People <http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Older-People/ReshapingCare>

⁴ Caring Together: The Carers Strategy for Scotland 2010-2015

<http://www.scotland.gov.uk/Publications/2010/07/23153304/0>

⁵ Social Care (Self-directed Support)(Scotland) Act 2013 <http://www.legislation.gov.uk/asp/2013/1/contents/enacted>

allied health professionals etc.) and secondary care (hospitals). The second disconnect is between health and social care, responsibility for delivery of which lies with local authorities.

8. These disconnects make it difficult to address people's needs holistically, and to ensure that resources follow patients', service users' and carers' needs. Problems often arise in providing for the needs of people who access many services over prolonged periods, such as people with long term conditions, and people with complex needs. Many of these people, though by no means all, are older. Problems are also encountered at transition points, particularly as children with complex needs reach adulthood.

9. From the perspective of people who use the system – patients, service users, carers and families – the problems to be addressed can be summarised as follows:

- There is inconsistency in the quality of care for people, and the support provided to carers, across Scotland, particularly in terms of older people's services;
- People are too often unnecessarily delayed in hospital when they are clinically ready for discharge; and
- The services required to enable people to stay safely at home are not always available quickly enough, which can lead to avoidable and undesirable admissions to hospital.

10. The consultation on integration of adult health and social care, and the public engagement exercise of Reshaping Care for Older People, indicated that these are the main problems that people want to see addressed. Clinicians and other professionals who provide health and social care support also indicate that, as far as possible, it is better for people's wellbeing if they are supported in their own homes or another homely setting in the community, rather than being admitted unnecessarily to hospital.

11. In terms of older people's services specifically, it is also known that:

- Almost one third of total spend on older people's services annually is on unplanned admissions to hospital;
- More is spent annually on unplanned admissions for older people than is on social care for the same group of people; and
- Even allowing for the possibility that people may live longer and in better health in future, and taking into account the Scottish Government's current emphasis on improving anticipatory and preventative care, Scotland will in future experience a material increase in the number of people who require care. The resources required to provide support will rise in the years ahead⁶.

12. Despite a good track record of partnership working over many years, Scotland's current system of health and social care still incorporates within it barriers in terms of structures, professional territories, governance arrangements and financial management that often have no helpful bearing on the needs of the large, growing group of older service users, and in many cases work against general aspirations of efficiency and clinical/care quality. Reform is needed

⁶ Reshaping Care for Older People <http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/>

to address these barriers and to deliver care that is better joined up and, as a consequence, delivers better outcomes for patients, service users and carers.

13. The goal for integration of health and social care is to tackle these challenges and, in particular, to address the disconnects described above – so that the balance of care shifts from institutional care to services provided in the community, and resources follow people’s needs. This is in line with the Scottish Government’s commitment to a person-centred approach, which builds on the Scottish Government’s policy on Self Directed Support⁷ and the principles of the Healthcare Quality Strategy for NHS Scotland.⁸

14. In considering the legislative context for these reforms, it is worth noting that the Scottish Government is clear that legislation alone will not achieve the scale of improvement that is required in order to address the challenges of demographic change and fiscal constraint. Leadership is key, locally and nationally, to achieve the changes in working practices, culture and behaviour that are required.

Scope – demographic considerations

15. The Scottish Government’s ambitions for improving integration of adult health and social care services are not limited to improving older people’s services but extend to all adult health and social care services. People can, and do, experience complex care and health support requirements at any age, and it is recognised the importance of ensuring that better integration of health and social care services results in improvements for all patients, service users and carers.

16. However, the factors driving closer integration are particularly relevant to care and support for older people. It is known that, too often, older people are admitted to institutional care for long periods when a package of assessment, treatment and rehabilitation, and support in the community – or more support to their carers – might have served their needs, and maintained their independence, better.

17. Demographic change in itself also makes the case for change urgent, and suggests that focus is required as a priority on improving services for older people. The Registrar General has projected that the number of people in Scotland aged over 75 will grow by around 10,000 every year, over the decade ahead. Changes in demography will vary in scale depending on location. Around one quarter of Scotland’s population will be aged 65 and over by 2033; for some of Scotland’s more rural areas the proportion is predicted to rise by nearly one third.

18. Given these pressures, it might seem appropriate to focus integration of health and social care on older people exclusively. However, there are a number of arguments against limiting plans for integration in this way. Conditions associated with old age and frailty are often experienced much earlier than 65, particularly but not exclusively in areas with high levels of deprivation. People with disabilities also have requirements for care across all age groups. A focus on older people alone would create an artificial divide within adult services, with people at transition from children’s services, and with younger adults with physical and learning difficulties.

⁷ Self Directed Support <http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Self-Directed-Support>

⁸ The Healthcare Quality Strategy for NHSScotland <http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf>

Scope – enabling integration beyond adult health and social care

19. The Bill enables Health Boards and local authorities to integrate planning and service provision arrangements for all areas of health and social care. Regulations will set out functions that may not be delegated (such as, for example, nationally delegated and funded NHS functions and certain mental health social work functions). Regulations and statutory guidance will establish the requirement on Health Boards and local authorities to integrate services for adults, which will be the minimum functions to be required to be delegated to achieve approval by Scottish Ministers of integration plans. Nationally agreed outcomes for health and social care will employ measures that enable local and national partners to understand success at local level in terms of shifting the balance of care towards support provided within the community for people with complex support needs.

Partnership working – more than statutory partners

20. The Bill is designed to enable locally-implemented integration. It focuses on bringing together the accountability of statutory partners – Health Boards and local authorities – in an equitable way, to deliver better outcomes for patients, service user and carers. The Bill enables, through secondary legislation, Health Boards, local authorities and integration joint boards to fully and appropriately involve non-statutory providers of health and social care with planning and decision-making within the partnership arrangements. This is consistent with principles of co-production⁹, which underpin the Government’s vision for mutual and person-centred public services¹⁰, which encourage the utilisation of the talents, capacities and potential of all of Scotland’s people and communities in designing and delivering health and social services¹¹. In addition, it will be important, and is intended through secondary legislation, to involve and consult carers and users of health and social care services in all aspects of the integrated arrangements.

21. The third and independent sectors, including carers’ organisations, also provide significant levels of care and support and are crucial partners, with the statutory services, in the provision of a wide range of support. As work continues with partners and stakeholders to deliver this agenda for integration of health and social care, it will be particularly important that there is a focus on building on the principles of inter-agency working enshrined in the Change Fund for older people’s services¹². The fundamental purpose of the policy on integration, which underpins the legislation, is to improve people’s wellbeing; the reform will not succeed if, in bringing health and social care together, the need to build upon the progress that has been made in bringing third and independent sector partners to the table when planning delivery of services is overlooked. The contribution of the third and independent sectors in enabling delivery of

⁹ Co-production of Health and Wellbeing in Scotland <http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/community-capacity-building/community-capacity-building-resources/>

¹⁰ Renewing Scotland’s Public Service; priorities for reform in response to the Christie Commission <http://www.scotland.gov.uk/Resource/Doc/358359/0121131.pdf>

¹¹ The Healthcare Quality Strategy for NHS Scotland <http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf>

¹² Reshaping Care for Older People <http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Older-People/ReshapingCare>

better outcomes is also a crucial factor in the Scottish Government's wider public service reform¹³ plans.

22. Other areas of service also play a key role in the delivery of better outcomes for people with long term conditions and complex needs, and for older people in particular. Housing is an important example of this. The National Strategy for Housing for Older People¹⁴ highlights ways in which the right housing and related services (such as adaptations and handyperson services) can help to support independent living, and can contribute to health and social care objectives. It will be important that, in bringing primary and secondary health closer together, and health and social care closer together, partners ensure that housing services (including those provided by housing associations and the third sector, as well as by local authorities) are fully included in the integrated approach to service planning and provision, and that health and social care planning and local housing strategies are mutually supportive.

CONSULTATION

23. During the 2011 Scottish elections, almost all party manifestos included a commitment to integrate health and social care, with a majority of MSPs agreeing with the principle of a substantive shift towards better joined up working across primary and secondary health care, and between health and social care. Following the election, the Scottish Government worked closely with stakeholders from across the health and social care landscape to develop proposals for integration.

24. In May 2012, the Scottish Government published its consultation on proposals for the integration of adult health and social care¹⁵. The consultation described the proposals for which the Scottish Ministers intend to legislate, and set the context for the Bill. The consultation closed on 11 September 2012.

25. Over the period of the consultation, Scottish Government officials held a number of consultation events¹⁶ across Scotland, providing the opportunity for professionals, patients, service users and carers, as well as providers of services, to hear first-hand about the consultation proposals and to have the opportunity to ask questions and discuss the proposals. In addition, officials met with a broad range of stakeholders at events and meetings organised by local partnerships to provide further opportunities to discuss the consultation proposals.

26. Three hundred and fifteen written responses to the consultation were received from a range of different stakeholders and individuals, reflecting the breadth of interest in this area of public service reform. Non-confidential responses¹⁷ were published on the Scottish Government website. An analysis¹⁸ of written responses to the consultation was published on 19 December 2012.

¹³ Public Service Reform <http://www.scotland.gov.uk/Topics/Government/PublicServiceReform>

¹⁴ A Strategy for Housing for Scotland's Older People
<http://www.scotland.gov.uk/Publications/2011/12/16091323/0>

¹⁵ Integration of Adult Health and Social Care Consultation on Proposals
<http://www.scotland.gov.uk/Publications/2012/05/6469>

¹⁶ Consultation events <http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration>

¹⁷ Responses to the Consultation <http://www.scotland.gov.uk/Publications/2012/10/5025>

¹⁸ Consultation Analysis Report <http://www.scotland.gov.uk/Publications/2012/12/1068>

27. The Scottish Ministers and officials considered the consultation responses and continued to work collaboratively with key stakeholders to develop the proposals further.

28. The Bill Advisory Group was established to provide advice on the development of the Bill. Members of the Group represent a wide range of stakeholders involved in the provision of health and social care. The Group also has oversight of the working groups that support the development of the Bill on professional and technical aspects of the policy. The Bill Advisory Group takes into account other policies and developing legislation as part of its role to provide scrutiny to the development of the Bill. The Cabinet Secretary for Health and Wellbeing chairs the Bill Advisory Group at relevant points in the Bill process alongside Cllr Johnston, COSLA Health and Wellbeing Spokesperson, as vice chair. Further information regarding the Bill Advisory Group¹⁹, including remit and minutes of meetings, can be found on the Scottish Government website.

29. A number of working groups²⁰ were established in 2012, to support the development of the consultation proposals in the first instance, and to provide practical and, subsequently, technical advice on the detail of the practical implementation. The members of these groups provide professional expertise on a range of matters, such as development of outcome measures, commissioning skills, finance and accounting issues, and workforce issues.

30. The Scottish Government response to the consultation²¹ was published on 13 February 2013, and provided further detail on the Scottish Ministers' intentions for the forthcoming Bill.

31. As part of the consultation, officials held discussions with equality groups on the possible impact of the proposals, and this formed an Equality Impact Assessment. The results of this assessment have been taken into account in the development of the Bill, and are outlined later in this Policy Memorandum.

OUTCOME OF THE CONSULTATION

National outcomes for health and wellbeing and scope

32. The majority view supported nationally agreed outcomes to be included in Single Outcome Agreements (SOAs) 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.

33. Those in favour expressed the view that it is sensible to start with the largest group of service users, allowing integration authorities to incorporate improvements before extending to all adults.

¹⁹ Bill Advisory Group <http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Meetings>

²⁰ Integration Bill Working Groups <http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/IntegrationBillWorkingGroup>

²¹ Scottish Government Response to the Consultation <http://www.scotland.gov.uk/Publications/2013/02/4208>

34. 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’.

35. Sometimes, as people responded to the consultation, a question was asked about whether the proposed scope was limited to older people. Where this point was raised at discussion events, Scottish Government officials reiterated the point that the Scottish Ministers intend to legislate for all areas of adult health and social care, providing flexibility for integration beyond adult health and social care services, for example children’s services, where there is local agreement to do so.

Governance and accountability

36. 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.

37. Many respondents expressed the view that an integration authority should be about the synergy between a single council and a single Health Board. Concerns were raised that should an integration authority 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.

38. 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.

39. 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.

40. 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

41. 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.

42. In terms of whether or not the Scottish 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 the Scottish Ministers prescribe a minimum, only that minimum will be included in the integrated budget.

43. There were mixed views regarding whether 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 integration authority. 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 integration authorities are able to demonstrate this working, moving to include more services. There were some respondents who expressed the view that the Scottish 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.

Chief Officer (referred to as Jointly Accountable Officer within the consultation document)

44. Respondents expressed differing views regarding the appointment of chief 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.

45. There was general agreement that if chief 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 integration authority. Many respondents expressed the view that the chief officer post must be senior enough to reflect these requirements.

Professionally led locality planning and commissioning of services

46. 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.

47. The proposal that a duty should be placed upon integration authorities 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.

48. 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 integration authorities could be strengthened by setting up joint professional and stakeholder advisory committees to contribute to the development of strategic plans. It was suggested that structured support for stakeholder involvement would be required.

49. 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.

50. The Bill reflects the proposals detailed in the consultation document, with some modifications in response to stakeholder views. For example, locality planning will be part of the strategic planning process but the Bill will not be prescriptive with regard to size or scope of localities themselves. This responds to stakeholders’ consistently expressed view that locality arrangements should be determined locally. The Bill also clarifies that the appointment of a chief officer only applies where the ‘body corporate’ model is used.

BILL OUTLINE

51. The Bill is designed to establish a framework to support the integration of local authority and Health Board functions. The Bill will permit the Scottish Ministers to require the integration of, as a minimum, adult health and social care, based on the principles of a person-centred approach to service planning. The principles established in the Bill for integration, along with the national outcomes that the Bill enables the Scottish Ministers to put in place, will focus Health Boards’ and local authorities’ attention on ensuring that arrangements for governance, planning, investment and risk management take full account of the consequences, challenges and opportunities that present as the shape of Scottish society changes.

52. For the purposes of the Bill, partnership arrangements are described as integration authorities, which can be established using any of the models of integration described below. Health Boards and local authorities will be expected to agree, locally, which model to use:

- the Health Board and local authority choose to deliver integrated services through delegation to an integration joint board, established as a body corporate;
- the Health Board and local authority choose to deliver services through delegation to the Health Board in a delegation between partners arrangement and establish a joint monitoring committee;

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- the Health Board and local authority choose to deliver integrated services through delegation to the local authority in a delegation between partners arrangement and establish a joint monitoring committee; or
- the Health Board and local authority choose to deliver integrated services through delegation to the Health Board and the local authority in a delegation between partners arrangement and establish a joint monitoring committee.

53. In summary, the Bill:

- Provides for the Scottish Ministers to specify national outcomes for health and wellbeing, and for delivery of which, Health Boards and local authorities will be accountable to the Scottish Ministers and the public (note that the provisions of the Bill apply to area Health Boards and not Special Health Boards)
- Sets out principles for planning and delivery of integrated functions, which local authorities, Health Boards and joint integration boards will be required to have regard to. They set out that the main purpose of integrated services is to improve the wellbeing of recipients, as well as an expectation that planning and delivery will take account of key principles relating to integrated delivery; the requirement to balance the needs of individuals with the overall needs of the population; anticipation and prevention of need; and effective use of resources.
- Establishes integration joint boards and integration joint monitoring committees as the partnership arrangements for the governance and oversight of health and social care services. The Bill will remove Community Health Partnerships from statute.
- Requires Health Board and local authority partners to enter into arrangements (the integration plan) to delegate functions and appropriate resources to ensure the effective delivery of those functions. The Bill provides for two options for integrating budgets and functions. First, delegation to an integration joint board established as a body corporate - in this case the Health Board and the local authority agree the amount of resources to be committed by each partner for the delivery of services to support the functions delegated. Second, delegation between partners. In this case the Health Board and/or local authority delegates functions and the corresponding amount of resource, to the other partner.
- Requires integration joint boards to appoint a chief officer, who will be jointly accountable, through the board, to the constituent Health Board and local authorities, and responsible for the management of the integrated budget and the delivery of services for the area of the integration plan. The chief officer will also lead the development and delivery of the strategic plan for the joint board.
- Requires integration joint boards, and Health Boards or local authorities to whom functions are delegated acting in the capacity of “integration authority” to prepare a strategic plan for the area, which sets out arrangements for delivery of integration functions and how it will meet the national health and wellbeing outcomes. The integration authority will be required to involve a range of partners in the development of the plan and consult widely. In addition, locality planning duties will require the integration authority to make suitable arrangements to consult and plan locally for the needs of its population.
- Delivers opportunities for more effective use of public services and resources by allowing for Health Boards to be able to contract on behalf of other Health Boards

for contracts which involve providing facilities, and by allowing the Scottish Ministers to form a wider range of joint ventures structures to collaborate effectively with local authorities and enable a joint approach to asset management and disposal.

- Provides for the extension of the Common Services Agency's ability to deliver shared services to public bodies including local authorities.
- Enables the Scottish Ministers to extend the range of bodies able to participate in the CNORIS scheme for meeting losses and liabilities of certain health service bodies . The scheme is established for relevant bodies to meet expenses arising from any loss or damage to their property; and liabilities to third parties for loss, damage or injury arising from the carrying out of the functions of the scheme members. The Bill amends the bodies able to participate in the scheme to include local authorities and integration joint boards.

54. The underlying principle, of key importance in the Bill, is that Health Boards and local authorities must take joint and equal responsibility for the delivery of nationally agreed outcomes for health and wellbeing.

55. Factors identified from areas elsewhere in Scotland and the UK²² as key to success include: planning across existing delivery systems for the wellbeing of identified care groups (e.g. planning for older people across health and social care, not producing separate plans); integrating resources across systems to support the delivery of integrated services; assuring a strong role for local care professionals and clinicians in the planning of local services; and strong, committed local leadership focussed on clearly identified local needs. The Bill sets out the process for establishment and governance of partnership arrangements as follows:

- a) Each Health Board and local authority will be required to establish an integration authority (body corporate or delegation between partners arrangements) to deliver nationally agreed outcomes for health and wellbeing.
- b) In the "body corporate" model, the Health Board and the local authority delegate functions and resources to the integration authority, which is a joint board established as a body corporate. In this model, the integration joint board is required to appoint a chief officer who will lead development of the strategic plan, and manage the integrated budget and integrated planning and delivery of services.
- c) In the "delegation between partners" model of integration, the Health Board or local authority or both, delegates functions and resources to the other or each other, for delivery of services. This model is sometimes referred to as a "lead agency" model, with the partner to whom functions are delegated becoming the "lead agency". In this model, the Bill does not require the appointment of a chief officer. The integration plan will establish that the chief executive of the "lead agency" will be jointly accountable to the Health Board and local authority for management of the integrated services, and will lead development of the strategic plan.
- d) The terms of the arrangement will be described in an integration plan, the details of which will include the model of integration to be used, functions and resources to be delegated, to the integration authority (integration joint board, Health Board and/ or local authority) and method of calculating money to be delegated to support delivery of the functions.

²² <http://www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay>

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- e) The integration plan will also cover a wide range of other aspects of the arrangement, such as provision for dispute resolution, financial management, staff governance and clinical and care governance. Regulations will be made specifying the required content of the integration plan.
- f) Nationally agreed outcomes provide the context for effective joint planning, and the requirement to establish partnership arrangements reinforces the importance of establishing integrated arrangements that span traditional structures. The principle of joint and equal accountability is enshrined in the role of the chief officer in the “body corporate” model, and in the dual accountability of the lead chief executive in the “delegation between partners” model.

56. Once established, the integration authority will be under a duty to produce a strategic plan, which will set out the detailed arrangements for the joint carrying out of integrated functions in its area, as well as the outcomes to be achieved by the integration authority via delivery of services, using the resources delegated to it by the Health Board and/or local authority, which form the integrated budget.

57. In the “body corporate” model, the chief officer will lead the process of producing the strategic plan and its subsequent delivery. In the “lead agency” model, that responsibility will fall to the chief executive of the lead partner. Where the Health Board delegates functions to the local authority and the local authority delegates functions to the Health Board, both chief executives will be jointly responsible for the preparation and delivery of the strategic plan, which will cover more than the delegated functions.

58. The strategic plan is therefore a joint plan that spans the integrated services, and it is of critical importance to the success of the integrated arrangement.

59. In both models, services are delivered via the Health Board and local authority, and third and independent sector providers. Staff will continue to be employed by the Health Board and local authority. If in future it were considered appropriate to change this position so that, where the “body corporate” model is used, the integration joint board itself should be able to employ staff, there is a power for the Scottish Ministers to provide for this by regulations.

60. The Bill places a duty upon integration authorities (integration joint boards, Health Boards and/or local authorities) to work with local professionals, across extended multi-disciplinary teams and the third and independent sectors, to determine how best to put in place local arrangements for planning service provision. Integration authorities will be required to put in place, and to subsequently support, review and maintain such arrangements. On an on-going basis, integration authorities will be required to take account of the input of localities to the development of their strategic plans.

61. Further detail on the objectives that lie behind the Bill provisions is provided below.

OBJECTIVES OF THE BILL – KEY FEATURES AND PROVISIONS

62. The Bill responds to the changing shape and needs of Scotland’s population. More people are living longer, some of them with significant, complex needs for support, an effective, sustainable response to which requires better joined up health and social care services.

63. The context for these legislative changes is characterised by complexity; complexity of people's needs and complexity in the service planning and delivery landscape. As a country, Scotland's response to such complexity must be driven by strong local leadership and effective local planning based on a strong understanding of local needs and priorities. For all of these reasons, a key objective of this Bill is to enable and require appropriate, local, responses to changing patterns of need, within a national context of accountability for clearly articulated, joint outcomes.

64. From the outset of this programme of reform, the Scottish Government has stated that it is not its intention to develop proposals that rest on a principle of centrally directed structural change in NHS Scotland and local government. That does not mean, however, that the Scottish Ministers will fail to address aspects of current structures that are not currently well suited to achieving an effectively integrated response to need. The reform focusses on those aspects of governance, accountability and management arrangements that must be integrated to avoid the detriment of working in silos. Beyond that threshold, local leaders and local systems will determine effective local delivery and management arrangements, within the context of a presumption of integration, joint working, and a focus on planning for and providing person-centred care.

Part 1 – Functions of local authorities and Health Boards

Integration plans: principles

65. The Bill will establish the framework within which partners will plan and deliver integrated services. However, the Scottish Government recognises that legislation alone is not sufficient to enable the cultural shift required to transform decision-making about service planning and activity spend, in order to shift the balance of care from institutional to community settings and embed preventative and anticipatory care provision.

66. The integration principles establish the objectives of the policy within the legislative framework, setting out the aims that partners must take account of when undertaking their duties. Importantly, this will provide for public assurance that, at the heart of the Bill, is the desire to embed a person-centred approach to public service delivery of health and social care.

67. In terms of the aims of the reform, the principles enshrine the observation by the Christie Commission²³ that “effective services must be designed with and for people and communities”, underpinning the planning and decision-making process from the outset. Public bodies will be required to cooperate, not simply for their own administrative convenience, but with a view to the changing needs of the population, whose health and social care needs are not experienced in isolation from one another.

National outcomes

68. The Scottish Government is committed to an outcomes based approach to planning and delivery of public services.

²³ Commission on the future delivery of public services
<http://www.scotland.gov.uk/About/Review/publicservicescommission>

69. Currently, performance management and reporting frameworks for NHS Scotland and local authorities are considerably different from one another.

70. The introduction of the Concordat²⁴ between the Scottish Government and COSLA in November 2007 brought with it the end of ring-fencing of local government funding and associated scrutiny by the Scottish Government of local authority spending. Single Outcome Agreements (SOAs) are now agreed between each Community Planning Partnership (CPP) and the Scottish Government.

71. SOAs provide the mechanism via which CPPs agree local strategic priorities and outcomes, and demonstrate how the SOA contributes to the National Outcomes that are part of the Scottish Government's National Performance Framework. Each SOA is specific to local priorities, with performance management and continuous improvement arrangements that are unique to individual local authorities, although with some common characteristics between local authorities.

72. In contrast, within NHS Scotland, management plans and decisions for the delivery of national targets are scrutinised and agreed with the Health and Social Care Directorates within the Scottish Government, with decisions for major service change ultimately sitting with the Scottish Ministers.

73. By introducing nationally agreed health and wellbeing outcomes, the Scottish Government will, for the first time, introduce a mechanism for ensuring that Health Boards and local authorities are jointly and equally accountable for planning and delivery of effectively integrated services. To strengthen this, the national outcomes will be established in legislation.

74. The Scottish Government also recognises that, by definition, outcomes may need to develop over time. Underlying measures will, in time, need to respond to changes in the wider environment, patterns of service planning and delivery, and so on. The Bill, therefore, establishes that the Scottish Ministers will set out national outcomes for health and wellbeing in regulations, which can, in future, be amended to keep pace with developing needs and aspirations for health and social care in Scotland.

75. Partners will play a key role in the development of the outcomes and, indeed, the performance indicators, and the Scottish Ministers will be required to involve a range of key stakeholders, including health and social care professionals, third and independent sector, carers and service users.

76. The nationally agreed outcomes for health and social care will be consulted upon, agreed and will be reflected in SOAs.

²⁴ Concordat between Scottish Government and local government
<http://www.scotland.gov.uk/Resource/Doc/923/0054147.pdf>

Integration plans

77. An integration plan (referred to in the consultation on integration as a “Partnership Agreement”) between the Health Board and local authority will set out the terms of establishing each integration authority arrangement, which applies where the area of the local authority falls within the area of that Health Board. Some partners are already delivering shared services and the Scottish Ministers have been clear that they did not want to cut across these arrangements. Therefore, the Bill provides flexibility for one or more local authorities to join together, where they fall within the area of the same Health Board, to prepare an integration plan for the delegation of functions and resources. The Bill will establish the framework for such arrangements and their approval process.

- The purpose of the integration plan is to establish the context and provide the necessary clarity of the arrangements in which the integration authorities will operate. It will set out the governance arrangements for the integration authority, functions and budgets to be delegated, outcomes to be achieved, and the model of financial integration to be implemented. Other aspects of the integrated arrangements, such as dispute resolution, clinical and care governance will also be set out in the integration plan.
- Health Boards and local authorities will be required to involve and consult a wide range of stakeholders including health and social care professionals, representatives of Health Board and local authority employees, carers, and service users. Health Boards and local authorities will be required to take account of the views of the consultees.
- The integration plan will be agreed by the full council and Health Board, approved by the Scottish Ministers, and will be made publicly available.

Models of integration

78. The Scottish Ministers recognise that some partnerships have already made good progress in terms of integration, using the mechanisms available to them under current permissive legislation, and have sought to ensure that such arrangements can, with minor adaptation, continue. For this reason, the Bill continues to permit the arrangement for “delegation between partners”, sometimes referred to as “lead agency arrangements”, an example of which has been implemented by NHS Highland and the Highland Council. So as to ensure flexibility in models for integration, the Bill also provides for a “delegation to a body corporate” model, which establishes a joint board to enable it to hold an integrated budget, and allocate it between the constituent Health Board and local authority or authorities.

Body corporate model

79. In this model, the integration authority is established as a body corporate with its own functions and budgets acquired through delegation to the integration joint board. It is anticipated that the joint board will exercise those functions and manage use of the budget by arranging for the provision of services by the Health Board or local authority (which in turn may make arrangements with others). If in future it were considered appropriate for the integration joint board to provide services, there is a power for the Scottish Ministers to provide for this by regulations.

80. The integration joint board is an executive board. Ministerial intention is that its responsibilities are to:

- Oversee development of, and prepare, the strategic plan for the area covered by the integration plan;
- Allocate resources at a high level, between the Health Board and the local authority, in accordance with the strategic plan and within the parameters set out in the integration plan; and
- Ensure delivery of the national and local outcomes.

81. The integration joint board is required to appoint a senior accountable officer, the chief officer, to lead development of the strategic plan and oversee its delivery, to use the resources to best meet both local and national outcomes, set out in the strategic plan within the scope of the integration plan. The chief officer of the integration joint board will be appointed in consultation with the Health Board and local authority, and guidance will further describe the relationship with the two chief executives.

Delegation between partners

82. In this model, functions and budgets are delegated between statutory partners. Where functions and budgets are delegated to the local authority by the Health Board, the local authority becomes the “lead agency”, and is responsible for the delivery of the delegated functions using the delegated budgets. Where functions and budgets are delegated to the Health Board by the local authority, the Health Board becomes the “lead agency”, and is responsible for the delivery of the delegated functions using the delegated budgets.

83. It is possible for the Health Board and local authority to delegate functions in both directions – the two agencies can each be lead agencies at the same time, for different areas of service delivery (e.g. the arrangement in Highland).

84. An integration joint monitoring committee will scrutinise the effectiveness of the integrated arrangement on behalf of the local authority and the Health Board.

85. The integration joint monitoring committee will be a joint committee of the local authority and the Health Board and will be accountable to both. Membership of the joint committee will be determined by the full council and the Health Board (some members appointed by the Health Board and others by the council), and the joint committee will report to the full council and the Health Board.

86. The role of the joint monitoring committee is to:

- Hold the lead agency to account for the agreed resources/budgets on behalf of the Health Board and the council (and doing that in a manner designed to ensure integrated provision of services in a person-centred way); and
- Report to the Health Board and council in relation to those matters using a robust reporting mechanism specified in the integration plan.

87. Under these arrangements, Health Boards and local authorities remain statutorily responsible for the delegated functions. Duties set out in legislation that apply to integrated

functions remain the responsibility of the relevant statutory partner, although the lead agency is accountable, through the integration joint monitoring committee, for the discharge of functions delegated to it by the delegating partner. To support these arrangements and ensure effective delivery and accountability for functions, the lead agency is conferred the same duties, rights and powers in relation to them as the Health Board and local authority would have. This includes the ability to enforce rights in connection with the carrying out of the functions as well as liability in respect of any liabilities incurred.

Integration joint boards and integration joint monitoring committees

88. Integration joint boards and integration joint monitoring committees will be established as the joint and equal responsibility of Health Boards and local authorities to oversee planning and delivery of integrated services. This arrangement is in contrast to the status of Community Health Partnerships, which were introduced through the NHS Reform (Scotland) Act 2004 as committees of Health Boards.

89. The joint and equal accountability of the integration authority (integration joint board, Health Board and/or local authority) is important because it establishes a mechanism to provide governance, oversee the individual's whole journey of care, through social care, primary and community health care, and secondary health care, and provides an oversight of use of the whole envelope of resource that supports service planning across that journey. In the eyes of the patient and service users, their experience of care is, as a whole, not neatly segmented into traditional planning mechanisms – so the structures established now need to reflect that. Integration joint boards and integration joint monitoring committees will be accountable and provide scrutiny of the integrated arrangements to the full council and Health Board.

90. The Bill repeals section 2 of the National Health Services Reform (Scotland) Act 2004, removing Community Health Partnerships from statute and establishing integrated arrangements under the requirements set out in the Bill.

Governance

91. To ensure that proper joint governance and assurance is put in place for the new integrated arrangements, the Health Board and local authority will be required to establish either a joint monitoring committee or joint board to oversee the partnership arrangements, dependent on the model of integration chosen. The integration joint monitoring committee will be established where partners choose the “delegation between partners” model, and a joint board will be established where partners choose the “delegation to a body corporate” model.

92. The integration joint monitoring committee's role is to scrutinise the operation of the lead agency arrangement and provide assurance to both the Health Board and the local authority that it is achieving the aims and objectives as set out in the integration plan, as well as delivering the national and any local outcomes expressed through the strategic plan. The integration joint monitoring committee will ensure that an appropriate governance arrangement is in place for the Health Board and local authority to discharge their statutory responsibility for health and social care provision respectively, whilst delegating the delivery of these services to another body.

93. The integration joint board will be accountable to the Health Board and the full council for the delivery of the delegated functions and the national and local outcomes expressed through

the strategic plan. The integration joint board will be a decision-making body and take responsibility for the delivery of outcomes, the discharge of the integrated budget, and the performance management of the partnership arrangements. The board will provide direction to the chief officer in the discharge of his or her duties, which will be to deliver the strategic plan using the integrated budget.

94. Whichever model of integration is used, similar requirements will apply with regard to membership of the integration joint boards and integration joint monitoring committee, which will be defined in secondary legislation. In terms of voting rights, the Scottish Government remains mindful of the significant statutory and budgetary responsibilities of the local authority and Health Board. Decision-making will only be effectively delegated to integration authorities if local authorities and Health Boards remain confident that all voting committee members are publically accountable for their decisions and there is parity in the number of Health Board and local authority representatives.

95. The regulations set out matters relating to voting members allowable on the integration joint boards and similar terms for integration joint committees. This will ensure that local democratic accountability is respected and that these governance arrangements do not become overly large and bureaucratic. Partners will have flexibility within these parameters to agree the numbers of members who will sit on the integration joint board and integration joint committee.

96. The Scottish Government recognises that for these governance arrangements to operate most effectively, integration joint boards and integration joint committees will need access to a range of advice from those who are partners in the delivery of services, and from those who support or receive it. The Scottish Government will require, through regulations, that integration joint boards and joint monitoring committees have representation from health and social care professionals representing the whole pathway of care, staff, the third sector, users, the public, and carers. This will ensure that the decision-making processes and scrutiny of the operational delivery are fully informed and take account of these perspectives.

97. The Health Board and the local authority remain statutorily responsible for discharging their responsibilities with regard to the provision of these services. However, in the integration joint board model, as in the lead agency model, to support these arrangements and ensure effective delivery and accountability for functions, the joint board is conferred the same duties, rights and powers in relation to them as the Health Board and local authority would have. This includes the ability to enforce rights in connection with the carrying out of the functions as well as liability in respect of any liabilities incurred.

Scope of delegated functions

98. The policy is to require integration of adult health and social care services and the Bill provides for the Scottish Ministers to establish by regulation the functions that must, may and may not be delegated. It is to be left to statutory partners to agree locally whether to include other services, such as children's or housing services, in the integrated arrangements. The Bill enables the Scottish Ministers, in the future, to extend the scope of services that must be integrated. Approval of the integration plan by the Scottish Ministers will ensure that, as a minimum, adult health and social care functions are included in the integrated arrangements.

99. Functions that can be delegated, and functions that cannot be delegated, are described via regulations and statutory guidance, to provide clarity and flexibility, and to keep pace with future service innovation. Budgets will follow delegated functions.

100. It is the Scottish Ministers' intention, via regulations, to replicate the current scope of mental health social work functions that cannot be delegated, and to prohibit delegation of nationally delegated and funded NHS functions (e.g. national breast cancer screening programme).

Integrated budgets and resourcing

101. The premise underpinning integration of budgets is that the allocation and utilisation of resources should recognise the interdependencies between health and social care services, and that the service imperative of integrating all aspects of care from prevention through to specialist treatment in improving care should be reflected in, and enabled by, integrated resources models.

102. The ability to look at overall expenditure for defined populations and user groups, and to use budgets flexibly, is a hallmark of integrated care. This is important, both to enable efficient allocation of resources and also to ensure that needs are met in the most appropriate and cost-effective way. The experience of integrated partnerships outside Scotland is that pooling resources has resulted in funds that are nominally allocated to one sector being used to increase investment in another, contributing to measurable changes in the location of care over a period of years, including reduced use of hospitals and care homes²⁵.

103. Alongside the introduction of this Bill, the Scottish Government continues its work on the Integrated Resource Framework²⁶ for health and social care, and continues to work with Information Services Division of NHS Scotland and COSLA, in order to develop a database to provide partners with this information at individual client/patient level on a routine basis.

104. The Scottish Ministers have committed to establishing a minimum scope for inclusion in the integrated budget. The minimum scope is not included on the face of the Bill, but will be defined via regulations and statutory guidance, through the scope of the delegated functions; the Bill itself takes the power to the Scottish Ministers to make such direction. The focus of the minimum scope will be to identify those areas of spend and activity where the greatest opportunity exists for service redesign in favour of preventative and anticipatory care. With respect to hospital services, the minimum scope will therefore target specialties that are predominantly for unplanned care.

105. The Bill permits two models of integration, as described previously. Financial arrangements for each model are as follows:

- In the “delegation to a body corporate” model of partnership, budgets for the delegated functions are delegated to the body corporate under the management of the chief officer; and

²⁵ Transforming the delivery of health and social care Kings fund 2012
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf

²⁶ Integrated Resources Framework <http://www.scotland.gov.uk/Publications/2012/07/4786>

- In the “delegation between partners” model of partnership, the budgets for the delegated functions are combined with the lead agency’s own resource to form the integrated budget for the population of interest. The lead agency hosts the integrated budget on behalf of both partners, under the management of the chief executive of the lead agency.

106. Whichever model is used, each integration authority will allocate operational budgets for service delivery from the integrated budget, in order to deliver the strategic plan. The integrated budget will be made up of the sum of operational budgets as follows: community health care; adult social care; and the budget for in-scope hospital services (i.e., the budget for appropriate aspects of hospital activity included in the integration authority arrangement. It is intended that the strategic plan will set out how the integrated budget will be allocated each year across the sectors to deliver the required improvements in outcomes. In this way, the strategic plan will effectively define the in-year operational budgets across the integration authority for community health care, adult social care, and the budget for in-scope hospital services.

107. The Scottish Government’s focus on people with multiple complex support needs, and, particularly, older people, reflects patterns of spend and activity across health and social care, which demonstrate that, in 2010/11, approximately two thirds of spending on health and social care support for people over 75 took place in institutional settings; 90% of occupied bed days for people aged over 75 was the result of unplanned admission to hospital; and 70% of all hospital expenditure on people aged over 75 was unplanned²⁷.

108. This demonstrates the importance of ensuring that health and social care services are effectively integrated, in order to put in place the context for planning and delivering support that focusses on anticipatory and preventative care. It also illustrates the scale of the challenge being addressed. Activity and spend on this care group – people with multiple complex support needs, many of whom are aged over 75 – is not a peripheral aspect of health and social care activity. It is a fast growing area of need that is rapidly dominating day-to-day pressures across the system. The Scottish Government’s consideration of the minimum scope of budgets for inclusion in the integrated budget must reflect that scale, as must the requirement on Health Boards and local authorities to delegate sufficient functions and budgets to the integration authorities to achieve the level of change that is required.

109. The status quo is not an option. The risks in current arrangements can be described as follows:

- In **policy** terms:
 - a. they do not fit with the resource models anticipated by the Christie Commission, which should bring together and deploy as flexibly as possible all resources devoted by partners to respective localities.
 - b. local clinicians, elected members, user and carer groups and other stakeholders will not engage in locality planning arrangements if budgets for unplanned hospital capacity, which make up the single largest component of resource spent on unscheduled care, are not included.

²⁷ 2010/11 IRF mapping. ISD.

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- In **clinical** terms, given pressures in terms of demand resulting from demographic change, existing unscheduled care pathways, which are biased to reactive care in institutional settings, are expanded. The risk here is that the transformational improvements possible through integration, and seen outside Scotland, will not be achieved, to the detriment of patient and service user outcomes. A likely consequence is that the system will increase capacity along current patterns of institutional care – i.e., a vicious cycle of spending more and more money on services that do not support people with multiple complex needs many of whom are frail older people, to best effect.
- In **financial** terms, they do not recognise the reality of the integrated nature of health and social care services, particularly for frail elderly people and those with complex needs. Unless it is recognised that all parts of this system have a direct bearing on the effectiveness of the others, it will not be possible to plan overall expenditure for defined populations and user groups, and to use budgets flexibly, resulting in inefficient use of resources and poor outcomes.

110. There are risks associated with any change and the arrangements described in the Bill, by requiring allocations to the integrated budget, will constrain Health Boards and local authorities in their ability to manage across the whole of their budgets, both in setting their budgets and in managing in-year variances, for example:

- In setting budgets, Health Board and local authority flexibility to allocate their resources across the full range of their budgets may be constrained by “ring-fencing” of their previous allocations to the integration authority (integration joint board, Health Board and/ or local authority). This risk will be proportional to the extent of the minimum scope of services to be included in the integrated budget.
- In managing variances on the budget for hospital services due to unforeseen cost pressures; the risk here is that the Health Board is left to manage the overspend whilst being unable to direct under-spends in community health budgets to offset these, a facility that is currently available to Health Boards.
- Both Health Boards and local authorities need to address adverse variances on their out-of-scope budgets. Here, the parent bodies are limited in their options for managing compensating in-year under-spends to those from within the out of scope budgets; under existing arrangements they have greater flexibility and are able to direct under-spends from the in-scope integration authority budgets as well.

111. These risks will be mitigated through the joint nature of governance of the integration authority and the provisions of the integration plan and strategic plan, whichever model is used, and through the direct accountabilities and responsibilities of the chief officer in the body corporate model. Statutory guidance will specify the content of the integration plan in order to put in place a framework that enables appropriate local management and mitigation of these risks.

Chief officer

112. In the integrated health and social care environment for which the Scottish Government is legislating, joint accountability at senior level is required, in simple terms, to achieve two objectives:

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- To provide a point of joint accountability upwards, from the integration joint board, via which there is accountability to the full council and Health Board; and
- To provide a single, senior point of joint and integrated management down through the delivery mechanisms in each partner organisation.

113. Where the “delegation to a body corporate” model is used, the Bill requires integration joint boards to appoint a senior, accountable officer, the chief officer, who will manage the integrated budget for health and social care, and deliver the outcomes specified in the integration plan through delivery of the strategic plan. The consultation paper on integration of health and social care referred to this post as the “Jointly Accountable Officer”. The chief officer will oversee carrying out of the functions of the integration joint board. The relationship with the chief executives is important to ensure that the proper consideration of areas of health and social care outwith the integrated arrangements are taken account of in the course of planning and delivering integrated services.

114. In the “delegation between partners” model, the first objective – accountability upwards, via the joint committee and thence to the full council and Health Board – is provided via the chief executive of the lead agency. Joint and integrated management of delivery is achieved via delegation from the chief executive to other staff in the lead agency.

115. The Scottish Ministers recognise the key importance of statutory roles as currently defined in legislation and have no intention of changing these. This should provide firm reassurance of the Scottish Government’s commitment to the role of the Chief Social Work Officer role, the Chief Financial Officer, the Director of Public Health, and other statutory roles, and to professional and clinical leadership in general. The Scottish Government is strongly of the view that the influence of high quality professional leaders in partnership arrangements is central to the effectiveness of the new arrangements. The Scottish Government is already working closely with professional leaders on this agenda, for example, in revising the Scottish Government guidance to strengthen the role of the Chief Social Work Officer, the development of clinical and care governance guidance, and the development of financial management guidance within the new integrated arrangements.

Health and social care workforce

116. Where the delegation to the body corporate model is used, it is the policy intention that the body corporate will not employ staff at this stage and that staff will continue to be employed by the Health Board and local authority. However, the Bill provides for the Scottish Ministers to enable the body corporate to employ staff, at a later stage, should they consider it necessary to deliver effective, quality, integrated services. Notwithstanding, it is understood that staff may transfer between partners, regardless of the model of integration used, to ensure service delivery mechanisms are aligned, and provision to permit this is included in the Bill.

Strategic commissioning of health and social care services

117. Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services, and working in partnership to put these in place.

Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget.

118. Audit Scotland was critical of commissioning skills in Scotland in its report, *Commissioning Social Care* (March 2012²⁸), and recommended that local authorities, along with Health Boards and other relevant partners, should develop commissioning strategies. Following that publication, the Public Audit Committee recommended that “it should be a requirement for each of the proposed partnerships to produce a long-term joint social care commissioning strategy”. Furthermore, the Finance Committee²⁹ recently invited the Scottish Government to respond to the findings that there were few examples of good joint planning, and a slowness to develop strategic commissioning.

119. The Scottish Government believes that it is through the strategic commissioning process that the required shift in the balance of care will be achieved. This is not a low-level or peripheral service planning activity. It is a central, and key aspect of these reforms, which will have a significant impact on future development of Single Outcome Agreements and local delivery plans.

120. The Bill establishes that integration authorities (integration joint board or Health Board and/or local authority in a lead agency arrangement) are required to produce a strategic plan (strategic commissioning plan), which sets out how they will plan and deliver services for their area over the medium term (3 years). Guidance will set out that strategic plans will also be expected to plan for the longer term (10 years). Further, the role of clinicians and care professionals, along with the full involvement of the third and independent sectors, service users and carers, will be embedded as a mandatory feature of the commissioning and planning process. This will strengthen the cross-sector arrangements that have been established during the first two years of the Change Fund³⁰.

121. As part of the strategic commissioning process, the Bill will require integration authorities to:

- Embed patients/clients and their carers in the decision-making process;
- Treat the third and independent sectors as key partners; and
- Involve GPs, other clinicians and social care professionals in all stages of the planning work, from the initial stages to the final draft.

Good strategic plans should also:

- Identify the total resources available across health and social care for each client group and relate this information to the needs of local populations;
- Agree desired outcomes and link investment to them;
- Assure sound clinical and care governance is embedded;

²⁸ Audit Scotland: Commissioning Social Care report

http://www.audit-scotland.gov.uk/docs/health/2012/nr_120301_social_care.pdf

²⁹ Demographic change and an ageing population

<http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/59613.aspx>

³⁰ Change Fund Plans <http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/change-fund-plans/>

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- Use a coherent approach to selecting and prioritising investment and disinvestment decisions; and
- Reflect closely the needs and plans articulated at the locality level.

122. The Bill establishes the framework for preparation of, and consultation on, the strategic plan, with a duty on integration joint boards, Health Boards and local authorities to have regard to statutory guidance.

Locality planning

123. Different kinds of planning for health and social care services respond to different kinds of need, from individual care plans, for example, to specialist national services delivered from a single site. In general terms, service planning is at its best when it focusses on the needs of its target population and the outcomes it will deliver for individuals.

124. Some aspects of service planning, particularly in relation to the provision of preventative and anticipatory care, can, the Scottish Government believes, operate with greater effectiveness and efficiency at a more local level than the integration authority itself - at the level, instead, of local communities, which may be identified by their distinct geographic, cultural or demographic features. This is entirely consistent with a renewed emphasis on integration at the local level in line with the Christie Report.³¹

125. This kind of planning, which is described as “locality planning” in the consultation, should be led by and actively involve professionals, including GPs, acute clinicians, social workers, nurses, allied health professionals, pharmacists and others. The evidence is clear that the active involvement of such professionals will be key to success. The Bill requires a co-production approach to planning activities and this must also include carers and users of health and social care services. Local professionals are well-placed to contribute to, and lead, locality planning arrangements that to a large extent shape the development of the strategic plan by the integration joint board, Health Board and local authority (depending on which model is used). In order to achieve maximum benefit for patients and service users, locality planning also needs to ensure the direct involvement of local elected members, representatives of the third and independent sectors, and carers’ and patients’ representatives.

126. The Bill does not prescribe a model, or models, of locality planning, because it is believed that, by definition, arrangements that work best locally are developed and agreed upon locally. A range of examples of this type of planning can be seen in both health and social care services across Scotland. They are typified by professional teams, along with representatives of the various groups described above, working together to better understand the requirements and desired outcomes of particular local care groups (groups of people with similar health and social care needs), and to decide and put into effect changes to improve the delivery of those outcomes.

127. In order for locality planning to have real traction on strategic commissioning, integration authorities will need to ensure that professionals have time to participate in the process and are transparent and effective mechanisms for effecting change. They will also need to ensure that

³¹ Commission on the Future Delivery of Public Services
<http://www.scotland.gov.uk/About/Review/publicservicescommission>

localities can genuinely influence how resources are allocated within their communities, within a broadly equitable share of integrated resources, rather than on the basis of historic patterns of resource allocation and service provision.

128. As the Bill does not prescribe mechanisms for locality planning, the modalities are left to local agreement but there is a clear requirement to ensure a pivotal role for locality planning arrangements with respect to strategic commissioning.

129. As locality planning arrangements mature and develop, the Scottish Government would expect, for example, to see integration authorities choosing to delegate to localities decisions on a material proportion of the integrated budget, and ensure that local communities benefit from any shift in service provision towards preventative and anticipatory care that they achieve.

130. The Bill places a duty upon integration authorities to work with local professionals, across extended multi-disciplinary health and social care teams, and the third and independent sectors, to determine how best to put in place local arrangements for planning service provision and on the operation of their locality function. Integration authorities will be required to put in place, and to subsequently support, review and maintain, such arrangements. Integration authorities will be required to develop their strategic plans on the basis of their respective locality plans.

Scrutiny

131. Healthcare Improvement Scotland (HIS) and Social Care Social Work Improvement Scotland (SCSWIS) (commonly known as the Care Inspectorate) are to have a joint scrutiny role of integration authorities. The scrutiny bodies will retain their current functions in relation to health services and social services respectively.

132. In the “delegation to a body corporate” model, joint inspections will scrutinise the integration joint board and the services provided under their direction.

133. In the “delegation between partners” model, joint inspections will scrutinise the lead agency and the services which it provides on behalf of the delegating partner, as well as the services of the lead agency as part of the integrated arrangements.

134. The scrutiny bodies will be required to scrutinise strategic plans for quality and standards, and to ensure the plan will effectively achieve the objectives of the integration plan and the nationally agreed outcomes.

Part 2 – Shared services

135. The National Health Service (Scotland) Act 1978, enables the Common Services Agency (commonly known as NHS National Services Scotland (NSS)) to provide goods and services to NHS bodies in Scotland, as well as a limited range of goods and services to other public bodies, and then only to a limited range of public bodies.

136. A review by the Scottish Government identified that expansion of the remit of the Common Services Agency offered the potential to improve efficiency and productivity across

the public sector by making available to other public bodies the Common Services Agency's expertise in the delivery of competitive based shared services.

137. In particular, the following services currently delivered by the Common Services Agency to NHS Scotland have been identified as having the potential to be shared with the wider public sector:

- Legal services – The Central Legal Office (CLO) have expertise in delivering legal services in a public sector environment covering litigation, employment, commercial contracts and property;
- Counter fraud services – The Counter Fraud Services currently protects NHS Scotland from fraud, using a centrally-based, professionally accredited team of specialists, dedicated to counter fraud work;
- Procurement – National Procurement (NP) has a well-established capability that services the whole of NHS Scotland with approximately £1.1 billion of NHS expenditure managed under NSS contracts; and
- IT services – National Information Systems Group (NISG) is currently the single point of support to NHS IT systems and is already engaged in cross-sector initiatives which are at the forefront of the realisation of the McClelland recommendations.
- Information – The Information Services Division (ISD) provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and social care, and facilitates robust planning and decision-making.

138. The delivery of the Common Services Agency shared services and goods across the wider public sector will not be mandatory and it will remain a matter for these bodies themselves to determine the benefits of engaging with the Common Services Agency.

CNORIS indemnity scheme

139. The National Health Service (Scotland) Act 1978, provides for the creation of an indemnity scheme for bodies list in section 85B of the Act and is operated by NHS Scotland. The resulting regulations provide for the scheme to meet:

- Expenses arising from any loss or damage to their property; and
- Liabilities to third parties for loss, damage or injury arising from carrying out of the functions of such members.

140. Currently regulations limit the members of the scheme to all NHS bodies and the Mental Welfare Commission for Scotland and also define the scope of the functions covered by the scheme. Under these arrangements, local authorities are not permitted to participate in the scheme nor are social work functions permitted to be covered.

141. The Bill amends the 1978 Act to extend the range of bodies that can participate in the scheme to include local authorities and integration joint boards. It will be a matter for each local authority and integration joint board as to whether to participate in the CNORIS scheme.

142. Given that the premise of the Bill is that health functions are able to be delegated to local authorities, in the case of delegation between partners, and where there is agreement to do so or delegation to the integration joint board, the Scottish Ministers consider it appropriate to extend the CNORIS indemnity scheme to local authorities and integration joint boards.

143. The Bill amends the 1978 Act to extend the range of bodies that can participate in the scheme to include local authorities and integration joint boards and to extend the scope of functions that can be covered by the scheme to include local authority functions.

Part 3 - Health service: functions

Joint ventures structures

144. To facilitate opportunities brought about by integration and in order to ensure the most effective use of resources, the Scottish Government wants to broaden the opportunities to allow Health Boards to form joint venture structures. There are two issues that need to be addressed: the ability of Health Boards to form companies under the National Health Service (Scotland) Act 1978; and the ability of a Health Board to exercise its functions outwith its own Health Board area.

Ability of Health Boards to form companies

145. Currently there are a number of opportunities available to local authorities which are not available to Health Boards, with regard to management and disposal of surplus assets. Under the National Health Service (Scotland) Act 1978, Health Boards are only able to form joint ventures as company structures as defined in the Companies Act 1985.

146. To support Health Boards to collaborate effectively with local authorities and to benefit from the efficiency that a joint approach to asset management and disposal would generate for Health Boards, the Scottish Government wants Health Boards to be able to form corporate structures other than companies for joint ventures purposes, such as for the management and disposal of property and assets.

147. The Bill gives the Scottish Ministers the power to form, to participate in forming, and to participate in other “corporate structures”, in addition to their ability to form and participate in forming companies. The Bill also gives the Scottish Ministers the power to invest, provide guarantees and make other kinds of financial provisions to other corporate structures as well as companies. These powers of the Scottish Ministers will be delegated to Health Boards in accordance with the National Health Service (Scotland) Act 1978.

Ability of a Health Board to exercise its functions outwith its own Health Board area

148. The “Hub Initiative” is a programme led by the Scottish Futures Trust³², which works collaboratively with local authorities and Health Boards across Scotland (as well as many public sector bodies) to deliver value-for-money on public sector infrastructure. The initiative provides an opportunity to improve the planning, procurement and delivery of community based infrastructure in support of local services through the creation of a joint venture company between the public and private sectors. The Scottish Futures Trust³² is an arms-length company

³² Scottish Futures Trust <http://www.scottishfuturestrust.org.uk/>

wholly owned by the Scottish Ministers (and accountable through the Board of Non-Executive Directors).

149. As the Hub Initiative has been developed and a pipeline of projects identified, it has become clear that in order to attract revenue finance (from lenders such as banks) there requires to be a critical mass of capital investment in order to deliver value for money. One key method of creating such a critical mass is to aggregate or “bundle” a number of projects together either within a single Health Board Area or across the broader hub territory (which can incorporate a number of Health Board areas).

150. In the former scenario, there are no legal issues. In the latter scenario, where there are a number of Health Boards involved, currently powers do not allow one Health Board to procure facilities on behalf of another Health Board. This therefore requires multiple project agreements and special purpose vehicles.

151. For example, several Health Boards who are members of the hub North Territory are proposing to enter into a design, build, finance and maintain (DBFM) contract with a special purpose vehicle formed for this purpose by their hubco. Under this contract, each Health Board will be provided with individual facilities. Bundling the various facilities into one DBFM contract will maximise financial efficiency through economies of scale and avoid the additional costs of setting up and running Special Purpose Vehicles for each facility and will also facilitate funding by aggregating the otherwise individual borrowing requirements.

152. The simplest and most cost efficient way to achieve this contractually is for one Health Board to act as a lead in the project and enter into a contract for the building of such facilities across the whole area (i.e. including the areas outwith its own boundaries), with “back to back” contracts between that Health Board and the other Health Boards.

153. A Health Board would therefore be attempting to enter into a contract for the provision of facilities that it will not use itself (i.e. the facilities in the other Health Board areas). Health Boards, at the moment, do not have the power to enter contracts for facilities on behalf of other Health Board.

154. A similar problem arises in relation to a Health Board’s ability to enter into externally financed development agreements (which would be relevant in undertaking a “bundle” of projects which are spread across a number of Health Board areas). Currently Health Boards do not have the ability to exercise this power on behalf of other Health Boards, which they would need if they were to enter into contracts as described above.

155. The Bill therefore seeks to allow Health Boards to be able to contract on behalf of other Health Boards for contracts which involve providing facilities, for example a DBFM contract.

156. The Bill therefore also allows Health Boards to be able to enter into externally financed development agreements in relation to the provision of facilities for other Health Boards.

ALTERNATIVE APPROACHES

157. As the Scottish Government developed these proposals, considered the evidence³³ regarding improving outcomes for people using health and social care services, and consulted partner organisations and stakeholders on priorities for integration, the conclusion was reached that reform based on centrally-directed structural change would be unlikely to deliver the shift in outcomes required. Available evidence suggests particularly that structural change per se is not a pre-requisite for achieving better outcomes, though it can be helpful where local leadership for change is strong and consistent.

158. A number of apparently straightforward mechanisms to bring health and social care together were apparent from the start of policy consideration of this commitment. Social care might be moved from local authority control to NHS control; part of community health provision could be moved from NHS control to local authority control; a new, “third provider” of health and social care could be established; or health and social care could be placed in the control of Community Planning Partnerships. The Scottish Ministers rejected each of these for the following reasons:

- The first option – moving social care from local authority control to the NHS – would have involved considerable upheaval and costs in terms of moving staff between employers, and would also have presented a serious distraction to the need to focus more effectively on improving outcomes and people’s experience of care. In order to work – and address the barriers within health, as well as between health and social care – the outcome would have to be a completely new national health and care service, not “just” an NHS with additional responsibility for social care.
- The second option – moving community health provision to the control of local authorities – would have failed to address the key issue of improving the degree of integrated working between primary and secondary care. This option would also have carried with it the costs, in terms of money and time, of centrally-directed staff transfer noted above.
- The third option – establishing a new “third provider” of health and social care – is a variation on the first, in which social care, along with all of health provision, is transferred to the control of a new body, and the same potential pitfalls would apply.
- The fourth option – placing delivery of health and social care in the hands of Community Planning Partnerships – was rejected because Community Planning Partnerships are not delivery constructs. Instead, they provide an environment for a range of statutory partners in an area to come together to make sure that their individual planning activities add up to an effective whole in terms of local service design and provision..

159. Available evidence drew out the importance of certain aspects of high-functioning integrated arrangements elsewhere in the UK and further afield:

- Planning in terms of population needs, rather than in terms of historic structures (planning across health and social care for older people, for example, or for children

³³ Integrating Health and Social Care in Torbay <http://www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay>

with complex needs, rather than developing separate “health” and “social care” plans).

- Integrating resources across health and social care to support population-based planning and eliminate the risk of cost-shunting between agencies.
- Assuring a strong role for local professionals and clinicians in the processes of planning for local populations.
- Strong local leadership and shared accountability for delivery.

160. Having rejected the structurally-led models described above, Ministers chose to take forward proposals for legislation that enshrine these key features of effective integration in practical local arrangements. Health Boards and local authorities will be required to plan together for the delivery of services that address the needs of the local population, focussing in particular on preventative and anticipatory care, using their combined resources to best effect, and ensuring a key role for local professionals and leadership in planning.

161. The Scottish Ministers looked at whether Community Planning Partnerships (CPPs) could deliver integrated health and social care. However, CPPs are not delivery constructs; they provide an environment for a range of statutory partners in an area to come together to make sure that their individual planning activities add up to an effective whole in terms of local service design and provision. Partnership arrangements under the Bill, on the other hand, have been designed to bring together resources, planning and delivery of adult health and social care. Integration authorities will be expected to play a strong and effective role in community planning.

162. In terms of existing legislation, the provisions under the Community Care and Health (Scotland) Act 2002 provide one mechanism for integrating NHS and local authority functions: delegation of functions and resources between partners. This is the model that was used by the Highland partnership to integrate health and social care for adults and children in 2012, and it remains available to Health Boards and local authorities under the provisions of this Bill.

163. When considering how best to give effect to how to integrate health and social care, and taking into account extensive discussions with partner organisations and stakeholders, the Scottish Ministers concluded that another model should also be developed, building upon arrangements for joint working already seen in some areas (such as West Lothian), which would permit Health Boards and local authorities to put arrangements in place that are best suited to local need and experience. This model is described in the Bill as delegation to a body corporate.

164. It was considered necessary to improve the model of integration provided by the Community Care and Health (Scotland) Act 2002 (delegation between partners) because it has not successfully delivered the consistent approach to integrated working that is required. This Bill improves that model of integration by putting strategic planning for person-centred, preventative care, with strong local and professional leadership, at its heart. The Bill also changes the context for local use of this model by requiring all Health Boards and local authorities to engage in integrated working, using either this approach or the body corporate model.

165. The policy intention is to integrate planning and delivery of health and social care functions. The Bill permits delegation of a broader range of local authority functions to the integration authority, although powers are taken to the Scottish Ministers to define in regulations which functions must, may and may not be delegated by either a local authority or Health Board. It is the Scottish Ministers' intention to use these powers to describe what is meant by the broad term "social care", which extends beyond social work functions to include, for example, some aspects of housing provision by local authorities. The Scottish Ministers have concluded that, for the purposes of integrating health and social care, it is more appropriate to describe what is meant by social care functions in regulations, rather than in primary legislation, as this will allow for greater flexibility in future as innovative patterns of service provision, which the Scottish Government anticipates will blur traditional lines between "health" and "social care" support, are developed.

EFFECTS ON EQUAL OPPORTUNITIES

166. An Equality Impact Assessment (EQIA) has been carried out and a summary of the results will be published on the Scottish Government website. The Scottish Government considered the potential impacts, both positive and negative, across the protected characteristics required for EQIAs.

167. To help increase the Scottish Government's understanding of all equality groups, it set up an Equalities Reference Group (ERG). The group met for the first time in October 2012 and has provided valuable input to the impact assessment process. Membership is made up of a variety of representatives with an interest in equalities, including Age Scotland, Carers Network, Stonewall and Health and Social Care Alliance.

168. The EQIA concluded that the legislation will not directly or indirectly discriminate on the basis of age, disability, gender, gender reassignment, pregnancy and maternity, sexual orientation, race and religion or belief.

169. The EQIA has informed the Bill process, including plans for the implementation of the policy. For example, the consultation proposed that legislation should apply to adult health and social care services, with a particular focus, at first, on improving outcomes for older people. Respondents to the consultation clearly and consistently stated that it would not be a good idea to restrict integration to older people defined by age. While acknowledging that there is a strong correlation between long term conditions and age, respondents felt that it would be better to think in terms of people's wellbeing and state of health, and the complexity of their needs, rather than in terms of chronological age itself. The Bill and policy will therefore focus on improving outcomes for people with complex needs, for their wellbeing, and also to ensure that the whole health and social care system works effectively for everyone who needs support, whatever their age or circumstances.

170. To ensure that there will be continual assessment of equalities in communities, statutory partners via the partnership arrangements in the Bill will be responsible for developing an EQIA and for monitoring and evaluating implementation of the policy within their local area. Integration authorities will be expected to take account of the findings from the Scottish Government's EQIA and on-going advice from the Equality Reference Group.

EFFECTS ON HUMAN RIGHTS

171. The Bill does not give rise to any issues under the European Convention on Human Rights. In fact, it is arguable that the Bill goes further in enhancing the relevant rights of individuals by providing mechanisms that will provide a level of consistent care for the population of Scotland, so that people do not experience variation in quality of service provision. One of the principles of these proposals is putting the individual at the centre of health and social care service planning, ensuring a patient and service user centred approach, which means that the Bill will provide the mechanisms to ensure that individuals receive the care they need and that the individual encounters a seamless and joined up experience of the care pathway.

EFFECTS ON ISLAND COMMUNITIES

172. The Bill applies to all local authority areas and Health Boards and therefore to all communities across Scotland, including island communities. Island communities may experience a more concentrated need for services for older people and may also experience difficulty in recruiting and retention of health and social care practitioners. However, it is hoped that the opportunities afforded through the partnership arrangements will result in a more planned, joined up and flexible service provision to island populations, which will contribute to alleviating these difficulties.

EFFECTS ON LOCAL GOVERNMENT

173. The Bill directly impacts on local authorities in discharging their duties under social care legislation. The effect is already set out in this policy memorandum and in the other accompanying documents to the Bill. The principles of the Bill establish the approach which local government is required to take in carrying out its integrated functions. The Bill establishes equality of responsibility and accountability of service planning and delivery between the local authority and Health Boards, whilst leaving the statutory responsibility for social care with local authorities. To deliver the duties in the Bill, local government is required to better understand the needs of its constituent population and the associated spend, including the associated outcomes.

174. The Bill does not remove existing duties and requirements of local government in respect of the assessment and charging for some social care services.

EFFECTS ON SUSTAINABLE DEVELOPMENT

175. The Bill will have no negative impact on sustainable development and will have a strong positive effect on the health and wellbeing of the population of Scotland by helping to make health and social care services more responsive to individual needs.

176. The environmental impact of the Bill has been considered and it is likely to have a minimal effect in relation to the environment and, as such, is exempt for the purposes of section 7 of the Environmental Assessment (Scotland) Act 2005.

This document relates to Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

PUBLIC BODIES (JOINT WORKING) SCOTLAND BILL

POLICY MEMORANDUM

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