Health and Sport Committee

11th Report, 2013 (Session 4)

Stage 1 Report on the Public Bodies (Joint Working) (Scotland) Bill

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Health and Sport Committee

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Health and Sport Committee

Remit and membership

Remit:

To consider and report on health policy, the NHS in Scotland, anti poverty measures, equalities, sport and other matters falling within the responsibility of the Cabinet Secretary for Health, Wellbeing and Cities Strategy apart from those covered by the remit of the Economy, Energy and Tourism Committee.

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Health and Sport Committee

11th Report, 2013 (Session 4)

Stage 1 Report on the Public Bodies (Joint Working) (Scotland) Bill

The Committee reports to the Parliament as follows—

INTRODUCTION

1. The Public Bodies (Joint Working) (Scotland) Bill\(^1\) was introduced in the Parliament on 28 May 2013, by Alex Neil, Cabinet Secretary for Health and Well-being. The Health and Sport Committee was designated as the lead Committee by the Parliamentary Bureau. The lead committee is required, under Rule 9.4.1 of the Parliament’s Standing Orders, to report to the Parliament on the general principles of the Bill.

2. Following the Bill’s introduction, the Committee issued a call for evidence. A total of 81 submissions was received. A further six submissions were received following the closing date.

3. The Committee took oral evidence on the Bill at its meetings on 3, 10, 17 and 24 September and 1 October 2013. The Committee thanks those organisations and individuals who submitted written evidence and those who gave oral evidence and participated in round-table sessions at Committee meetings.

4. Two visits were also undertaken by Committee members. On 23 September 2013, members of the Committee visited projects in Inverness, as guests of Highland Council and NHS Highland. On 30 September 2013, members visited West Lothian Council and the Lothian Centre for Independent Living. The Committee thanks these bodies for their helpful input into the scrutiny process.

5. The Committee also received reports on the Bill from the Finance Committee, the Local Government and Regeneration Committee, and the Delegated Powers and Law Reform Committee. The reports from these committees are considered later in the report.

\(^1\) Public Bodies (Joint Working) (Scotland) Bill, as introduced (SP Bill 32, Session 4 (2013)). Available at: http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Bill/b32s4-introd.pdf
BACKGROUND

6. There is no single definition of ‘integration’ or ‘integrated care’. The Bill’s policy memorandum states that what is meant by integration is that “services should be planned and delivered seamlessly from the perspective of the patient, service user or carer, and that systems for managing such services should actively support such seamlessness”.

7. Commonly in Scotland, the terms are used to refer to the joined-up delivery of NHS and social care services. Integration may be vertical, between the different levels of the NHS, or horizontal, between different statutory and non-statutory services. The quest for integrated care is replicated internationally and is a burgeoning discipline within health research.

8. Recent impetus behind integration policy in Scotland has come both as a result of various pieces of work (for example the Christie Commission) that have considered the impact of demographic change, the forecast increased demand for health and social care over the coming decades, and declining levels of public expenditure. It is also an attempt to solve other problems (considered in more detail below) that people experience on their care pathway.

9. Greater integration of health and social care is not a new concept to Scotland and there have been many attempts to achieve greater integration dating back to the 1970s. Previous structures which attempted to achieve greater integration included Local Healthcare Co-operatives (LHCCs) and Community Health Partnerships (CHPs).

10. LHCCs were part of Primary Care Trusts (PCTs) and were organised around groups of GP practices in distinct geographical areas. They were not underpinned by legislation, but they were intended to bring health and social care providers together to deliver services.

11. CHPs were created under the National Health Service Reform (Scotland) Act 2004 and replaced LHCCs. They were established as committees of the health boards and were intended to bridge the gap between primary and secondary healthcare, and between health and social care. The current Bill, if passed, will remove CHPs from statute.

12. Despite such initiatives, however, there have been persistent concerns that joint working between partners has not been as effective as it could have been, or that it has at least been patchy across the country.

13. The Policy Memorandum notes that while there has been “very significant progress” in improving pathways of care in recent years, 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. One of these disconnects is found within the NHS, between primary care (GPs, community

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2 Public Bodies (Joint Working) (Scotland) Bill. Policy Memorandum (SP Bill 32-PM, Session 4 (2013)), paragraph 6. Available at: http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Bill/b32s4-introd-pm.pdf
nurses, the allied health professionals etc.) and secondary care (hospitals). The other is found between health, delivered by the NHS, and social care, delivered by local authorities.

14. The Policy Memorandum goes on to note that these disconnects make it difficult to address people’s needs holistically, and to ensure that resources follow the needs of patients, service users and carers. Moreover, it says, 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.

15. These problems are summarised by the Policy Memorandum, from the perspective of people who use the system (patients, service users, carers and families) as:

- inconsistency in the quality of care for people, and the support provided to carers, particularly in terms of older people’s services;
- people too often being unnecessarily delayed in hospital when they are clinically ready for discharge, and
- services required to enable people to stay safely at home not always being available quickly enough, sometimes leading to avoidable and undesirable admissions to hospital.

16. The Policy Memorandum also notes that, in terms of older people’s services, almost a third of total annual spend is on unplanned admissions to hospital and more is spent annually on unplanned admissions than on social care. Finally, even allowing for the possibility that people may live longer and in better health in future, and taking into account the current emphasis on improving anticipatory and preventative care, Scotland will in future experience an overall increase in the number of people who require care. The resources required to provide support will, therefore, rise in the years ahead.

17. The Scottish Government has concluded, according to the Policy Memorandum, that despite “a good track record of partnership working” Scotland’s health and social care still incorporates “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, the Policy Memorandum therefore argues, is needed 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”.

18. The Bill is intended 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”.

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STRUCTURE AND MAIN PROVISIONS OF THE BILL

19. The Bill is made up of four parts. Part 1 is the largest part, with 43 sections, and contains the main provisions intended to establish the integration of adult care and health services.

20. Part 2 contains provisions to enable the functions of National Services Scotland (also known as the Common Services Agency) to be extended to other public bodies.

21. Part 3 is intended to enable health boards to form a wider range of corporate structures and to exercise functions outside their own board area.

22. Part 4 contains general provisions relating to interpretation, subordinate legislation, ancillary provision, repeals, commencement and the short title.

Main policy provisions in the Bill

23. The Policy Memorandum sets out a summary of the policy provisions contained in the Bill. According to the Memorandum, the Bill:

- Provides for the Scottish Ministers to specify national outcomes for health and wellbeing, which health boards and local authorities will be accountable to the Scottish Ministers and to the public for delivering

- Sets out principles for the planning and delivery of integrated functions

- Establishes integration joint boards and integration joint monitoring committees for the governance and oversight of health and social care services and removes community health partnerships from statute

- Requires health boards and local authorities to prepare jointly an integration plan (using one of two possible models) to delegate functions and appropriate resources to ensure effective delivery of those functions

- Requires integration joint boards to appoint a chief officer, jointly accountable through the board to the constituent health board and local authorities, and responsible for management of the integrated budget, delivery of services for the plan area and 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, setting out arrangements for delivery of integration functions, involving a range of partners in the development of the plan and consulting 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.

- Provides for health boards to be able to contract on behalf of other health boards for contracts which involve providing facilities, and powers for
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Scottish Ministers to form a wider range of joint ventures structures to collaborate 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 (to include local authorities and integration joint boards) able to participate in the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) scheme\(^3\) for meeting losses and liabilities of certain health service bodies.

OVERALL VIEWS ON THE BILL: THEMES FROM THE WRITTEN EVIDENCE

24. The written evidence received by the Committee was broadly supportive of the policy intentions behind the Bill. The Committee’s call for evidence had invited respondents to indicate whether they agreed with the general principles of the Bill and its provisions. The SPICe summary of evidence\(^4\) reports that few respondents answered with an outright yes/no and 15 respondents either did not answer or did not express a clear opinion. However, 64 of the 65 that did address the question responded positively and expressed general support for the Bill and its policy objectives. Only one submission (from the Chartered Institute for Public Finance and Accounting) clearly did not support the Bill on the grounds that it felt the case for legislation had not been made.

25. Although most respondents were positive about the Bill and supported its policy intentions, some had concerns about its implementation or some of its provisions.

26. The Committee’s call for evidence had also invited respondents to comment on the extent to which they believed that the Bill would achieve its policy objectives. The SPICe analysis has categorised the responses in terms of those who thought the Bill would achieve its objectives, those who thought it might achieve its objectives, and those who thought it would not achieve its objectives.

27. By far the largest proportion of respondents felt that the Bill might achieve its objectives, with just a handful of responses unequivocally of the opinion that the Bill either would or would not work.

28. Of those who thought the Bill might achieve its objectives, the main reasons given for this were—

- integration requires more than just structural change, cultural change is also required

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\(^3\) 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 has the potential to help so long as certain other things happen (e.g., effective local leadership, effective strategic commissioning, greater focus on co-production and stakeholder involvement).

- it will depend on the detail of implementation, much of which will be within regulations and guidance.

- it has the potential to help but there are concerns about specific aspects of the Bill (e.g., may make services and structures more complex, may increase fragmentation, will not address integration within the NHS).

29. The themes of general broad support for the policy intentions behind the Bill, coupled with reservations about different aspects of its implementation, also ran broadly through the oral evidence taken by the Committee. These themes are explored in more detail in subsequent sections of the report.

COMMITTEE’S EVIDENCE AND ANALYSIS

Need for the bill: high-level issues and general comments

30. Almost all written and oral evidence received by the Committee supported the intentions of the Bill, but a number of concerns were consistently raised about the extent to which the provisions in the Bill would enable the overall policy objectives to be achieved.

31. The Scottish Independent Advocacy Alliance argued that the Bill and its policy intentions were “not clearly aligned”. It argued that the Bill “appears to concentrate on structural and financial aspects of integrating the NHS and [local authorities] and does not give enough regard to the cultural shift that is required.”

32. Glasgow City Council suggested that a key issue in the patient/service user overall experience was the “disconnect between acute and primary care within the NHS in relation to the patient experience and their outcomes” which was “in addition to the disconnect between health and local authorities which the Bill provides for”. The council’s submission went on to argue that the Bill failed to address the first disconnect and it was therefore “difficult to see how addressing only one of the key disconnects identified as having a negative impact on the patient/service user experience is likely to achieve the policy objectives”.

33. COSLA’s submission expressed its broad support for a public service reform agenda that develops outcomes-based approaches, uses resources flexibly, promotes co-production, early intervention and prevention, facilitates service integration and enhances local democratic scrutiny. It concluded that “the overall thrust of the Scottish Government proposals on health and social care integration would align with many of these general principles”. COSLA went on to argue, however, that the proposals were too prescriptive and too detailed, and

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5 Scottish Independent Advocacy Alliance. Written submission, paragraph 3.
6 Glasgow City Council. Written submission.
7 COSLA. Written submission. COSLA’s submission has not been counted in the analysis of responses because it was received too late.
8 COSLA. Written submission, paragraph 8.
suggested that there should be more flexibility at a local level to determine the shape and governance of the proposed partnership arrangements. The issues of the tensions between local democracy and ministerial direction from the centre is considered in more detail later in the report.

34. A number of submissions, for example the one from the Coalition of Care and Support Providers in Scotland (CCPS), suggested that integration should be seen as a means to an end, not an end in itself. Professor Alison Petch went further, saying—

“We must focus on the individual and think about all aspects of their life. People need housing, which is a critical element that tends to be forgotten, and they need training, health support and social care support. If we start by thinking about the individual and all the bits around them, some of the boundaries fall away. I know that the word “holistic” is much misused, but the approach must really consider what is necessary to deliver what people need.”

35. Many witnesses pointed out that while the proposed legislation would assist the process of integration, it would not, in itself, make it happen. Andrew Eccles of Glasgow School of Social Work, told the Committee that the bill would not guarantee integration, saying that it would be “folly to imagine that”. He noted that “more subtle and complex engagement with some of the issues” was required. He did, however, accept that legislation was required, stating that the Bill “puts down a marker”, and that it was “important that the issue is not off the agenda.”

36. More detailed reasons why the bill is needed were provided to the Committee by Peter Gabbitas of the City of Edinburgh Council. Firstly, he explained that the current legislation governing establishment of committees by local authorities (the Local Government (Scotland) Act 1973) requires that any committee formed by a council has to have elected members as at least two thirds of its membership. Secondly, there were “issues to do with assets and different accounting regimes”, and “issues with the budgets” both of which will be addressed by regulations. The bill, he concluded, was therefore required for a number of reasons, but he suggested that the biggest one was to do with community health partnerships, which, under the legislation that established them, were responsible for commissioning and influencing acute services but had not been established “in a way that allowed them to do that effectively.”

37. Professor Alison Petch reminded the Committee of the need “to be clear about what we mean by [outcomes] and whether we are talking about outcomes for the individual or for communities, or of a particular policy.” She argued that alongside the proposed national health and social care integration outcomes” – which she thought were “pretty much going in the right direction with their

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9 COSLA. Written submission, paragraph 8.
10 Coalition of Care and Support Providers in Scotland. Written submission.
emphasis on the individual – “there are organisational outcomes such as the health improvement, efficiency, access and treatment, or HEAT, targets and single outcome agreements, along with “the most important outcomes of all—the outcomes for the individual”15.

38. The MS society’s written submission argued that the Bill was in danger of focusing too heavily on structural change and how to achieve it at “the expense of the primary focus on improving outcomes for people”16. Delivering coordinated and effective care, it went on to argue, “requires more than structural change and integrated budgets” noting that “strong leadership and a radical change in culture will be key to improving services”.

39. The themes of the need for strong leadership and cultural change were echoed in many of the other submissions and in the oral evidence. Andrew Eccles said in oral evidence that the key issue would be one of working cultures. It would be about spending time and effort getting people to understand where each other was “coming from” and “developing trust, which is key”17. That, he said, would “be more important than organisational or procedural shifts”18.

40. Professor Alison Petch, noting that there were “some very good examples of the traditional barriers melting away when teams work together at the front line” cautioned that “the large amount of ignorance among different professional groups about what their future partners do” was not to be underestimated. She went on to argue that while increasing people’s knowledge and understanding would “address some of that”, there was also a challenge because, “in times of uncertainty and change, people tend to scuttle back to their tribes”. She said there was a “need to ensure that people look in the other direction and see that, through working together, they will better support the people whom all this is for.”19

41. The Local Government and Regeneration Committee (LGRC) held a joint evidence session with the Cabinet Secretary for Health and Well-being and the Minister for Children and Young People. The Committee’s report20 notes that “both the Cabinet Secretary and the Minster in evidence stated similar aims for their bills, principally “improving outcomes for the service user” while recognising that the approach taken differed”. The Bills, the LGRC was told, “complement one another”21 and “will streamline structures and make it easier to see the focus for partnership working”22.

16 MS Society. Written submission.
20 Scottish Parliament Local Government and Regeneration Committee. Committee Memorandum on the Children and Young People (Scotland) Bill and the Public Bodies (Joint Working) (Scotland) Bill. Available at: http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/LGR_Committee_memorandum_on_SP_Bill_27_and_SP_Bill_32.pdf [Accessed 28 October 2013]
21 Local Government and Regeneration Committee, Official Report, 4 Sept 2013, Col 2526.
22 Local Government and Regeneration Committee, Official Report, 4 Sept 2013, Col 2526.
42. This Committee also questioned the Cabinet Secretary on the need for the Bill. He told the Committee—

“Many attempts have been made to make it happen. It has happened in one or two areas—West Lothian is the most notable example—but without statutory underpinning it has not happened. In one or two areas there is still, frankly, resistance to the proposals. We cannot deliver the quality of care that we require to deliver to our adult population—in particular, the disabled population and older people—without the full integration of adult health and social care services.

Our strong view, which is based on the evidence of the past 10 or 20 years, is that integration will not happen without statutory underpinning. We hope that statutory underpinning will not only make it happen on the ground throughout Scotland, but help to change the culture in health boards and local authorities so that people see the need to put the person—the end user, the patient—at the centre of everything that we do and to give overriding consideration to their needs rather than the needs of either a health board or a local authority.”

43. The Committee notes the views of some witnesses that much could have been done to integrate adult health and social care under existing legislation. However, the Committee also recognises that voluntary progress towards integration under current legislation has been limited, although there are clearly some examples of excellent progress.

44. Many of the witnesses told the Committee that structural change brought through legislation would not, in itself, deliver the integration of services that is desired. That will require cultural change within local government and NHS boards, which will require strong leadership that is committed both to improving outcomes for individual patients and to true integration that will be capable not only of delivering those outcomes but of doing so with more efficient use of the available resources. The Committee endorses these views.

45. The Committee, nevertheless, accepts that the Bill is required both to generate the momentum needed to make the widely desired progress a reality and to give a solid, statutory footing to the policy.

Models of integration

46. Each health board and local authority will be required to develop an integration plan, setting out its proposals for the establishment an ‘integration authority’. The integration authority may be established under one of two possible models.

47. Under the ‘body corporate model’, a joint board would be established from the local authority and the health board, with the same number of voting members from each body. This board would have its own chief officer who would lead

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development of the strategic plan, and manage the integrated budget and integrated planning and delivery of services. In this model, the integration authority would be 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 would 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 proposed in the bill for the Scottish Ministers to provide for this by regulations.

48. Alternatively, local authority and health board partners may delegate agreed functions to each other under the so-called ‘lead agency model’. Under this model, a joint monitoring committee of the local authority and the health board, accountable to both, would be established to scrutinise the effectiveness of the integrated arrangement on behalf of the local authority and the health board. It would also hold the lead agency to account for the agreed resources and budgets on behalf of the health board and the council (in a manner designed to ensure integrated provision of services in a person-centred way). It would report to the health board and council in relation to those matters using a “robust reporting mechanism” specified in the integration plan. No chief officer would be required, as the existing chief officers of the health board and the local authority would be accountable for delivery of the national well-being outcomes according to an agreed division of responsibilities. Under these arrangements, health boards and local authorities would remain statutorily responsible for the delegated functions. Duties set out in legislation that apply to integrated functions would remain the responsibility of the relevant statutory partner, although the lead agency would be accountable, through the integration joint monitoring committee, for the discharge of functions delegated to it by the delegating partner.

49. It is understood that only NHS Highland and the Highland Council are likely to choose the lead agency model, with all others expected to opt for the body corporate model.

Body corporate model – governance issues

50. A number of issues were raised in the Committee’s oral evidence sessions regarding the governance arrangements for the body corporate model. COSLA, in its written submission to the Committee, noted that the merits and demerits of this model had been “debated extensively within the local government family, without reaching a consensus”\(^{24}\). It noted that some councils – including West Lothian, East Renfrewshire and others – already successfully operated a similar structure, with jointly-appointed directors overseeing the activity of the Health and Social Care Partnership.

51. The COSLA submission went on to argue, however, that many councils were “concerned about the body corporate model in general and the role of the Jointly Accountable Officer in particular”\(^{25}\). It said there was “a perceived challenge around the power, budget and authority invested in the JAO role, particularly for large councils”, noting that the body corporate could hold a budget greater than

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\(^{24}\) COSLA. Written submission, paragraph 52.

\(^{25}\) COSLA. Written submission, paragraph 51.
either parent organisation. Some COSLA members had argued that, given the scale and nature of the budgetary authority, the lines of accountability were “not sufficiently strong”\(^{26}\) and that the joint board would not “carry the same authority or capacity to scrutinise” as the parent bodies.

52. COSLA also noted a “perceived challenge”\(^{27}\) that the body corporate model “threatens integrated social work services” in that it has the potential to separate adult care from children’s services. This was considered to be of particular importance for those councils with significant levels of deprivation, large numbers of looked-after children, a high prevalence of drug and alcohol misuse, violence and crime and health inequalities. Acknowledging that it was open to councils to “bring all social work services into the integrated partnership”\(^{28}\), it suggested that this would “create barriers with other important services (such as education)”\(^{29}\) and would make the budgetary problem “even more pronounced”\(^{30}\) by giving the JAO an even larger operational resource to manage.

53. Peter Gabbitas of City of Edinburgh Council told the Committee—

“At times, the bill is a bit confusing and unclear about the relationship with the parent body, and I think that that is because it is trying to empower and give a status to the health and social care partnership. In doing so, however, it does not make it clear what the relationship of the body corporate is to the parent body and, as a consequence, both parent bodies in Lothian are concerned about that. Some things do not require the parent bodies’ approval and it does not actually say in the legislation that the plan for which it is responsible has to be signed off by the two parent bodies. We can assume that that might be what is required implicitly, but the bill does not say that explicitly.”\(^{31}\)

54. Mr Gabbitas went on to raise some further points related to the governance of the body corporate model. First, he suggested that the Bill did not say that the parent bodies were to appoint the jointly accountable officer, arguing that the bill was written in a way that implied that the health and social care partnership would be established and would then appoint the jointly accountable officer. He suggested that this was about “the principle and what the bill is saying about the power balance between the parent bodies and the organisation”\(^{32}\).

55. Secondly, he argued that it was unclear whether the parent bodies would retain ultimate responsibility. In the event, for example, of a health and social care partnership doing “something really awful to a patient”\(^{33}\) it was not clear whether the partnership, the NHS board or the local authority, or all three, would be legally accountable for that.

\(^{26}\) COSLA. Written submission, paragraph 53.

\(^{27}\) COSLA. Written submission, paragraph 53.

\(^{28}\) COSLA. Written submission, paragraph 54.

\(^{29}\) COSLA. Written submission, paragraph 54.

\(^{30}\) COSLA. Written submission, paragraph 54.


56. Finally, Mr Gabbitas raised other concerns about power and authority—

“For example, the bill says that ministers may appoint people to the integration board directly. There is concern about that power because the policy memorandum implies that it is the two parent bodies that will appoint people to the board, whereas the bill says that ministers may appoint people to the integration board. That implies that, at some stage, down the line a minister could just arbitrarily decide to appoint people who are not members of the health board or the local authority. I am sure that that is not the intention, but at present the bill gives ministers that power.”

57. A number of written submissions also drew the Committee’s attention to governance issues. Falkirk Council said that there was “some uncertainty around the details of the governance arrangements”. The Chartered Society of Physiotherapy Scotland argued that “a ‘statutory governance framework’ must be put in place to ensure that joint arrangements and new corporate bodies operate consistently and effectively across Scotland”. The Care Inspectorate believed that the governance arrangements needed “to be further clarified through partnership arrangements”. The Royal College of Nursing noted a general concern that “significant issues on the future governance and operation of integrated care are being left to secondary legislation, leaving many questions which have been raised during the development of this Bill as yet unanswered.”

Scottish Borders Partnership noted that clarity around joint accountability and governance would “assist partnerships to move forward in an open transparent culture”.

58. A number of points were raised by Audit Scotland regarding the governance arrangements—

“The Bill sets out plans for a Chief Officer. This addresses one of our concerns that the existing CHP model was not given sufficient powers and authority to lead on key decisions about how resources are used in the local area. However, there are challenges and tensions with this proposed approach and the role and remit of the Board of the NHS board and the council elected members. There need to be clear arrangements for any disagreements between the partners, including disagreements about finances, services, performance, and leadership to be resolved. The Chief Officer may be accountable for significant resources; therefore, the leadership dynamic within both the NHS board and the Local Authority will be shifted by this arrangement. It is essential that there is more clarity about how the Chief Officer will report into the NHS board and into the Local Authority, and that clear performance management and accountability arrangements are put in place.”

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35 Falkirk Council. Written submission, paragraph 2.
36 Chartered Society of Physiotherapy Scotland. Written submission.
37 Care Inspectorate. Written submission, paragraph 23.
38 Royal College of Nursing. Written submission.
39 Scottish Borders Partnership. Written submission.
40 Audit Scotland. Written submission, paragraph 13.
59. The Committee also heard a number of comments about governance in its oral evidence sessions. Allan Gunning of NHS Ayrshire and Arran told the Committee that governance was one of the areas that needed to be “clarified and nailed down”. He said there were “some uncertainties” adding that

“we do not want to set up the new bodies when there are uncertainties that will dominate the agenda; instead, we want the bodies to deliver the policy changes that are envisaged in the bill. There is still some work in progress there, but I am sure that it will be sorted out in due course.”

60. A similar point was made by Susan Manion of the Association of Community Health Partnerships, who said that a “significant amount of clarification” was required on governance and accountability. She noted that existing accountability issues “cause difficulties between councils and health boards”, and it would be “absolutely central to get that aspect sorted”.

61. The Cabinet Secretary responded to some of these points when he gave evidence to the Committee, saying—

“I will be clear. The chief officer will be appointed by the joint board. He or she will report to it. That person will not be able to make unilateral decisions; they will be answerable to the joint board … The first thing to stress is that the chief officer will be responsible to and report to the board. They will not be unaccountable. The second thing to stress is that, on a strategic level, they will report simultaneously to the chief executives of the health board and the local authority.

“Clear lines are laid out for the role, powers and job description of the chief officer. Some of the fears are perhaps based on misconceptions rather than being real, because it is clear to us that what the officer does will be very much under the board’s control.”

62. The Committee notes that, while most of the evidence it received is supportive, in principle, of the body corporate model, a number of detailed concerns remain around the governance arrangements.

63. Specifically, the Committee notes, from the evidence, firstly, that a degree of confusion remains over the relationship between the joint board (under the body corporate model) and its parent bodies – the relevant NHS board and local authority. While the Committee understands that the chief officer will be accountable to the board, there is much less clarity, at this stage, on how the joint board, the NHS board and the local authority will relate to each other and how this will work in practice. The Committee also notes that there is no requirement for the parent bodies to sign off the strategic plan. It is clear that it is for the body corporate to sign off such a plan. However, the Committee would welcome clarity as to the recourse of a

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parent body should it be unhappy with any strategic plan. The Committee therefore invites the Cabinet Secretary, in his response to this report, firstly, to set out his plans in more detail regarding the governance arrangements and specifically to address in detail how it is expected that the bodies concerned will relate to each other.

64. Secondly, the Committee notes the power at section 12(1) of the Bill for the Scottish Ministers to make provision by order (either generally or making different provisions about different joint boards) about the membership, proceedings and general powers of joint boards, the supply of services or facilities to joint boards by local authorities or health boards and any other matter as they think fit in relation to the establishment or operation of joint boards. These are wide-ranging powers, but currently it is unclear how they might be used. The Committee therefore calls on the Cabinet Secretary to set out in detail the kinds of circumstances in which he considers that it would be appropriate to use the powers set out in section 12(1) of the Bill.

65. The Committee also recognises that much of the subordinate legislation that is to follow the enactment of the Bill will, rightly, be the subject of consultation. Nevertheless, it would be helpful if drafts of some of the proposed regulations could be made available for consideration by stakeholders before the Bill has completed its parliamentary passage.

**Lead agency model**

66. COSLA’s submission argued that the lead agency model, and in particular the specific arrangements in the Highland partnership, represented “a key step in the formation of more outcome focused and integrated service delivery models”[46]. It notes, however, that very few of its member councils had indicated that the lead agency model was being considered locally. Despite this, COSLA’s submission goes on to argue that the lead agency model has “untapped potential”. It called for partnerships to “consider the delegation of appropriate public health services from NHS boards to the council”, noting that there were already examples of NHS boards and councils adopting an integrated approach to public health. It argued that this might “allow for a more focussed approach to tackling health inequalities” exploiting the “link-in with related council-run services like environmental health and the 'place-making' function of councils”[47]. It also pointed to the experience in Denmark, where 98 local municipalities are responsible for all domiciliary personal and domestic help, home nursing, supported housing, nursing homes, and public health care.

67. As noted earlier, it is understood that the Highland Council/NHS Highland area is the only area expected to choose the lead agency model.

68. A delegation from the Committee visited Inverness on 23 September 2013 to hear from staff and management in NHS Highland of their experience of working as an integrated adult health and care service, under the lead agency model, since April 2012. The NHS Highland Chairman and Chief Executive, along with frontline

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[46] COSLA. Written submission, paragraph 55.
[47] COSLA. Written submission, paragraph 57.
staff, many of whom had transferred from Highland Council to NHS Highland, attended the meeting at the Mackenzie Centre.

69. It was indicated by NHS Highland that it and Highland Council had rejected the body corporate model, on the basis that the board and council had coterminous boundaries that made it perhaps easier to adopt the lead agency model, particularly given the degree of integration that already existed.

70. Committee members noted the enthusiasm of the staff present for the way that services were developing under the new structural arrangements and the leadership and commitment shown by the senior officials, elected members of the council and the chair and members of the NHS board to initiate the steps towards integration. There was an acknowledgement that, although much had been achieved, a great deal still remained to be done on the road to full integration and that it was very much a work in progress. Nevertheless, it was clear that at all levels in the new organisation, there was a strong commitment to placing the person at the centre of the process, and towards developing a service that was as flexible as possible and focussed on securing the best possible outcomes for that person.

71. The NHS Highland senior management and chairman at the meeting welcomed the Bill, though they noted that all that had been achieved in Highland could, and indeed, has been, achieved without it. Nevertheless, they were thankful that the Bill cemented the lead agency model, as it has been developed in Highland, as one of two possible models of integration, and that nothing in the Bill would require any of the development work in Highland to be undone.

72. Asked about why it appeared that no other part of Scotland was set to follow the Highland lead agency model, staff responded that it was, in their view, because the model required partners to be genuinely prepared to give up power, and to be prepared to fully integrate budgets and transfer staff.

73. UNISON and the Royal College of Nursing both raised concerns about staffing arrangements under the lead agency model. These are returned to later in the report in the staffing section.

74. The Committee recognises that the lead agency model will be appropriate for NHS Highland and Highland Council, given their geography, scale and history of joint working. The Committee therefore welcomes the fact that the Bill does not require the two partners in Highland to dismantle what has been developed so far and gives them the opportunity to build on and enhance the work that has already been done to integrate services in that area.

75. The Committee notes that, so far, no other councils and NHS boards appear to be likely to choose the lead agency model, but accepts that the local partners are best placed to make the decision.
National outcomes

76. The Policy Memorandum notes that performance management and reporting frameworks for NHS Scotland and local authorities are currently “considerably different from one another”\(^{48}\).

77. Currently in local government, Single Outcome Agreements (SOAs) are agreed between each Community Planning Partnership (CPP) and the Scottish Government. They provide the mechanism through 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. In 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.

78. The Policy Memorandum argues that, by introducing nationally agreed health and wellbeing outcomes, the Scottish Government will “introduce a mechanism for ensuring that Health Boards and local authorities are jointly and equally accountable for planning and delivery of effectively integrated services”\(^{49}\). It also says that, to strengthen this, the national outcomes will be established in legislation.

79. Acknowledging that outcomes may need to develop over time, the Scottish Government proposes to take powers through the Bill for Scottish Ministers to set out national outcomes for health and wellbeing in regulations, which can be amended over time to “keep pace with developing needs and aspirations for health and social care in Scotland”\(^{50}\). The Policy Memorandum also acknowledges that partners will play “a key role”\(^{51}\) in the development of the outcomes and the performance indicators, and 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. Finally, it indicates that the nationally agreed outcomes for health and social care will be consulted upon, agreed and will be reflected in SOAs.

80. The idea of national outcomes and the general emphasis on an outcomes-based approach was broadly welcomed in the majority of the evidence received by the Committee. In the local authority sector, North Ayrshire Council welcomed “the focus within the Bill on outcomes for the citizens of Scotland and the drive to judge partnership effectiveness through nationally agreed outcomes”\(^{52}\). West Dunbartonshire Community Health and Care Partnership welcomed key outcomes agreed for the new Partnerships being visible within their Community Planning Partnership (CPP) SOAs but made the plea that national guidance be “disciplined” in “not specifying too many headline outcomes/targets as national non-negotiables”\(^{53}\), which could be argued to undermine the fundamental concept of an

\(^{48}\) Policy Memorandum, paragraph 69.
\(^{49}\) Policy Memorandum, paragraph 73.
\(^{50}\) Policy Memorandum, paragraph 74.
\(^{51}\) Policy Memorandum, paragraph 75.
\(^{52}\) North Ayrshire Council. Written submission.
\(^{53}\) West Dunbartonshire Community Health and Care Partnership. Written submission.
SOA. South Lanarkshire Council welcomed the national outcomes framework while South Ayrshire Council supported “the development of new national outcomes which should permit the progress and success of the new arrangements to be effectively measured, thus driving continuous improvement”\(^{54}\). Finally, North Lanarkshire Council said it was “supportive of the concept of a national outcomes framework provided local government is seen as an equal partner in [its] development”\(^{55}\).

81. Within the NHS sector there was similar broad support. NHS Lanarkshire recognised “the importance of being jointly accountable for the delivery of national outcomes and for improving service delivery”\(^{56}\). The Care Inspectorate welcomed “the approach to develop high level national strategic outcomes with regard to health and wellbeing”\(^{57}\) while NHS Education for Scotland indicated that “the core of having national outcomes for health and well being which involves a range of key stakeholders in developing these outcomes and performance indicators is clearly a strength”\(^{58}\).

82. There was a similar picture within the voluntary sector. Carers Scotland welcomed “commitment to prescribe national outcomes”\(^{59}\) which it said had “the potential to achieve consistency across Scotland in the delivery of holistic health and social care services”. Coalition of Care and Support Providers in Scotland Linked stated that the Bill should “make it clear that integration authorities will be held accountable for the agreed national outcomes”\(^{60}\). It also suggested that, while the Bill makes provision for such outcomes to be prescribed by Ministers, it does not require integration authorities to achieve them – only to ‘have regard’ to them in integration and strategic planning processes. Children in Scotland’s submission argued that the development of the national health and wellbeing outcomes would be key to integrating health and social care, and that “the third sector and service users should have a voice where possible in shaping these”\(^{61}\).

83. The Committee also welcomes the general emphasis in the Bill on outcomes-based approaches and the provision for the Scottish Ministers to set national outcomes following consultation. The Committee believes it is important to have national outcomes to ensure a degree of consistency of standards across the country, but also recognizes the importance of retaining a degree of local flexibility in order to take account of local circumstances.

84. The Committee also welcomes the Bill’s provision that NHS boards and local authorities will be jointly accountable for delivery of the national outcomes locally. This should help to cement joint partnerships and reinforce the message that health, wellbeing and care are not the sole responsibilities of any single agency. NHS boards, local authorities and,
indeed, third and independent sector partners all have an important role to play.

85. Finally, the Committee believes that, while it is clearly helpful to have national outcomes, the most important outcomes are those for the individual patient, and it is important to bear in mind that the national outcomes must be focused on continuous commitment to improving these individual outcomes.

Ministerial powers, scope and democratic oversight

86. The Bill has been criticised by some organisations in relation to the powers it would afford to the Scottish Ministers and the perceived degree of latitude in terms of other services beyond adult care that could, in future, come within its scope. The Association of Directors of Social Work (ADSW) submission, for example, stated that the Bill was “more prescriptive” than anticipated and was “very mechanistic about the steps expected to be taken by local authorities and NHS Boards to achieve integrated services”. It went on to say that the Bill “ascribes extensive powers to Ministers that had not previously featured in the consultation document” and noted its firm view that “these cover areas that are a matter for local determination”.

87. COSLA’s submission supported a public service reform agenda that develops outcomes-based approaches, uses resources flexibly, promotes co-production, early intervention and prevention, facilitates service integration and enhances local democratic scrutiny. It concluded that “the overall thrust of the Scottish Government proposals on health and social care integration would align with many of these general principles”. COSLA went on to argue, however, that the proposals were “at times too prescriptive and too detailed”, and suggested that, as a general rule there “should be more flexibility at a local level to determine the shape and governance of the proposed partnership arrangements”. COSLA also maintained that health and social care partnership arrangements “should be subject to stronger-than-proposed local democratic oversight”.

88. COSLA went further during one of the Committee’s roundtable sessions on 10 September 2013. Ron Culley, COSLA’s chief officer of health and social care, told the Committee—

“I do not think that there has been a departure in terms of the policy intention, but there is a very clear departure in terms of what the bill allows. That is why we are fundamentally concerned about the current articulation of the integration project in the bill, particularly in respect of its scope. All local government functions are within the scope of the bill as it is written. Through regulation, a Scottish Government minister could bring any local government function within the scope of the legislation—not just social care but education, housing or whatever. We are fundamentally opposed to that.

63 COSLA’s submission has not been counted in the analysis of responses because it was received too late.
We think that there must be a bill that represents the policy intention and that this bill does not do that. That is why we have strongly advocated an amendment that would provide a much tighter definition of the local government functions that may or may not be delegated. The policy intention is all about adult social care, so we want a bill that carries out that intention. That is our fundamental concern.\textsuperscript{64}

89. Ron Culley went on to suggest that the issue of reform of health and social care could be looked at on two axes. One was the relationship between the NHS and local government, on which Mr Culley said that COSLA was “comfortable with that discussion and wanted to see reform advanced in that area”\textsuperscript{65}. The other axis, he said, was the central/local dimension, on which he argued that the bill would “give far too much power to the centre” and that COSLA wanted “partnerships to be given more authority and responsibility to get on with the job”. He concluded that COSLA’s objection was not to the legislation as such but “to the way in which the bill has been framed”.\textsuperscript{66}

90. Similar points were made by Falkirk Council, which was concerned that the Bill “provides Ministers with the power to extend the scope of integration authorities by regulation” The Council argued that this was “a very far reaching power which could see the delegation of a much wider range of local authority without recourse to further legislation”\textsuperscript{67}.

91. COSLA’s position, as noted above, is that the Bill should be amended to make it clear that its provisions were restricted to adult health and social care and that Ministers should not have powers, for example, to require local authorities and other bodies to integrate children’s services. However, other witnesses, including some individual local authorities, did not want to see such a restriction. North Ayrshire Council, for example, welcomed “the local flexibility which the Bill has captured”, which had “allowed us to agree to integrate our children and family services within our local partnership agreement”\textsuperscript{68}.

92. The City of Edinburgh Council commented that children could not be seen in isolation from their families, and that, where local authorities had integrated their children’s social care services with their education services, there was a need to consider the best approach to linking with children’s health services to ensure whole families can be well supported. The council would like to “establish a separate partnership for children’s health and social care services” and that it would “be helpful if the Bill could provide a steer on the practicalities of this”\textsuperscript{69}.

93. West Dunbartonshire Community Health and Care Partnership argued that while there was a “pragmatic logic for the proposition of an initial focus on improving outcomes for older people” there was “a risk that a series of arrangements could be developed that would not be efficiently scaled up or transferable to other care groups”. Noting that there was, in the context of the

\textsuperscript{67} Falkirk Council. Written submission.
\textsuperscript{68} North Ayrshire Council. Written submission.
\textsuperscript{69} City of Edinburgh Council. Written submission.
Older People’s Change Fund “considerable focus” on the Reshaping Care for Older People’s agenda the initial focus on older people would, in practical terms, “probably provide little (if any) added value to what is already being driven forward” and would “possibly skew the implementation of integration more generically” as it might “suggest a piecemeal approach, with different integration models devised for different care groups with complicated structures and unwieldy bureaucracies as a consequence”\(^{70}\).

94. Other bodies also expressed support for the wider provisions in the Bill that would permit the future integration of other services. Children in Scotland’s submission welcomed “the intent to extend integration of health and social care services beyond older people’s services as the original intention seemed to be”\(^{71}\). It went on to note that the responses received to the initial consultation “suggested that an arbitrary point or age at which integration begins to apply (e.g. age 65) would not be helpful” adding that it “would be concerned that where only adult health and social services were integrated there would be issues in transitioning from children’s to adult services”.

95. A similar point was made by Barnardo’s, which expressed a “major concern” that “the intent behind the proposals is still far too adult focused”. It went on to argue that it was “important for policy-makers to recognise and understand that these proposals will also affect children’s services” and stated its concern that children’s services would “not be recognised as an equal priority and suffer as a result”. Barnardo’s also argued that it was “far from clear” where the responsibility for children’s services would lie in those areas where integration authorities do not choose to take on responsibility for them, saying that this would “create significant uncertainty”\(^{72}\).

96. The College of Occupational Therapists (COT) made a similar point, noting that decisions on the possible integration of services other than adult health and social care services would be a matter for local decision making. COT said that this raised some concerns in relation to “true integration”.

97. A number of submissions also argued that there was a need for housing services to be included within the scope of the legislation. The submission from the Care Inspectorate, for example, stated—

> “Some local authorities have integrated Housing Services with Social Work Services, yet there is no emphasis on Housing Services as being part of integration plans. Housing Services are integral to supporting people within their local communities and are often key to individuals remaining in a homely, community based environment. We believe it would be helpful to see the role of Housing Services in integration clarified. Whilst we have specifically mentioned housing we are aware that a number of local authority services (particularly education, through lifelong learning, and leisure), health services, the third sector and others within Community Planning Partnerships have a key role in delivering successful integration plans.”

\(^{70}\) West Dunbartonshire Community Health and Care Partnership. Written submission.

\(^{71}\) Children in Scotland. Written submission.

\(^{72}\) Barnardo’s Scotland. Written submission.
98. Other submissions made very similar points. The submission from the Housing Co-ordination Group (HGC)\textsuperscript{73} made the point that the housing sector supports the principles of integration for improved outcomes set out in the Bill and understands the need for legislation to promote joint working to pursue these principles. However, it added that the success of the new ‘integrated authorities’ would “largely depend on effective joint strategic commissioning to which the housing sector can make a crucial contribution”. The HCG submission went on to note—

“The current arrangements for involving the housing sector have not produced a consistent [or] adequate approach and the Bill, as it stands, could result in an ‘integrated authority’ deciding not to involve the housing sector as a partner. To ensure that housing issues, and the housing sector, form an integral part of contributing to the delivery of national outcomes, the HCG urges that the contribution of the housing sector be recognised within the legislation, urging the new ‘integrated authorities’ to involve their strategic housing partners.”\textsuperscript{74}

99. The HCG also made a submission on the Bill to the Local Government and Regeneration Committee, calling for the legislation to recognise the contribution of the housing sector. Addressing this point, the LGRC report stated that it “would expect that in situations when housing is likely to be central to the delivery of successful partnership working, [housing] are involved at board level.”\textsuperscript{75}

100. In relation to the wider legislative landscape, the Local Government and Regeneration Committee considered how the proposed community empowerment and renewal bill would sit alongside the Public Bodies (Joint Working) (Scotland) Bill and the Children and Young People (Scotland) Bill. Specifically, the report called on the Scottish Government to “provide clarity around implementation of the Bills and how they fit with the role of CPPs (Community Planning Partnerships) in the new partnerships and arrangements.”\textsuperscript{76}

101. The points raised by COSLA were put to the Cabinet Secretary by the Committee. The Cabinet Secretary’s reply appeared to indicate that he had taken on board the points made by COSLA—

“COSLA has expressed concern that it believes that there is a need for tighter definition of what we mean by “social care” in the bill. The concern is that the way in which the bill is drafted could be interpreted to mean that I have the power not just over social care, but over a whole gamut of local authority services. We have been working at political and official level and we

\textsuperscript{73} The HCG consists of the Association of Local Authority Chief Housing Officers (ALACHO); the Chartered Institute of Housing in Scotland; the Scottish Federation of Housing Associations (SFHA); Glasgow and West of Scotland Forum of Housing Associations (GWSF); the Housing Support Enabling Unit (HSEU); and Care and Repair Scotland.

\textsuperscript{74} Scottish Parliament Local Government and Regeneration Committee. Committee Memorandum on the Children and Young People (Scotland) Bill and the Public Bodies (Joint Working) (Scotland) Bill. Available at: \url{http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/LGR_Committee_memorandum_on_SP_Bill_27_and_SP_Bill_32.pdf} [Accessed 28 October 2013]

\textsuperscript{75} Memorandum from Local Government and Regeneration Committee. Paragraph 45.
have agreed that we will lodge amendments at stage 2. Those amendments, jointly agreed between COSLA and us, will I think absolutely allay any fears that I am trying to widen my powers. I am absolutely sure that my Cabinet colleagues would not want that to happen, anyway. The bill, with those amendments, will make it absolutely definitively clear what is meant by the powers in relation to social care and that they do not cover much wider areas of local authority responsibility.\textsuperscript{77}

102. The Committee notes that there are different views within the evidence about whether the provisions in the Bill to enable Ministers to require services to be integrated beyond adult health and social care are appropriate.

103. The Committee also notes the strong representations it received arguing that it was essential that housing services be included within the proposed integration arrangements.

104. The Committee notes the indication by the Cabinet Secretary that the Scottish Government will be lodging amendments at Stage 2 that will restrict the services that require to be integrated under the Bill to adult health and social care.

105. While the Committee notes concerns about statutory integration of additional services, it would support a permissive and flexible approach that would allow health boards and local authorities, if they so wished, to develop the integration of appropriate services in cases where it would improve the service and be of benefit to service users.

Relationship with other legislation and other local partnerships

Existing and proposed legislation

106. A number of submissions received by the Committee questioned how the provisions in the Bill would integrate with other existing legislation, with other bills currently making their parliamentary passage and with bills that are planned but have not yet been introduced.

107. The question of how the provisions in the Bill would work alongside those of The Social Care (Self-directed Support) (Scotland) Act 2013 was raised by a number of written submissions.\textsuperscript{78}

108. Most of the points raised in relation to the Social Care (Self-directed Support) (Scotland) Act 2013 simply called for clarity about how the two pieces of legislation would relate to each other once both were in place. The submission from Glasgow City Council was fairly typical—


\textsuperscript{78} Carers Scotland, NSPCC, British Association of Social Workers, Voluntary Health Scotland, Youthlink Scotland, CCPS, Children in Scotland, MS Society, Scottish Health Council, Scottish Association for Mental Health, Health and Social Care Alliance, UNISON, Barnardo's Scotland, Enable Scotland, Capability Scotland, Inclusion Scotland and Independent Living in Scotland, Audit Scotland, Scottish Care, Marie Curie Cancer Care and Glasgow City Council.
“The Bill fails to make any connection with the recently passed Self Directed Support Act and as such it is difficult to see how these two very different pieces of legislation impacting on the delivery of services to the adult population will work alongside each other. The Bill would be strengthened by making this connection and also by giving an indication as to how self directed support will impact on the NHS functions of a Partnership within a local area.”

109. Similar points were raised by a number of witnesses in relation to the Children and Young People (Scotland) Bill and the proposed community empowerment and renewal bill, which has been announced in the Scottish Government legislative programme for 2013-14, but has not yet been introduced.

110. Again, most of the submissions suggested that there was a lack of clarity about how these different pieces of legislation would mesh with each other. The submission from NSPCC Scotland, for example, argued that the Bill and its supporting documents made “very few connections with other pieces of recent and proposed legislation that will impact on children, young people and their families” noting, in particular, that there was “no mention at all of the Children and Young People (Scotland) Bill”.

111. The latter Bill makes provision for a duty on Scottish Ministers and public bodies to take steps to “secure better or further effect” the requirements of the United Nations Charter on the Rights of the Child (UNCRC) (ss1-2 of the Bill). It also seeks to create a framework for joint planning of children’s services, involving local authorities, health boards and other ‘service providers’ (ss7-18). Noting that there would be “certain crossover” between both bills, NSPCC argued that this raised questions about how they were intended to ‘fit’ together. NSPCC further commented that there appeared to be no consideration of children’s rights in the Public Bodies (Joint Working) (Scotland) Bill and no apparent consultation with children and young people. NSPCC was, therefore, “unsure how the proposed children’s services planning processes in the Children and Young People Bill, and the proposed integration planning and functions set out in the Bill at hand, will interact in practice”.

112. NSPCC made similar points in relation to the Social Care (Self Directed Support)(Scotland) Act 2012 and the proposed Community Empowerment and Renewal Bill and concluded—

79 Glasgow City Council. Written submission.
80 Children and Young People (Scotland) Bill, as introduced (SP Bill 27, Session 4 (2013)). Available at: http://www.scottish.parliament.uk/S4_Bills/Children%20and%20Young%20People%20(Scotland)%20Bill/b27s4-introd.pdf
81 NSPCC Scotland. Written submission.
82 NSPCC Scotland. Written submission.
83 This Act aims to give services users greater choice and control over the support they receive. See http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Self-Directed-Support/Bill
84 This Bill will seek to strengthen community participation and development. See http://www.scotland.gov.uk/Topics/People/engage/cer
“It is unclear to us whether all of these parallel developments have been considered in the round. There appears to have been little strategic thinking about the position of children’s services and we are concerned that this might lead to confusion and fragmentation. It is arguable whether the disparate nature of the various pieces of legislation which affect children’s services suggests a lack of coherent vision for how the whole range of services meet the needs of children and young people in Scotland.”

113. The Cabinet Secretary told the Committee—

“Alongside the Social Care (Self-directed Support) (Scotland) Act 2013 and the Children and Young People (Scotland) Bill, the Public Bodies (Joint Working) (Scotland) Bill is part of the Government’s broader agenda to deliver public services that better meet the needs of people and communities. The bill provides the legislative framework for partnership working at both a strategic and a local level, involving professionals, service users and partners. The planning and delivery principles in the bill encapsulate the principles of Christie, putting the person at the centre of service planning and delivery, and requiring a focus on prevention and anticipatory care planning.”

Other local partnerships

114. Some submissions also raised questions about how the proposed structures set out in the Bill would be expected to relate to Community Planning Partnerships, established under the Local Government in Scotland Act 2003. Barnardo’s, for example, said—

“The legislation and accompanying documents have not made it clear what the relationship will be between the proposed integration authorities and Community Planning Partnerships (CPPs). We are concerned that if this is not laid out clearly either on the face of the Bill or in subsequent guidelines then there will be blurred lines of responsibility and accountability. We are concerned that this may lead to confusion and ultimately affect service delivery.”

115. The Committee notes the Cabinet Secretary’s comments on how the Bill is part of the broader agenda to deliver public services that better meet the needs of people and communities. Nevertheless, it is clear that there are widespread perceptions of lack of clarity about what the implications of the different pieces of legislation will be in practice, some general concerns about the extent to which the different pieces of legislation have been considered in the round, and some uncertainty about how the proposed new structures will articulate with established local structures such as community planning partnerships.

116. The Committee appreciates that the Bill is an enabling and permissive one that leaves much for local determination, and that flexibility is welcome. However, witnesses believed that what is set out in the Bill and the Policy

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85 NSPCC Scotland. Written submission.
87 Barnardo’s Scotland. Written submission.
Memorandum has been insufficient, or at least requires additional detail, to give them a clear enough picture about how the existing and planned legislation and existing local decision-making partnerships are expected to inter-relate.

117. The Committee therefore calls on the Scottish Government to consider in more detail, and report back to the Committee, firstly, how the Bill is expected to work alongside the Social Care (Self-directed support) (Scotland) Act 2013 and the Children and Young People (Scotland) Bill (when enacted); and secondly, how the proposed integration joint boards will work alongside existing community planning partnerships. Additionally, the Committee invites the Cabinet Secretary to consider whether there is a need to include guidance on these matters within the statutory guidance that is expected to follow the passage of the Bill.

Role of the third and independent sectors

Views from the third sector

118. The Committee received a large number of submissions from third sector organisations regarding the role of the third sector within the proposed integrated arrangements. Most of these submissions argued that the third sector should be stated in the Bill as a key strategic partner alongside the health board and local authority. Voluntary Health Scotland, for example, stated that the “third sector should be acknowledged as a strategic partner in the integration of health and social care, and engaged with throughout the development of integration authorities and strategic plans”\(^{88}\). The British Psychological Society expressed a similar view, saying that the involvement of the third sector “should be extended beyond the requirement for them to be consulted, to being included as equal partners in the strategic planning and governance arrangements”\(^{89}\).

119. The view of the third sector can perhaps best be summed up by this comment from CCPS —

“The Bill places duties on integration authorities to **consult the third sector** (and, in certain sections, to consult third sector service providers specifically); in our view this duty is not strong enough. The third sector, and providers specifically, should be treated not as consultees, but as full partners in the planning and delivery of care and support.”\(^{90}\)

120. Many other submissions made similar points. However, Youthlink Scotland, while arguing that the third sector “must be fully involved in the planning and decision-making processes” acknowledged that there were “a number of questions regarding how this would work in practice”. The third sector, it noted, was “diverse, with a range of sometimes competing views”. Who, it asked, would the third sector representatives be, and how would this be decided? It also noted that there would be “practical difficulties for national voluntary organisations in engaging in … diverse models of integration across Scotland” and that while it was possible

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\(^{88}\) Voluntary Health Scotland. Written submission.
\(^{89}\) British Psychological Society. Written submission.
\(^{90}\) CCPS. Written submission.
umbrella bodies, such as voluntary organisations’ councils, could represent the sector, but this required “further discussion”. Youthlink Scotland also noted that the Policy Memorandum suggested that the third sector would not have voting rights on the governance bodies, which it said “could lead the third sector being perceived as a ‘second tier’ member with less influence”.

121. The Committee’s evidence session on 17 September 2013 heard from representatives of the third sector. Martin Sime of the Scottish Council for Voluntary Organisations told the Committee that this issue “goes to the heart of one set of concerns that we have about the bill, which clearly sees the third sector in a secondary role”. He went on to say—

“There is still a widespread view that we are here to deliver other people’s priorities. That is a misunderstanding and misrepresentation of the crucial role the sector has to play, and of its many different interests in this field. We understand that the bill is structured as it is, providing for an equal number of representatives from the two big public service “beasts” for the balance of power. We recognise that if the third sector had a voting seat at that table it would, in effect, hold the balance of power.”

122. Mr Sime went on to argue that the third sector should be represented at all levels in the new structures adding that it was important that the sector had “a seat at the strategic tables because it has a strategic contribution to make to the bill, and not just to its objectives”. He also argued that if it were only the statutory agencies who would to be able to vote, the third sector and other interests should have “some power of veto over the plans” and how they were developed.

123. Ranald Mair of Scottish Care told the Committee that it would be “a missed opportunity” if the third (and independent) sectors were not “fully included in the governance arrangements in the future”. He noted that the sectors had been full partners in the change fund and the reshaping care for older people programme, which were “four-way partnerships within which the third and independent sectors have sign-off responsibilities, and which have created a sense of joint ownership of delivery of care and of development of new models of care. He concluded that the Bill “sets us back dangerously to a point where the third and independent sectors become “consultees”, and not full partners in a process.

124. These comments were echoed by Nigel Henderson of the Coalition of Care and Support Providers in Scotland, who told the Committee: “It is interesting to reflect that we are trusted to provide care and support to some of the most vulnerable people in Scotland but are not trusted or respected as equal partners”. He added, while acknowledging that the third sector “does not always speak with one voice” and “includes a diverse range of organisations” with “diverse interests”, that the “basic premise” should be involvement of the third sector. It was, he said, “very important that we do not leave the two big statutory authorities to do this by

91 Youthlink Scotland. Written submission.
themselves” because “they need people like us to help to shape, to create and to innovate for the desired outcomes.”

125. A similar point was made by Pam Duncan of Independent Living in Scotland—

“health boards and local authorities are bridling a bit about the third sector’s requirements for plan sign-off, and I know that MSPs will be concerned about that as well, because there is a statutory responsibility. Where we have had collective sign-off for change fund plans over the past three years, we have had quite a significant change in the culture of how local officials work with their partners. The sign-off of plans is not a power thing for the third sector; it is a mechanism to get collaboration and culture change in services.”

126. Third sector organisations accepted in evidence to the Committee that the third sector had been recognised within the Bill’s Policy Memorandum, but argued strongly that these principles should be set out on the face of the Bill. Nigel Henderson of CCPS told the Committee—

“The Parliament has a history of putting principles right up front in bills, but with this legislation, many of the principles and aims are in the policy memorandum. We would like more of those to appear in the text of the bill, particularly in respect of the inclusion and equal status of the third sector.”

127. Ranald Mair of Scottish Care told the Committee that the text of the bill did “not need to go into huge detail about the involvement of the third and independent sector, but it should contain the requirement for the sector to be fully included”. He said that the issue was the absence of any reference to the third sector. While he said that the sector did “not need a lot of comfort built into the text of the bill”, but that “some acknowledgement that we exist would be marginally helpful”.

Views from the statutory sector
128. Evidence received by the Committee from the statutory sector, though welcoming the involvement of the third sector, placed less emphasis on its involvement in planning. Allan Gunning of NHS Ayrshire and Arran spoke of the “point of principle” of the “more formalised role of the third and independent sectors and of users and carers in local communities, which will build very well on the good work that has been done through reshaping care for older people” missed opportunity.

129. Jeff Ace, of NHS Dumfries and Galloway, told the Committee—

“I would not want there to be a requirement for third and independent sector bodies to be represented on committee X, Y or Z or board A, B or C. That

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could require a lot of commitment from the sectors, for relatively little advantage. Where we need the sectors to work with us is on actual service provision and the local solutions that we can put in place—that would be preferable to their having what might be a tokenistic presence at a region-wide committee, which would not play to their strengths.”

130. This view was backed up by Allan Gunning of NHS Ayrshire and Arran, who said it was “important that there is positive engagement with the sector”. He added, however, that “the arrangements must follow the governance and accountability arrangements” and that “we must be very clear about the distinction between strategic involvement and where the responsibility lies at the end of the day, which will be with the statutory partners”.

131. The Committee questioned representatives of the third sector about the potential for a conflict of interest if third sector organisations were to be involved in strategic planning and commissioning of services for which they or other third sector organisations might tender. In response, the third sector organisations pointed to the evidence base from the reshaping care programme and the change fund that the third sector had “discharged that involvement in an even-handed and non-partisan way”, and pointed out also that it had the option to “withdraw from certain decisions” and/or declare their interest if there were a perceived conflict. They also noted that not all charities had a service delivery interest; some – like third sector interfaces – had a representational interest. They also mentioned that charities were subject to regulatory frameworks, and that voluntary organisations that deliver care do not distribute profit and there is no personal gain or private advantage, with any resources generated going back into their cause. Finally, they referred to what they saw as “the pursuit of the institutional self-interest of health services and local government” and called for “one set of rules for everybody, as well as transparency for everyone”.

Others

132. The British Medical Association’s submission to the Committee noted, the intention (expressed in the financial memorandum, Paragraph 62) to fully involve the third sector as key partners in strategic commissioning, locality planning and service delivery activity. The BMA agreed that there was “a need to ensure closer working relationships between health boards, local authorities and the third and independent sector”, but went on to say that “there should be clarity on the exact nature of this involvement, how representation would be achieved and perhaps more importantly how this non-statutory sector would have influence over the resources in the statutory health and local authority structures”.

106 BMA Scotland. Written submission.
Scottish Government view

133. When the representations from the third sector were put to the Cabinet Secretary by the Committee, he told members that “the third and independent sectors will be embedded in the process as key stakeholders in shaping the redesign of services”\textsuperscript{107}. Later, he told the Committee—

“The absolute guarantee is that we need to make sure that all the key stakeholders—the public, the end users, the third sector and the independent sector—are involved. The bill states throughout that they have to be involved—not just consulted, but involved—at both partnership level and, more important, the local level, because that is where a lot of the key decisions that will concern end users will be made.”\textsuperscript{108}

134. The Committee notes that the Bill makes little specific reference to the third and independent sectors, beyond the requirement in section 4 (Integration planning principles) that services provided in pursuance of functions delegated under an integration plan should be provided in the way which, so far as possible, (amongst other things) makes the best use of the available facilities, people and other resources. (sub paragraph vi) and section 6 (Consultation) which provides that, before submitting the integration plan for approval by the Scottish Ministers, the local authority and the health board must jointly consult persons appearing to the Scottish Ministers to have an interest and “such other persons as the local authority and the Health Board think fit”.

135. The Policy Memorandum, however, refers to the third and independent sectors more specifically. It notes, at paragraph 21, that the third and independent sectors, “provide significant levels of care and support and are crucial partners, with the statutory services, in the provision of a wide range of support”\textsuperscript{109} adds that “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 services”. It continues that “the reform will not succeed if … 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 paragraph also notes that the “contribution of the third and independent sectors in enabling delivery of better outcomes is also a crucial factor in the Scottish Government’s wider public service reform plans”.

136. Later, at paragraph 60, The Policy Memorandum notes that the Bill places a duty upon integration 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”\textsuperscript{110}. At paragraph 75, it stresses the key role that partners will play in the development of the national outcomes noting that 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”\textsuperscript{111}. Finally,
at paragraph 96, noting that, for governance arrangements to operate 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”. It then indicates that 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\(^{112}\).

137. The Committee recognises the concerns of the third sector and its wishes to be fully involved in the strategic planning process under the new integrated arrangements. The Committee also recognises the good practice that can be demonstrated by the third and independent sector in the social care field, the value that it offers and the creativity that it can bring to the planning process. The Committee fully accepts that it is important that the third and independent sectors be seen as key partners as the process of integration is taken forward.

138. The Committee considers, however, that the Policy Memorandum does recognise the contribution made by the third and independent sectors and this may well be the appropriate place for it to be recognised. The duties set out in the Bill are placed on public bodies that were established by other statutes. Third and independent sector bodies are not established in this way, have their own governance and management arrangements and are not accountable to the Scottish Parliament or to the Scottish Ministers. This, as a number of witnesses have noted, limits what can be contained in the text of the Bill about the third and independent sectors.

139. The Committee also notes the evidence of representatives of third sector service-providing bodies, about the potential conflict of interest that might arise were third sector bodies to be directly involved in designing and commissioning services for which the sector might subsequently be expected to tender.

140. The Committee is also mindful of the comments of the BMA, calling for clarity on the exact nature of third sector involvement, how representation would be achieved and how the sector would have influence over the resources in the statutory health and local authority structures.

141. The Committee is reassured on the role of the third and independent sectors by the references to them in the Policy Memorandum and by the reassurances given by the Cabinet Secretary in evidence to the Committee. The Committee also considers that, though much of the written evidence referred to the third sector generically, there is probably a need to distinguish between the third sector that provides services and the third sector that represents users, which is considered in the next section of the report.

142. Nevertheless, the Committee acknowledges the strength of feeling on this issue, particularly in the third sector. The Committee therefore calls on

\(^{112}\) Policy Memorandum, paragraph 96.
the Cabinet Secretary to consider whether there is any way of strengthening the commitment to the involvement of the third and independent sectors in the integration process.

Carer, patient and service user involvement

143. Evidence from carers organisations to the Committee argued that there needed to be a more explicit commitment to the involvement of carers of the face of the Bill.

144. The Carers Trust Scotland submission stated that “service users, carers and the wider third sector must be involved in the planning, development and delivery of services”.

Similarly, the submission from the Scottish Association for Mental Health (SAMH) said, “The meaningful involvement of patients, service users, carers, and the third sector is necessary – even fundamental – to achieve the policy objectives of the Bill”. SAMH also called for service users to be represented on joint boards.

145. The Carers Trust Scotland also echoed points raised by the Health and Social Care Alliance regarding the need to clarify what will happen to Public Participation Forums.

146. The Scottish Health Council (SHC) was positive in its view that integration has the potential to lead to better public involvement, but called for the Bill “to go further to ensure this aspiration is enshrined effectively in the primary legislation”. SHC argued out that the Bill did “not appear to go as far as suggested in the Scottish Government’s response to the 2012 consultation exercise, which had said: “It is therefore our intention ... to legislate for a duty on Health and Social Care Partnerships to ‘engage with and involve’, rather than merely to ‘consult’ ... representatives of patients, people who use services, and carers regarding how best to put in place local arrangements for planning service provision.” The Scottish Health Council concluded that it “would like to see the Bill strengthened accordingly”.

147. In a further late submission to the Committee, the SHC built on its earlier evidence, suggesting that a single standard for participation in health and social care should be developed, alongside a quality assurance system to ensure improvement can be demonstrated. SHC argued that this should be linked to a national outcome, along the lines that “people are encouraged and supported to work with health and social care providers to achieve services that meet local needs and improve health and wellbeing”.

148. In other evidence received by the Committee, Children in Scotland said that the development of the national health and wellbeing outcomes would be key in this process, and that service users “should have a voice where possible in shaping these”.

[113 Carers Trust Scotland. Written submission.
114 Scottish Association for Mental Health. Written submission.]
149. In oral evidence, the Coalition of Carers in Scotland stated that “it is extremely important that, like other key stakeholders, carers feel that they have ownership of the process and that they are at the table from the beginning”\textsuperscript{115}.

150. According to the Policy Memorandum, 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”. It says that this will “ensure that the decision-making processes and scrutiny of the operational delivery are fully informed and take account of these perspectives”\textsuperscript{116}.

151. The Committee notes that involvement of carers, patients and services users and organisations representing them is not made explicit on the face of the Bill, although there is a consistent theme of their involvement throughout the Policy Memorandum.

152. The Committee notes the difficulties (which also apply to the third sector, as discussed in a previous section) of specifying the involvement of non-statutory bodies on the face of the Bill. Nevertheless, the Committee invites the Scottish Government to consider whether anything further can be done by way of amendment to provide carers and carers’ organisations with reassurance that their involvement in the design and production of future integrated services is guaranteed.

153. The Committee also invites the Scottish Government to consider the proposal from the Scottish Health Council that a single standard for participation, linked to a national outcome, be developed.

Quality and scrutiny
154. A number of submissions received by the Committee raised issues related to quality. The Royal College of Nursing Scotland submission, for example, argued that “quality and safety should be paramount, and deserve to be embedded in the heart of the primary legislation, not left to regulation or guidance alone.” The RCN went on to say that it was concerned that the Bill was “too lightly focused” on “ensuring robust assurances of care quality and safety in this new landscape”. It argued that “primary legislation should set the core foundations of reform, which secondary legislation, guidance and practice can build upon”, noting, however, that quality in care services had not been “included in the key principles of integration in the published Bill”\textsuperscript{117}.

155. This viewpoint was echoed by other respondents who also noted the absence of mention of scrutiny or quality in the Bill. CCPS commented that “the Bill makes no reference to any requirement for independent scrutiny of integration authorities in respect of quality, performance or the achievement of national outcomes”\textsuperscript{118}. The Scottish Independent Advocacy Alliance argued that “there needs to be more attention given to quality assurance so that there is greater

\begin{itemize}
  \item[115] Scottish Parliament Health and Sport Committee. Official Report, 24 September 2013, Col 4308
  \item[116] Policy Memorandum, paragraph 96.
  \item[117] Royal College of Nursing. Written submission.
  \item[118] CCPS. Written submission.
\end{itemize}
clarity and transparency about when principles are being adhered to and when they are not and when outcomes are achieved or not.\textsuperscript{119}

156. Parkinson’s UK argued that it was “essential that integrated services are planned and commissioned on the basis of quality, and not just cost.”\textsuperscript{120}

157. Addressing some of these concerns in its submission, Health Improvement Scotland (HIS) stated that it was “working with the Care Inspectorate to develop a joined-up approach to scrutiny and test a new methodology for integrated inspection of the care of adults, and will ensure that any new arrangements support the Bill’s approach.” Furthermore, HIS noted “we believe that integrated services must also be supported by a single set of standards across health and social care and would welcome progress with the review of the National Care Standards, to ensure aspects such as dignity are central to the patient experience, no matter where the care is delivered.”\textsuperscript{121}

158. Audit Scotland was supportive of “the introduction of a core set of national outcome measures and the requirement on partners to jointly plan and use their resources to best meet local needs.”\textsuperscript{122}

159. The Committee notes that work on developing quality assurance is being taken forward by the Care Inspectorate, Healthcare Improvement Scotland and others. The Committee looks forward to receiving details of this and calls on the Scottish Government to provide an update in its response to this report.

160. The Committee is sympathetic to the arguments put forward by the Royal College of Nursing and invites the Scottish Government to consider whether quality care principles should be embedded within the integration principles set out in the Bill. .

161. The Committee would also welcome clarification from the Cabinet Secretary on how it is anticipated that the nationally agreed outcome measures will articulate with existing frameworks such as Single Outcome Agreements (SOAs) and HEAT targets.

Complaints

162. Written evidence received by the Committee noted the absence of reference within the Bill to complaints procedures. The submission from Carers Scotland was typical of the comments received—

“We reflect concerns from other third sector partners over the lack of reference to formal complaints procedures within the Bill. Both local authorities and health boards currently have their own complaints procedures and processes and we believe that one complaint procedure should be

\textsuperscript{119} Scottish Independent Advocacy Alliance. Written submission.
\textsuperscript{120} Parkinson’s UK. Written submission.
\textsuperscript{121} Healthcare Improvement Scotland. Written submission.
\textsuperscript{122} Audit Scotland. Written submission.
introduced for integrated partnerships to avoid confusion for people who use services and carers.”

163. Youthlink Scotland’s submission noted that the integration of services would “presumably lead to the merging of three different complaints mechanisms”. It added that, whatever system was decided upon, it was important that means of complaint and redress were “accessible, local, and young-person friendly, so that problems can be resolved quickly and easily”.

164. Other bodies that expressed similar views included the Scottish Independent Advocacy Alliance, Enable Scotland, Parkinson’s UK, the Health and Social Care Alliance and Citizens Advice Scotland.

165. In oral evidence to the Committee, the Scottish Public Services Ombudsman (SPSO) questioned the lack of integration of complaints processes. Integration will see closer working between different entities with the aim of the service user experiencing a seamless delivery of health and social care, yet there are currently no firm plans for complaints procedures to be integrated too. Jim Martin, the Ombudsman, said the Bill “does not deal with situations where an individual is unhappy about the outcome they receive and does not address the complexity of complaints processes in place in this area”. He added—

“If we want to get the system to join up, we have to ensure that it is as easy as possible for people, when things go wrong, to get holistic solutions to the holistic problems that they face. The need for standardisation is there.”

166. The Ombudsman’s position was endorsed by Annette Bruton, Chief Executive of the Care Inspectorate. She noted that the advantage for people of the current complaints system in social care was that, when the Care Inspectorate carries out a complaint investigation, it prompts an inspection. This means that when someone complains to the Care Inspectorate about, for example, the care that their mother is receiving in a care home, it can not only investigate the complaint but, depending on its seriousness, immediately go ahead and inspect the home. She concluded that it was—

“not simply a case of having a coherent, joined-up complaints system that is systemically different from what we have now. We need to be able to use complaints to get immediate solutions to people’s problems.”

167. In oral evidence, HIS noted that there would be a challenge in merging complaints processes, particularly those of the Care Inspectorate and that of the Ombudsman (which deals with clinical care complaints), but noted their intention to conduct further work in this area, including undertaking pilot exercises of potential complaints systems.

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123 Carers Scotland. Written submission.
124 Youthlink Scotland. Written submission.
168. Audit Scotland and the Information Commissioner’s Office raised concerns surrounding legal entity when it comes to complaints, with differences in accountability between the body corporate and lead agency models of integration.\textsuperscript{128} Citizens Advice Scotland also voiced its concerns over the lack of reference to public feedback mechanisms, including complaints, within the proposals.\textsuperscript{129}

169. The Committee questioned the Cabinet Secretary on this issue, who said that the Scottish Government had “a stream of work on exactly the issue of establishing a complaints procedure that is fit for purpose”. He said he did “not anticipate needing a big change in primary legislation”\textsuperscript{130}. A working group was looking at this issue and was expected to report by the end of the year.

170. The Committee agrees with witnesses that there is a need for a streamlined complaints system that will be easy for users to access and navigate and will be able to be used across the integrated health and social care landscape.

171. It is noted by the Committee that a Scottish Government working group is working on this subject and is expected to report by the end of the year. The Committee looks forward to receiving and considering this report in due course.

Human rights and advocacy

Human rights

172. A number of responses called for the Bill to take a human rights-based approach, with human rights principles as an integral part of the legislation. Some referred the Committee to the guiding principles on public sector reform included in the report of the Commission on the Future Delivery of Public Services (the Christie Report). This report notes that “a first key objective of reform should be to ensure that our public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience.”\textsuperscript{131}

173. In its submission, for example, the Health and Social Care Alliance Scotland called for “a set of human rights based principles at the start of the Bill, or amendments to the existing principles so that they more strongly reflect an outcomes approach, rather than a needs-based approach and co-production/asset-based approaches rather than a professional/provider-led agenda.”\textsuperscript{132}

174. The Scottish Association for Mental Health (SAMH) spoke of “a rights-based culture as part of the new joint working, which would require a more person-
centred approach”. SAMH and others also raised the discrepancy between health (free at the point of need) and some social care services which are charged for. Inclusion Scotland called for “a human rights based social model of care”\textsuperscript{133}.

175. Participants at the event hosted by the Lothian Centre for Independent Living (LCiL) also argued strongly for the embedding of human rights within the legislation. This had been based on one of the so-called “5 asks” (statements of principle that had resulted from consultation that LCiL had undertaken) the first of which was that “independent living, equality and human rights should be explicit in the principles and outcomes of health and social care integration”.

176. The Policy Memorandum argues that the Bill “does not give rise to any issues under the European Convention on Human Rights”. It goes on to say—

“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.”\textsuperscript{134}

177. The Committee notes the comments of some witnesses regarding the embedding of human rights principles within legislation. The Committee also notes that it received similar representations during its Stage 1 scrutiny of the Social Care (Self-directed Support) (Scotland) Bill. In response to the Committee’s Stage 1 report, the Scottish Government agreed to consider the issue further, and subsequently brought forward amendments requiring that local authorities take reasonable steps to facilitate the principles that the rights (of a person choosing one of the SDS options) to dignity and to participate in the life of the community were to be respected. These principles are drawn from Article 27 of the United Nations Universal Declaration of Human Rights.

178. The Committee accepts that all legislation passed by the Scottish Parliament requires, under the Scotland Act 1998, to be fully compliant with the European Convention on Human Rights. Nevertheless, the Committee invites the Scottish Government to consider whether there might be an appropriate way of amending the Bill to ensure that human rights principles are more explicitly stated in the text of the Bill.

\textsuperscript{133} Scottish Association for Mental Health. Written submission.
\textsuperscript{134} Policy Memorandum, paragraph 171.
Advocacy

179. Submissions from Leonard Cheshire Disability and the Scottish Independent Advocacy Alliance called for consideration to be given to advocacy in the design and provision of care and support.

180. The Scottish Independent Advocacy Alliance argued that the Bill “should include a right of access to independent advocacy in the same way as identified in the Mental Health (Care and Treatment) (Scotland) Act 2003”.

181. Leonard Cheshire Disability said that research it had carried out had shown that people with learning disabilities often felt misunderstood or not listened to when accessing services. It urged the Committee to consider the need for advocacy in the design and delivery of care and support.

182. A similar point was made by Voices Of Experience Scotland (VOX), which said that in its view, “the approach does not sufficiently address the need for the voice of the individual service user to be heard or make provision for the advocacy support that will be vital in order to ensure that while these changes take place the individual has a strong voice in their care arrangements”.

183. None of the witnesses who gave oral evidence to the Committee made any specific reference to advocacy, which makes it difficult for the Committee to comment.

184. While the Committee recognises the value of independent advocacy in some circumstances, it thinks it probably unlikely that it will be required by the majority of patients and service users who will be impacted by the provisions of this Bill. In this sense, it does not necessarily seem appropriate to follow the example of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Involvement and engagement of GPs

185. Throughout the Committee’s Stage 1 inquiry, and during its fact-finding visits, reference was frequently made to the need to involve and engage GPs in the new integrated arrangements, if they were to be a success. It was suggested that one of the reasons that community health partnerships had not been as successful as had been hoped was because GPs were insufficiently engaged with them.

186. Glasgow City Council, in its written evidence, noting that the Bill requires partnerships to engage with health professionals, argues that this, in itself, “is not sufficient to ensure that GPs for instance will engage effectively given the independent status of that group of professionals”. It goes on to say, from experience of CHCPs in Glasgow, that “integration works best when GPs and other stakeholders are engaged effectively”. Merely requiring in law, it says, that health and social care partnerships must work with GPs, carers, the voluntary and independent sector within a locality planning framework “will not of itself deliver the policy objectives when there is no expectation set out on these stakeholder groups

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135 Leonard Cheshire Disability. Written submission.
136 Scottish Independent Advocacy Alliance. Written submission.
137 Voices Of Experience Scotland. Written submission.
to participate and work collegiately for the greater good”. The Council concludes that, with one third of total spend on older people’s services being accounted for by unplanned admissions to hospital, “clearly, without effective GP engagement, attempts to keep people in the community as opposed to within a hospital setting will be hindered. It “cannot be stressed enough that the inclusion of GPs within the legislation is vital if the overall objectives of the Bill are to be achieved”\(^{138}\).

187. Peter Gabbitas of the City of Edinburgh Council told the Committee that as somebody who was responsible for Edinburgh’s CHP for many years, he did not think that he and his colleagues had “effectively harnessed the hearts and minds of GPs in Edinburgh”\(^{139}\). He said he recognised that failing and the need to address it—

“...We are doing specific things locally to try to do that, not least of which is the move back to a locality infrastructure with clearly identified managers to whom GPs can relate in a geographical area that makes sense to them. That builds on what we used to have, going back a while, when there were local health care co-operatives.”\(^{140}\)

188. The “agendas”, in relation to integration, need to be locally relevant to practice populations, according to evidence presented by Allan Gunning of NHS Ayrshire and Arran. He gave an example of a GP who said GPs know that there is “necessary bureaucracy in the running of public services, and all of that can go on”\(^{141}\). He went on—

“However, what they want to see on the agenda is a debate about issues such as the quality of the incontinence service. That GP said that such things are real to them and that, if they can spend their time shaping that agenda, it will be worth engaging.”\(^{142}\)

189. A similar point was made by Robbie Pearson, Director of Assurance and Scrutiny at Healthcare Improvement Scotland. He told the Committee that, in developing health and social care integration, it was “crucial” that “we bring together elements such as GPs in local communities”. The increasing engagement of GPs in this agenda, he said, would be “a marker of success in the future”, whereas this had “not been so robust with the community health partnerships”\(^{143}\).

190. Some of the Committee’s witnesses noted that, while the involvement of GPs was highly desirable, it could mean taking them away from the provision of essential services.

\(^{138}\) Glasgow City Council. Written submission.
191. Soumen Sengupta of West Dunbartonshire Community Health and Care Partnership remarked that an “interesting conversation” was to be had with the BMA and others about the GP contract nationally and “how we create a set-up that obliges all GPs to be part of the discussion, so that it does not include only the ones who are interested in a particular area”. That, he said, posed “certain challenges, because those staff are colleagues who provide services, so the more involved they are in the ‘management’ of the service, the less time they have available to be part of service delivery”\textsuperscript{144}.

192. Peter Gabbitas of the City of Edinburgh Council raised the issue of the balance between what can be decided locally and what is determined through national negotiation. Peter Gabbitas told the Committee that although there had been a recent move from a (UK) national contract to a Scottish contract, the change had been “around the margins, because it is still a national Scottish contract and the number of things that we can determine locally is minimal”. He said that if the balance between what is determined nationally and what is up for local negotiation were reversed, that would “put health and social care partnerships into a much stronger relationship with primary care, because we could pull a lot of levers that we do not currently control”\textsuperscript{145}.

193. Mr Gabbitas acknowledged that the BMA would probably be “horrified at the thought of moving away from a national contract”. It would, however, make an “enormous difference” – even “a bit of change in the balance between the money that is determined at national level in the contract and what can be determined locally, with, for example, an 80:20 split, with 20 per cent determined locally” would “create a reason to get very active with primary care”\textsuperscript{146}.

194. The BMA’s written submission to the Committee set out its support for the fundamental principles of the Bill—

“Integrating health and social care successfully is a huge problem that has troubled past and present administrations in Scotland, but so far none has come up with a solution to the systemic problems that exist within the health and social care sectors. BMA Scotland hopes that this legislation will establish a robust vehicle for successful integration, and its broad objectives are in line with this. There is shared desire among everyone involved in the patient journey to provide high quality, seamless care wherever that care is provided, be it in hospitals, GP surgeries or in a patient’s home. The Bill is clear in its intent to drive this initiative forward, and it is appropriate that the fundamental principle throughout is to improve the wellbeing of recipients.”\textsuperscript{147}

195. The BMA also argued in its submission that (according to a 2012 BMA survey) doctors believed that collaborative cultures with shared values, good professional relationships and effective leadership were essential if integration was

\textsuperscript{147} BMA Scotland. Written submission.
to get off the ground. It also argued that these elements were also vital to securing improved clinical outcomes and better patient experiences, which it saw as key measures of success of efforts to integrate. This collaborative approach, the BMA said, would “need to be sufficiently robust in order to ensure that shared services deliver what is most needed by the local population”, citing a 2007 BMA survey, which had indicated that “the lack of influence of CHPs” was “a key factor in doctors’ disengagement from this structure". In that survey, two-thirds of respondents had considered the "lack of effective communication between CHPs and general practice to be a barrier to effective GP engagement" while 48.7 per cent of respondents had considered “the lack of financial support to allow effective GP/practice staff engagement with CHPs to be a barrier to effective GP engagement”. The submission also noted that the 2011 Audit Scotland report had highlighted the lack of engagement of GPs as “a key factor in the failure of many of these organisations”, concluding that “unless this is explicitly addressed during the legislative process, then there is a risk that the failures will be repeated”\textsuperscript{148}.

196. Many of the points made by the BMA were echoed in the oral evidence given to the Committee by the Royal College of General Practitioners Scotland (RCGP): Like the BMA, the RCGP set out its broad support for the general principles of the Bill. Its representative Dr John Gillies told members—

“First, in RCGP we believe that legislation is absolutely necessary, welcome and overdue. We have increased and appropriate expectations of health and social care because of the demographic shift to a more elderly population, the rise in complex conditions, multimorbidity among patients with long-term conditions and the deprivation in Scotland. We do not, however, have a health system or a social care system that is designed to address those problems. The bill should go some way towards addressing that.”\textsuperscript{149}

197. The RCGP made points similar to those raised by the BMA in relation to the support that would be required by GPs and other independent contractors in order to be able to participate fully in the new arrangements. He told the Committee that if a GP had to leave their practice for an afternoon to attend a group, they would need to be replaced by a locum. Such support arrangements, he said, needed “to be considered when we think about how we contribute to the future”. If the system was to function properly, he said, GPs would “have to be supported to attend the meetings” and it was “important to include provision for that”\textsuperscript{150}.

198. Dr Gillies, in common with representatives of other professions, also raised the question of capacity. He argued that “doing more in the community and adding responsibilities to those of clinicians, doctors and nurses in the community” would “have to be carefully thought through if it is to work”\textsuperscript{151}. There would, he said, be “no point in saying that we need to look after more people in the community” without having the clinical capacity (including AHPs) “to deal with the resulting

\textsuperscript{148} BMA Scotland. Written submission.
workload‖. The RCGP believed that while innovative ways of working, including virtual wards, could be used to develop capacity, there was “a need to increase the number of GPs to deal with demographic change”\textsuperscript{152}.

199. The report to the Committee from the Local Government and Regeneration Committee welcomed “all moves towards co-location of services recognising local solutions are required to meet local needs.” It also quoted written evidence from GPs at the Deep End, which stated that “general practice is the main public service that is in regular contact with virtually the whole of the general population … These intrinsic features make general practices the natural hubs around which integrated care should be based, with groups of general practices supported, within the context of local service planning, to deliver integrated care in partnership with secondary care, area-based NHS services, social work and community organisations.”\textsuperscript{153}

200. The Committee raised the question with the Cabinet Secretary of engagement of GPs. He said that GPs, along with the third and independent sectors, would “be embedded in the process as key stakeholders in shaping the redesign of services”\textsuperscript{154}. Comparing the current legislation with the experience of CHPs, he said that “a lot of enthusiasm is out there, because people realise that we are serious this time”\textsuperscript{155}. He went on—

“…We are going to do this—there will be a law—and people will have no other option, so integration will have to be done.”\textsuperscript{156}

201. In relation to what had been learned from the experience of CHPs, he said—

“Two mistakes were made with the CHPs. One was that they were made sub-committees of health boards. The other was that integration was not a statutory requirement; it is only now becoming a statutory requirement. That is why the disillusionment set in.

“Every medical professional—such as doctors, nurses and particularly community nurses—whom I have met has been utterly signed up to integration. We will make absolutely sure in guidance that, at the locality level and the partnership level, all the key people—the stakeholders who need to be involved and not just consulted—are involved.”\textsuperscript{157}

202. The Committee notes the evidence it heard about the importance of GPs being fully supportive of and engaged with the proposed arrangements for the integration of health and social care. Along with all its witnesses, the


\textsuperscript{153} Scottish Parliament Local Government and Regeneration Committee. \textit{Committee Memorandum on the Children and Young People (Scotland) Bill and the Public Bodies (Joint Working) (Scotland) Bill}. Available at: \url{http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/LGR_Committee_memorandum_on_SP_Bill_27_and_SP_Bill_32.pdf} [Accessed 28 October 2013]


Committee accepts that this will be absolutely vital if integration is to be successful in the longer term.

203. The Committee also notes the Cabinet Secretary’s comments about the lessons that have been learned with the experience of CHPs, the statutory basis that the new arrangements will have and the commitment that GPs, along with other professionals and the third and independent sectors will be “embedded” in shaping the redesign of services and seeks further clarification about how this will be achieved.

204. There was some evidence, however, from the doctors’ organisations that there is no spare capacity within the GP system to allow participation in planning and design of the new integrated arrangement without arrangements being made to cover, for example GPs attending meetings. The Committee invites the Cabinet Secretary to consider this point in more detail and report back to it on what arrangements the Scottish Government proposes in order to address this issue.

205. The Committee notes the Cabinet Secretary’s announcement on 5 November 2013[158] that the Scottish Government intends to “modernise” the GP contract as part of a review of access to GP practices across Scotland, which is to be undertaken in partnership with the BMA Scotland. The Committee calls on the Cabinet Secretary to consider what role the revised contract can play in encouraging or helping GPs to play a full role in the integration process.

206. The Committee also notes that there is provision at section 26(4) of the bill for the integration board to pay to members of the consultation group, established as part of the strategic planning process, such expenses and allowances as it determines. The Committee invites the Scottish Government to consider whether this provision could helpfully be extended to cover participation in the locality planning process.

Strategic plans

207. The Policy Memorandum notes that “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”[159]. The Policy Memorandum further notes the 2012 Audit Scotland report Commissioning Social Care, which was “critical of commissioning skills in Scotland”[160] and subsequent reports by the Parliament’s Public Audit Committee and Finance Committee, which called for there to be a requirement for each of the proposed social care partnerships to produce a long-term joint social care commissioning strategy and for the Scottish Government to respond to Audit Scotland’s findings respectively. The Bill, therefore, lays considerable stress on

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[159] Policy Memorandum, paragraph 117.

[160] Policy Memorandum, paragraph 118.
the importance of strategic commissioning. The Policy Memorandum states that the Scottish Government believes that through the strategic commissioning process “the required shift in the balance of care will be achieved”. It is, it argues not “a low-level or peripheral service planning activity” but 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”\(^{161}\).

208. Under the Bill, integration authorities (integration joint board or health board and/or local authority in a lead agency arrangement) would be required to produce a strategic plan (strategic commissioning plan), which would set out how they would plan and deliver services for their area over a period of three years. According to the Policy Memorandum, guidance would also set out that strategic plans would also be expected to plan for the longer term (10 years). The Policy Memorandum goes on to say that the roles of clinicians and care professionals and the “full involvement of the third and independent sectors, service users and carers” would be “embedded as a mandatory feature of the commissioning and planning process”. This, it says, will “strengthen the cross-sector arrangements that have been established during the first two years of the Change Fund”\(^{162}\).

209. The Bill’s proposals in regard to strategic plans were broadly welcomed in almost all the written evidence. NHS Lanarkshire, for example, describing the strategic planning proposals as “key strength” of the bill said that the approaches in the Bill around joint strategic planning “afford the opportunity to strike the right balance and flexibility to meet specific local priorities”\(^{163}\). NHS Dumfries and Galloway also saw the “focus on an agreed strategic plan that sets out how the partnership will deliver agreed outcomes, and ensuring accountability for delivery, coupled with local reporting these provisions”\(^{164}\) as a key strength. The submission from Midlothian Council suggested that the Bill’s provisions would be “helpful in encouraging the focus to be on improved joint working and on effective joint strategic commissioning with the objective of improving outcomes for users and carers”\(^{165}\), while Scottish Borders Partnership supported “the focus on outcomes and the approach to strategic planning”\(^{166}\).

210. CCPS welcomed the emphasis on strategic planning “as a driver for change” and noted that it was “enthusiastic about the potential of joint strategic commissioning to begin to reorient investment and activity towards the achievement of outcomes for communities and individuals”\(^{167}\).

211. Healthcare Improvement Scotland welcomed both the strengthened role clinicians and social care professionals would have in strategic commissioning and that strategic plans should “assure that sound clinical and care governance is embedded”\(^{168}\). However, the BMA, in acknowledging the development of strategic plans as a “first crucial step towards integrating health and social care services”

\(^{161}\) Policy Memorandum, paragraph 119.
\(^{162}\) Policy Memorandum, paragraph 120.
\(^{163}\) NHS Lanarkshire. Written submission.
\(^{164}\) NHS Dumfries and Galloway. Written submission.
\(^{165}\) Midlothian Council. Written submission.
\(^{166}\) Scottish Borders Partnership. Written submission.
\(^{167}\) CCPS. Written submission.
\(^{168}\) Healthcare Improvement Scotland. Written submission.
also stated that it would “welcome greater clarity on how the role of clinicians in the strategic commissioning of services for adults will be strengthened”. It also argued that there must be “a robust system in place to guarantee the opportunity for meaningful engagement with professionals in the planning of services”.  

212. In oral evidence, there was also a broad welcome for the strategic planning proposals. Ron Culley of COSLA told the Committee local authorities wanted to “invest their time and energy in the commissioning agenda” to “make local partnerships the bedrock of that agenda in order to ensure that we can use the resource differently in a very difficult financial context”. Alan Gunning of NHS Ayrshire and Arran, noting that the strategic planning proposals had “echoes of a return to the internal market for the NHS” went on to say that joint strategic commissioning was “really designed to bring about improvement by assessing needs, determining the best way to meet them and ensuring that the required services are delivered”.

213. Alan Gray of NHS Grampian stressed to the Committee the importance of spending sufficient time on the planning process. He said—

“It will take time to work through. The plan is strategic and it will have to have a horizon of five to 10 years. The important thing is that we do not rush into making short-term decisions but, instead, take the time to work out how to redesign our current healthcare system to meet the future demands that we are all facing. We need to change the way in which hospital services are organised.”

214. A number of witnesses touched on the challenges posed by the need for service redesign and disinvestment. Rachel Cackett of the Royal College of Nursing, for example, told the Committee—

“Strategic commissioning is a powerful process that will involve making decisions about investment and disinvestment, and assurance will be needed that any care that is commissioned is safe and of good quality. The link from that to the governance boards and back up to the partner agencies will ensure, similarly, that we have good-quality care that is delivered by the right people in the right place in accordance with the needs that have been identified.”

215. The Committee welcomes the proposals in the Bill for strategic planning and the commitment in the Policy Memorandum to the full involvement of the third and independent sector carers, patients and service users. It notes that the initial plan that is to be produced by integration authorities will cover a period of three years and that the Scottish

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169 BMA Scotland. Written submission.
Government will, in due course issue guidance in respect of longer term planning.

216. The Committee also recognises that a key part of the strategic planning and commissioning process will be the redesign of services, which may involve relocation or reprioritisation of resources under any new arrangements that might be agreed. This is likely to be challenging.

Locality planning

217. The Bill provides, at section 23(3) that strategic plans produced by health and social care partnerships must include provision for dividing the area of the local authority into two or more localities, and setting out separately arrangements for the carrying out of the integration functions in relation to each such locality.

218. The rationale for this is set out in some detail in the Policy Memorandum. It argues that – in line with the renewed emphasis on integration at the local level following the Christie Report – some aspects of service planning can operate more effectively and efficiently at a more local level than the integration authority itself.

219. The Policy Memorandum goes on to say that this locality planning should be led by and actively involve professionals, including GPs, acute clinicians, social workers, nurses, allied health professionals, pharmacists and others and that the active involvement of such professionals will be key to success. It is also intended include carers and users of health and social care services. In order to achieve maximum benefit for patients and service users, it says, 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.174

220. No model of locality planning is prescribed in the Bill, as it is considered by the Scottish Government that local arrangements are best developed and agreed upon locally. However, the Policy Memorandum indicates that the Scottish Government would expect, in due course, 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”175.

221. The written evidence received by the Committee was broadly welcoming of the idea of locality planning. NHS Dumfries and Galloway identified the “locality focus that delivers the agreed strategic aims in a way that makes sense locally and which takes account of different local contexts”176 as a key strength of the Bill. The focus on locality planning was also welcomed by the Scottish Borders Partnership177 and by South Ayrshire Council, which described it as “an important aspect of the Bill”. Many others also supported the principle.178

174 Policy Memorandum, paragraphs 124-125.
175 Policy Memorandum, paragraph 129.
176 NHS Dumfries and Galloway. Written submission.
177 Scottish Borders Partnership. Written submission.
178 South Ayrshire Council. Written submission.
222. North Ayrshire Council noted that one concerning aspect was “the need to balance the views and influence of all interested groups so that one group does not dominate others”. This, it said, would “be challenging given the range of interested groups”.

223. The Coalition of Carers in Scotland, noting that the Bill’s Explanatory Notes indicated that, through secondary legislation, integration authorities will be required to fully involve the third sector as key partners in strategic commissioning, locality planning and service delivery activity, also note that no such commitment is made in respect of carers.

224. NHS Education for Scotland argued that the relationship between national and locality planning “may require to be strengthened in order to ensure efficiencies across the sector on a national basis can be achieved”.

225. The BMA raised an interesting point—

“the BMA believes that it would be essential for localities to have budgetary authority if they are to genuinely influence the provision of services locally. We would therefore welcome more information on the government’s intentions as to how authority would be delegated between the Joint Integration Boards and the locality structures”.

226. Audit Scotland’s written submission noted that the Bill “provides little detail about how locality arrangements might work in practice” and concluded that “there needs to be a real contribution from professional staff groups to informing how resources are used and services improved”.

227. The oral evidence taken by the Committee provided a similar picture, with most witnesses welcoming the idea of locality planning. Allan Gunning, of NHS Ayrshire and Arran, for example, said—

“Finally, the third point of principle relates to the statutory underpinning for locality planning, which I think will be particularly important for health. Planning for place has not always been deeply embedded in the NHS planning process—we tend to look at disease classification, age or whatever. As we know, however, many of the challenges that face us relate to people with co-morbidities and complex needs who do not fall into the neat planning categories that we might have used in the past. I see a powerful model for locality planning that will build up a picture of and assess local needs and which will create the opportunity for a different type of relationship between public services, the other partners that I have mentioned and the communities that they serve. That will in turn flow into a coherent strategic

179 North Ayrshire Council. Written submission.
180 CCPS. Written submission.
181 NHS Education for Scotland. Written submission.
182 BMA Scotland. Written submission.
183 Audit Scotland. Written submission.
plan that will spell out the intended changes and a performance regime that
will monitor whether those changes are actually being delivered.”

228. Jeff Ace of NHS Dumfries and Galloway argued that the NHS had
“centralised” its decision making over the past five years or so, and integration
would provide “a critical mass back at the locality and community level so that we
can start to reverse some of that decision-making power and bring our general
practitioner community in particular strongly into the process.”

229. Rachel Cackett of the Royal College of Nursing, although acknowledging that
locality planning was “a key issue”, argued that the Bill was “fairly sketchy about it”
and suggested that professionals did not “entirely understand how it will work in
practice”. However, she disagreed that locality planning was the best way for
professions to get involved. She said—

“Although it is very important that those with local knowledge on the ground—
the service providers and those who are using the service—are engaged in
development, we must understand how the process fits in with the joint
strategic commissioning process … Locality planning is key, and especially
important in ensuring that there is wide involvement, but if it becomes the
only focus for involvement we will start to miss out on assurance
mechanisms and the important strategic oversight of professionals and
others in supporting the governance of the new bodies.”

230. Dr John Gillies of the RCGP noted that while most people who worked for
local authorities and health boards were employees, most general practitioners
and some other community providers, including pharmacists, were contractors
who worked for the national health service according to a contract, but were not
employees. He explained how this might affect their ability to take part in locality
planning—

“When one considers how GPs, pharmacists and other primary care
contractors will contribute to the new arrangements, it is important to
remember that they will need additional support. If a GP has to leave her
practice for an afternoon to attend a group, she will have to be replaced by a
locum. Such support arrangements need to be considered when we think
about how we contribute to the future. Many of those issues are covered in
the “All Hands On Deck” report, which was produced for the joint
improvement team. If the system is to function, GPs will have to be supported
to attend the meetings. It is important to include provision for that.”

231. From the trade union perspective, Dave Watson of UNISON told the
Committee—

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On locality planning, we need to see the detail. Part of the problem with locality planning in Scotland has often been that it has not been very local. In other words, there are genuine localities, but services have not drilled down to those levels, largely because local authorities and health boards are very large—there are those who argue that there should be fewer such bodies, but we are not among them; we have the largest such organisations in Europe.188

232. Alison Taylor, a Scottish Government official supporting the Cabinet Secretary at Committee explained why the Bill was not prescriptive about locality planning—

“As you can see from the bill, we have not set out a prescriptive process on locality planning. That is in direct response to what we were told by stakeholders and partners, particularly those who were already doing something like locality planning well. It would be difficult to find two examples that are particularly similar, as there is huge local variation in how locality planning works, who exactly is around the table—that can depend on the balance of local need—how often they meet and what sorts of decisions they look at. The onus was very much on us to encourage the development of local innovation and not to be prescriptive.”189

233. The Committee notes the evidence it received about locality planning, almost all of which was positive albeit with a few caveats.

234. The Committee is also fully supportive of the idea of locality planning, which will be essential if services are to redesigned in a bottom-up way that engages individuals and local communities in a flexible way that delivers the best possible outcomes for patients and other service users.

235. It is recognised that the Bill provides little detail on how locality planning will work in practice and is not prescriptive about the model to be used. The Committee understands that this is a cause for concern among some of its witnesses. However, the Committee accepts the Scottish Government’s argument that it is important that there is a high degree of local flexibility and opportunities for local areas to develop the model most appropriate to that area. There should be sufficient experience developed over the last 10 years through community planning, community health partnerships and the development of local consultation on a wide range of issues to enable partnerships to have the capacity to develop appropriate locality planning methodologies.

236. The Committee understands that work on developing methodologies for locality planning is continuing through the various working groups associated with the Bill implementation, but asks that the Cabinet Secretary respond to the Committee indicating how the principles of locality planning set out in the Policy Memorandum can be reflected in the Bill.

Financial and budgetary issues

237. The Committee was conscious, throughout its stage 1 inquiry, of the key role of financial and budgetary issues in relation to the implementation of the Bill’s provisions. Much of the thrust of the Bill is designed to provide for more efficient use of limited resources through integration and redesign of services to deliver better outcomes for individual patients and provide better value for the public funds that are invested in these services. Clearly, integration suggests a need for some degree of pooling of the budgets of the relevant bodies and organisations. As integrated budgets inevitably involves both organisations in a partnership giving up a degree of budgetary control, it is always likely to be one of the potentially more sensitive areas.

238. The Committee was also aware of the tension between NHS services, which are free at the point of delivery, and care services, which need not be free. This was coupled with the tension brought about by the differences in funding and governance arrangements between local government and the NHS, with the latter directly accountable to the Cabinet Secretary and with its funding currently protected within the Scottish Government budget, and the former accountable to its own electorate and with around 80% of its funding coming directly from central government without the same degree of protection within the budget.

239. Finally, the Committee was aware of the tensions around possible transfers of funding from NHS acute services to care services and the difficulties in determining the level to be transferred.

240. These tensions were reflected in the evidence received by the Committee, as the report will go on to explore.

241. The Bill was also scrutinised by the Parliament’s Finance Committee, which reported to the Committee. The contents of the Finance Committee’s report are also considered in this section of the report.

Cost creep

242. Parkinson’s UK raised the issue of ‘cost creep’ with the Committee. It said it had “very particular concerns about issues arising from integrating free, universal NHS Services with means tested social care that is subject to eligibility criteria”.190 This echoed previously expressed concerns over NHS Continuing Care, where it appeared that many people had been obliged to pay for social care to meet health needs which ought to have been funded by the NHS. The submission went on to argue that the Bill could “have the unintended consequence of expanding the problem to much larger numbers of people, who could find themselves having to pay for services that they are entitled to have funded by the NHS”. Parkinson’s UK was concerned that this was particularly likely to affect people with progressive neurological conditions and those with conditions, including Parkinson’s, which most commonly affect older people.

243. These concerns were echoed by the Health and Social Care Alliance, whose submission argued that “people with progressive neurological conditions like

190 Parkinson’s UK. Written submission.
Parkinson’s could be at high risk of ‘cost creep’ when means tested, chargeable social care services are merged with NHS services that are free of charge.\textsuperscript{191}

244. This issue was of particular concern to the independent living movement. Pam Duncan of Independent Living in Scotland) told the Committee that disabled people and their organisations believed that to charge people for a service such as community care, which was “so crucial to their independence and their human rights”, was “unfair and unparalleled” adding that “we do not charge anyone else for the privilege of enjoying their human rights in the same sense”\textsuperscript{192}.

245. She went on to say—

“we believe that the issue needs to be addressed in the bill, not least because of that unfairness, but also because of the bureaucracy and the difficulties around how we are going to tell which parts of the budget are chargeable and which are not. None of us wants people to start charging for services that people would ordinarily have got from the NHS for free; equally, we do not want people to continue to have to pay for social care when, without it, they could not possibly participate in society.”\textsuperscript{193}

246. Members of the Committee also heard similar concerns expressed when they visited Lothian Centre for Independent Living. According to the evidence from Independent Living in Scotland, the amount that is collected in charges for social care approximately £50 million across Scotland. Pam Duncan remarked that although this was “in the grand scheme of things” was “not a huge amount of money”, the charges could represent up to 100 per cent of a disabled person’s income.\textsuperscript{194}

247. The Committee notes the concerns expressed in written and oral evidence about the potential for “cost creep” and the possibility that, were this to happen, it would be likely to affect certain groups of patients and people disproportionately. The Committee recognises these concerns and invites the Scottish Government to indicate what measures it proposes to take to reassure these groups and individuals who might be most likely to be affected by cost creep.

248. The Committee will also wish to continue to monitor this issue as the implementation of the Bill, when enacted, is rolled out.

\textit{Budgets}

249. The Policy Memorandum sets out that in the body corporate model (expected to be adopted everywhere except Highland) the joint board, under the leadership and direction of its chief officer, would manage the integrated budget and integrated planning and delivery of services. Under the lead agency model,

\textsuperscript{191} Health and Social Care Alliance. Written submission.
functions and resources would be delegated to each other between the local authority and health board, for delivery of services. In both cases, the integration plan would include details of the method of calculating money to be delegated to support delivery of the functions.

250. The current expectation is that, under the body corporate model, the joint board would not employ any staff to deliver services (although there are provisions within the Bill to allow the joint board to employ staff in the future) – the delivery staff would either remain in the employment of the health board or local authority (or in third and independent sector organisations) – but the joint board would be responsible for negotiating agreement between the partners the level of resources required to deliver the services agreed in the plan and for developing the pooled or integrated budgets required to support these services.

251. Alison Petch of IRISS made an interesting general point in relation to the budget provisions in the Bill—

“An area in which I wonder whether the bill could be much stronger is budgets, because budget pooling will be critical to much of what we are talking about. With the best will in the world, we know that budget pooling is what sends people back to their little territories to try to protect their boundaries. I noted that some of the submissions to the committee express concern about protecting health budgets.”

252. Representatives of the third sector and carers expressed concern about the possibility of local authorities and health boards seeking to minimise the contribution they would make to the integrated budget. Nigel Henderson of CCPS, for example, told the Committee that his organisation worried that the Bill might create a whole new infrastructure that “might have very little control over very little money”. He concluded that there needed to be “more prescription about what money should be allocated to the joint health and social care partnership fund.”

253. He went on to say—

“Somewhat tongue in cheek, we put forward the notion that the Government should surely practice what it preaches. It currently has an NHS budget and a local government budget. Should it not start out with an integrated budget? You therefore do an element of top-slicing and say, “This is the budget for health and social care partnerships. This is the budget for the health service. This is the budget for local authorities.” You therefore have a new budget line in the Scottish Parliament budget.”

“I understand that that could be very controversial, as it would be seen to take away local control and accountability and perhaps to go back to the days of ring fencing. There are dangers, because we know that if money is


ring fenced that is as much as will be spent. However, to start the process off in the way that it needs to continue, it might be a possibility to start for a period of time with an integrated budget right at the centre.”

254. Much of the evidence, particularly from the local authority sector, concentrated on three areas: the assumptions in the Financial Memorandum and the extent to which they adequately reflected the costs that would be expected to fall on local authorities; the mechanics of agreeing a budget, and the level of budgetary resource that could be diverted from the acute sector in order to support the delivery of services in the community.

255. COSLA’s written evidence included a long list of cost issues\(^\text{198}\) that it considered had not been fully taken into account in the Financial Memorandum. These included the:

- increased audit burden – £150,000 across Scotland “seems too low”.
- financial recording and reporting costs are likely to increase, irrespective of the integration model adopted.
- whether funding for the Chief Officer can be met from the current CHP General Managers’ salary.
- financial provision being made to the NHS for CHP leadership post-holders displaced as a result of the development of partnerships, but no similar resources, either recurring or non-recurring, being made available to local authorities.
- possibility of other management costs emerging within the parent bodies as a result of the restructuring caused by the formation of partnership boards.
- the anticipated recurring costs associated with ICT “seems low”.
- additional costs associated with development of financial information identified for health sector only.
- unclear whether any assumptions have been made around remuneration for Board Members.
- assumption that support services for the joint boards can be funded from existing CHP support services is “unrealistic” as not all CHPs currently have the full range of support services that will be required in the new partnerships.
- section 45 provision for extension of schemes for meeting losses and liabilities for health service bodies. COSLA has concern that this will allow NHS to carry reserves from one year to another.

\(^{198}\) COSLA. Written submission, paragraph 79.
• risks to VAT recovery and staff pay and conditions harmonisation estimated by FM as up to £32m and £27m respectively. No Scottish Government commitment to fund these pressures should they occur in future.

• Should staff transfer be required, TUPE implications may be significant and potential financial solutions may not meet TUPE regulations.

256. Many of these concerns were also reflected in the submissions from individual local authorities.

257. While the Finance Committee report made no reference to the extent to which the financial provisions in the Bill will be sufficient to cover its costs, it notes that the complexities involved in the move to integration and considers it, at this stage, “not unreasonable for there to be uncertainty as to the costs of establishing the framework for, and the delivery of, integrated services”\(^{199}\). However, the Finance Committee is “concerned” about the “level of uncertainty surrounding the estimated costs” and suggests that it will be “important for review and monitoring of the costs to be undertaken throughout the implementation”. It intends to include this as part of its “wider and ongoing commitment to monitor the delivery of the shift to preventative spending”. The Finance Committee also suggests that the Health and Sport Committee may also wish to actively monitor the cost of the implementation of the Bill by asking the Scottish Government to provide regular updates on the work of the integrated resources advisory group and on the establishment of the health and social care partnerships provided for in the Bill.

258. The Committee questioned the Cabinet Secretary on many of the funding and budgetary issues that had been raised by COSLA and others. In noting that work on many of these issues was ongoing through the Bill advisory group, the ministerial steering group, and the implementation group and associated working parties, he told the Committee—

“On funding, we have had a good discussion on the budget process this morning and we will provide an additional briefing on the mechanics of it and the flow of budget decisions. The key point is that there will be an integrated budget. We will no longer have the ridiculous position whereby for each hospital patient there is a dog fight between the health board and the local authority about who will pay when the person is discharged, which means that we end up with delayed discharge. There are a range of issues such as that one.”\(^{200}\)

259. He went on to say that he thought that, when the system had become fully operational, there would be “much more efficient and efficacious use of public funding”\(^{201}\). He thought that there would be a reduction in unnecessary hospitalisations, which would lead to better patient outcomes, and treating people


at home instead of “spending so much money on keeping them unnecessarily in the acute setting in hospital”. This, he said, would “free up resources that can be used to improve the quality of care more generally”\textsuperscript{202}.

260. **The Committee notes the comments of COSLA and others on the extent to which the cost assumptions are accurate and whether sufficient financial provision has been made.**

261. **The Committee fully accepts that the drive towards integration, although intended to deliver better outcomes for patients, is also about helping make more efficient and effective use of public funds invested in health and social care through NHS boards and local authorities. In that sense, the expectation is that, through integration, better and more efficient services will be able to be provided for approximately the same level of overall resource.**

262. **The Committee also accepts that work and discussions are ongoing on the detailed financial arrangements that will be put in place as the implementation of the Bill rolls out. The Committee agrees with the Finance Committee that it is not unreasonable for there to be uncertainties about the costs of the Bill at this stage, and also agrees with it that there will be a need for ongoing monitoring. However, the Committee also agrees with witnesses who indicated that further clarity on these matters, as the Bill progresses, would be helpful.**

263. Finally, the Committee welcomes the Finance Committee’s commitment to continue to monitor financial aspects of the implementation of the Bill as part of its monitoring of the delivery of the shift to preventative spending and its suggestion that the Health and Sport Committee also continue to monitor implementation issues as they arise.

264. **The Committee would expect to carry out this role as part of its wider, general role of scrutinising the Scottish Government and holding it to account as regards its delivery of health and sport matters, but there will be opportunities to monitor developments in more specific detail over the remainder of the parliamentary session as appropriate.**

**Transfer of resources from acute to care sector**

265. As mentioned earlier, many submissions and oral evidence comments referred to the issue of the transfer of funds between the acute and care sectors and how the level of any such transfers would be determined.

266. **The British Association of Social Workers submission argued that the “mechanisms of moving budgets” from acute health services into supporting complex chronic health and social care would “be key to achieving the objectives of this legislation”\textsuperscript{203}. A similar point was made by Carers Scotland.\textsuperscript{204} Although it recognised that it may take time for these changes to deliver savings, it said it was**


\textsuperscript{203} British Association of Social Workers. Written submission.

\textsuperscript{204} Carers Scotland. Written submission.
“unclear what mechanisms will be put in place to identify these savings and ensure that they are, over time, reinvested into integrated services, rather than being simply reabsorbed into acute health care settings”. This movement of resources, it said, was “critical to success”.

267. Similar points were made by a number of local authorities. Falkirk Council argued that further clarification was needed on what proportion of the acute budget from the NHS would be put into the partnership arrangements. South Ayrshire Council argued that the most effective use of the “total and very limited financial resources available cannot be fully addressed without partnerships having a say in how financial resources are used within the acute sector”. Without this, it said, there would “not be an end to ‘cost shunting’”.

268. The Committee took part in a wide-ranging discussion of some of these issues during one of its roundtable sessions on the Bill. Most contributors acknowledged the difficulties associated with determining which areas of acute provision might be within scope for transfer to care in the community and the fears in the acute sector that acute budgets could simply be disaggregated and reaggregated across a number of different partnerships organised in different ways across a health board’s area. COSLA was adamant that large elements of acute sector budgets should be within scope. Ron Culley told the Committee—

“We will probably want to look at unscheduled care, or what is known as the emergency pathway, because it eats up about a third of the total resource. That will be pivotal, and we need to explore what that pathway involves. It is not just about front-door and accident and emergency services, but about all the elements of our acute general hospitals that become involved, such as general medicine, psychiatry and so on. Once we begin to think about the issue in those terms, we start to see that a substantial part of the acute budget is in scope.”

269. He went on—

“It needs to be that way, however, because otherwise nothing will change. If we go through the pain of integration and nothing changes, I do not know what we will have done it for.”

270. The Committee put some of these points to the Cabinet Secretary. He was clear that Scottish Ministers did not intend to set a minimum figure or percentage for transfer—

“There cannot be a simplistic percentage cut in the acute budget that is then redirected. That is not the right way to plan ahead.

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205 Falkirk Council. Written submission.
206 South Ayrshire Council. Written submission.
The strategic commissioning role of the partnership is absolutely crucial. We already agree with COSLA that, where there is an acute budget related to the partnership’s responsibilities, how much is spent on acute care in relation to the overall responsibilities of the partnership will be very transparent. The partnership will then have the ability to influence the acute care budget.\(^{209}\)

271. The Cabinet Secretary went on to explain that a key point of the proposed changes was “substantially to increase acute care in the community”. He said that if the joint boards were not going to give some responsibility for the acute budget, that “would defeat that particular purpose of the integration agenda.” He also suggested that, because of the wide variation in responsibilities between different acute hospitals, it would not be appropriate to “think in terms of a precise percentage of the acute budget”\(^{210}\). He concluded—

“If we just said that a percentage of the acute budget should be transferred in the same way across the country, the impact of that would be extremely different in different areas, because of the different roles played by some of the bigger hospitals in particular. That is why it has to be a local decision, dependent on the configuration of acute services in each area.”\(^{211}\)

272. Kathleen Bessos, a Scottish Government official supporting the Cabinet Secretary provided the Committee with further detail on the technical aspects of how it was anticipated that integrated budgets would be developed. She said that the important thing is that “we stick with the principle that the resources that are associated with the functions that are delegated to the joint board go with the functions”. The key question, she said, then became “which aspects of acute resources lend themselves to being used in a different way”. She went on to explain that Scottish Government officials had been working closely with the chief executives of the NHS boards to unpick the complexities of how to give enough influence to change how acute budgets are used, “without introducing either incredible amounts of bureaucracy or complete chaos and confusion, with the potential for the acute service not to be able to plan coherently across their patch because they cover more than one local authority area”\(^{212}\). She concluded—

“We think that we have got a position that has been agreed with COSLA and with NHS boards on what that model looks like, so we are saying that the strategic commissioning plan must describe the money that is in scope. Within that commissioning plan there will be decisions taken by the partnership board, in discussion with the health board, the council and others, about the timeframe around which changes to acute services will happen. Those resources will then be realigned and redeployed as the commissioning plan is operationalised.”\(^{213}\)

273. She went to explain that, in the case of community acute hospitals, it would be likely that all of their budget would go with the functions and “be in the integrated pot”, so that that resource could “be used flexibly on a daily basis”.

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However, she said, redesigning and realigning some aspects of acute service “needs to sit within the context of the agreed commissioning plan, the timescale over which the change will happen, and complete transparency about what resource is available to be redeployed”\textsuperscript{214}.

274. Finally, she told the Committee that the deputy director for health finance in the Scottish Government had already asked partnerships to give an early indication of what percentage of resources would be in scope for transfer. Once she had a comprehensive picture, she said, she was sure that the deputy director “would not be unhappy to share the generality of that, given that the partners are in the early days of working through the amount”.

275. Following this, the Scottish Government provided the Committee with further information on this issue—

“We expect the extent of Health Board budgets included within the scope of integrated strategic planning to vary in different Health Board and partnership areas. Based on the discussions we have had with some Health Boards to date, and noting that the figures are high level and indicative at this stage, we anticipate that approximately half of the total Health Board budgets (one third of Health Board hospital budgets) will be included within the scope of the integrated strategic plan. This would represent approximately 75\% of total expenditure on unplanned bed days for people aged 75+, which is in keeping with the policy intention of integration to focus strategic planning on areas of activity with the greatest scope for redesign in favour of preventative and anticipatory care.”\textsuperscript{215}

276. The Committee accepts that, while budget discussions about which aspects and how much of an acute budget can be realigned and reallocated to an integrated services will be one of the most challenging areas for negotiation, it is essential that such challenges are met if services are to be redesigned on an integrated basis.

277. The views of COSLA and others that an element of acute budgets should be top-sliced at source and allocated to care services budgets are noted, but the Committee inclines more towards the Cabinet Secretary’s position that it is for each partnership to determine what functions and aspects of acute budgets are within scope for redesign and it would not be appropriate to impose a percentage figure from the centre. In this respect, the Committee is heartened to learn that a model has been agreed between the Scottish Government, COSLA and NHS boards on how the strategic commissioning plans would determine the resources that would fall within integration scope.

278. The Committee welcomes the additional information it has received from the Scottish Government officials setting out current expectations about the percentage of resources that would be likely to be in scope for transfer.

\textsuperscript{215} Email from Scottish Government officials to Committee clerks, sent 7 November 2013.
279. The Committee would intend to continue to monitor progress on this over the remainder of the parliamentary session, but in the meantime asks the Cabinet Secretary to clarify the extent to which there is expected to be variation between health boards. The Committee questions whether it would be the case, for example, that larger percentages would be expected to be within scope for transfer in the smaller board areas that have fewer specialised services, than would be the case in the larger boards such as NHS Greater Glasgow or Clyde or NHS Lothian.

280. The Committee would also be interested to learn from the Scottish Government the outcome of discussions with COSLA about the level of resources that local government would be expected to contribute to integrated budgets.

VAT

281. The Financial Memorandum\textsuperscript{216} explains that the different VAT status of the statutory partners (local authorities and NHS boards) complicates the recovery of VAT on goods and services under integrated arrangements, which introduces a risk that VAT currently recovered may not be possible post integration. The extent of potential exposure for this risk identified by the FM is a recurrent cost of £32m p.a. based on the estimated total VAT recovered by local authorities for adult social care services.

282. The FM goes on to explain that VAT implications for integration depend on whether partners opt for delegation between partners or delegation to a body corporate. In the case of the lead agency model, the VAT regime of the host partner in the delegation between partners model will apply to the integrated budget. This introduces a risk of additional recurrent costs in cases where local authority functions are delegated to health boards and VAT previously recovered by local authorities is no longer able to be recovered under NHS arrangements. According to the FM, this risk is “mitigated by establishing arrangements under existing HMRC guidance for delegation between partners, which allows a solution for partnerships that is VAT neutral compared to the pre-partnership position”\textsuperscript{217}. It is understood that the care trusts in Torbay and North East Lincolnshire both took advantage of the solution in the guidance, which led to a VAT neutral outcome. The FM reports that Highland Partnership is also following this approach and, although its position has not yet been finalised with HMRC, it also expects a VAT neutral outcome.

283. Under the body corporate model, there is no guidance available for this. Consequently, there is a risk that VAT currently reclaimed by local authorities would no longer able to be recovered under the VAT arrangements in the body corporate. However, the FM indicates that Scottish Government appointed VAT advisors have indicated that the key factor in determining recovery of VAT in this model will be the extent to which the body corporate delivers services, and that the

\textsuperscript{216} Public Bodies (Joint Working) (Scotland) Bill. Explanatory Notes (and other accompanying documents) (SP Bill 32-EN, Session 4 (2013)). Available at: http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Bill/b32s4-introd-en.pdf

\textsuperscript{217} Explanatory Notes, paragraph 76.
proposed arrangements are likely to be interpreted by HMRC as the body
corporate re-allocating the integrated budget and for delivery by boards and local
authorities. Consequently, it is likely, concludes the FM, that a VAT neutral
position is attainable. However, the FM cautions that, should the Scottish Ministers
extend, in future, the remit of the body corporate to allow it to take advantage of
employment and contracting powers, there would be a risk that HMRC would
revise its view to conclude that the body corporate was, in fact, providing services.
In that situation, the VAT status of the body corporate would be “less clear” and
the recovery of VAT would be “at risk”. The FM notes that the full extent of
potential exposure for this risk is a recurrent cost of £32m p.a. based on the
estimated total VAT recovered by local authorities for adult social care services.  

284. The COSLA submission to the Committee noted that—

“VAT is a particular concern for COSLA. We are seeking early clarification
from Scottish Government and HMRC as to the VAT arrangements that
would obtain under the body corporate model. Further thought also needs to
be given to the VAT implications of the body corporate acquiring more
general financial powers in the future.”  

285. The Cabinet Secretary updated the Committee on developments in relation
to VAT when he appeared before it on the Bill—

“We are in a state of advanced negotiations with HM Revenue & Customs on
that very issue. Although I cannot forecast exactly what the outcome will be, I
am reasonably confident that we will hopefully end up in a position where
there will be no VAT implications in terms of additional expenditure arising
from these measures.”  

286. The Committee notes that the Cabinet Secretary is “reasonably
confident” that there will be no VAT implications arising from the Bill’s
provisions. Nevertheless, the Committee would welcome an update in due
course, when the final outcome of discussions with HMRC has become
clear.

ICT

287. The Finance Committee’s report to the Committee indicates that the Finance
Committee received submissions from a number of local authorities and from
ADSW, that insufficient account had been taken in the FM of the likely costs of
integration of IT systems between health boards and local authorities.

288. The Committee questioned Maureen Falconer of the Information
Commissioner’s office regarding the issues around information sharing between
and within bodies. She told the Committee—

“Within the NHS, there is a problem in that the different systems cannot
speak to one another. The situation is the same in the local authorities—
many use the same systems, but not all do—and in education. The different
systems cannot talk to one another. Until we have the panacea of central procurement that sends down from on high a system that can be implemented in the public sector across the board—I do not think that will ever happen—the ability of organisations to talk to one another will always be a problem.”

289. The Finance Committee invited the Health and Sport Committee to ask the Scottish Government what discussions it has had with local authorities and health boards about the IT developments that will be necessary to improve data sharing, whether additional funding had been requested and, if so, why there was no discussion of this in the FM.

290. The Committee did not have time to put this question to the Cabinet Secretary during his appearance before it on 1 October 2013. However, the Committee is aware of historical difficulties in attempting to join up different electronic records and in IT procurement, which invariably seem to lead to rapidly rising costs. The Committee therefore invites the Cabinet Secretary to address the Finance Committee question in the Scottish Government response to this report.

Cost of additional inspections

291. Healthcare Improvement Scotland raised this issue with the Finance Committee, which, in turn referred to it in its report to the Committee. HIS had indicated to the Finance Committee in order to comply with the Bill, it would be necessary for it to review the skills and resources required for inspections. It said it would consider the associated financial implications in the context of its broader financial strategy, but noted that additional costs might “require some uplift to our baseline funding which is currently reducing on an annual basis” adding that any uplift would require to be agreed with Scottish Government finance colleagues.

292. The Committee asked the Cabinet Secretary about the additional costs that were expected to fall on HIS. In response, the Cabinet Secretary indicated that the Care Inspectorate and HIS were working together on the implications of integration for the delivery of inspection services and HIS would launch a consultation soon in which one of the subject areas that would be covered would be the implications of integration. He concluded that an integrated inspection strategy would ultimately be required.

293. The Committee understands that this work is in progress and requests that the Scottish Government provide an update on progress on this issue in its response to this report.

Staffing issues

294. UNISON, in its written submission to the Committee noted that, in its response to the 2012 consultation, workplace issues had been given “scant

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consideration’ and recorded its disappointment that, in its view, these issues remain unaddressed—

“We believe that one of the greatest challenges for implementation of the proposals will be the difficulties of bringing together two large groups of staff who have their own cultures, systems of governance, terms and conditions, all of which have the potential to create massive problems when implementing the plans. We continue to be disappointed that these issues have not been addressed and would strongly urge that a provision for staff and their trade unions to be involved in the integration and planning process should be included in the Bill.”

295. UNISON went on to set out a range of issues including staff transfer, pensions, secondment, staff employed by different employers, procurement, equality duties, governance and statutory roles. It also stated that it “did not favour models that involved the wholesale transfer of staff across councils and health boards, as in the Highland Model”. It noted that its members in Highland had “experienced many difficulties with terms and conditions of staff, pension arrangements, etc. and stated that it believed that major issues, such as the status and situation of Mental Health Officers, still remained to be resolved."224

296. The Royal College of Nursing submission expressed surprise at the inclusion in the Bill of a provision to enable, at a future point, through subordinate legislation, joint boards established under the body corporate model to employ staff directly. It said that this “risks undermining current arrangements” It concluded that “a far greater, open discussion [was] required to understand the consequences of this section on the sustainability and the principles of the NHS in Scotland”225.

297. The Committee discussed staffing issues with those who took part in the visits to Highland and West Lothian (where considerable work has already been carried out to integrate services). While in both locations, there was acknowledgement that there were issues that needed to be addressed with regard to staffing arrangements, there were no reports of major difficulties having arisen.

298. Dave Watson of UNISON enlarged on the union’s written submission when he gave oral evidence to the Committee—

“From our perspective, the staffing governance is particularly unclear. As you will know, in the health service we have a strong, internationally renowned staff governance framework. It is slightly different in local government, but nonetheless there are statutory and non-statutory provisions there. Our concern is that there are a lot of big decisions that the bodies could make if the budgets are allocated to them and that those decisions will impact not just them—because in most cases, they will not be the employer—but other

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224 Unison Scotland. Written submission.
225 Unison Scotland. Written submission.
226 Royal College of Nursing. Written submission
employers. The staff governance arrangements around that seem to be somewhat muddled and confused.”

227. Dave Watson went on to say that he could see “dozens of potential legal difficulties with the bill as it stands in terms of staffing issues”. These included arrangements for secondment and issues of staff on different terms and conditions. He concluded that while such matters were “mundane”, they were “absolutely key to getting better integration at local level”.

300. A similar point about staff governance was raised by Rachel Cackett of the RCN. She explained that different experiences of how well integration was working in different areas often came down to the amount of time that had been freed up in their teams to allow “really simple things to happen”. She mentioned specifically, for example, time “for a social worker and a district nurse to sit down and explain to each other the limits of practice within their regulatory bodies, and what they were allowed to do and not allowed to do to enable proper joint work”.

301. The Cabinet Secretary explained to the Committee the rationale for the joint board established under the body corporate model not to employ staff directly—

“let me just begin with the principle, which is that the body corporate itself will not be employing people. Obviously, that may change through time, but what we envisage is that, to start with, the people who work directly for the body corporate, such as the chief accounting officer, will be seconded from the local authority or the health board. The reason for that is that, as you will know, employment law is very complicated and it could raise a lot of issues that would make the whole integration process unnecessarily complicated. Therefore, the wisest thing to do at this stage is what we are doing, which is to work on the basis that people will technically be employees of the local authority or the health board, not of the body corporate.”

302. Challenged by the Committee on whether financial provision should have been incorporated into the Bill against the possibility of equal pay claims, the Cabinet Secretary told the Committee it would be “nothing to do with us”. Equal pay claims would be a matter for the local authority or health board, depending on which was the employer.

303. On pension funding, he suggested that concerns were “a wee bit of a red herring, in that the bodies corporate will not employ people and therefore will not be directly involved in pension issues”. He acknowledged, however, that, over time, they might employ people, so there could be an issue. He indicated that a “technical amendment” to the bill was probably required to deal with that. However, he said that beyond that, the Scottish Government did not see a big

issue with pensions, for the reason that the bodies corporate would not actually employ anybody.$\textsuperscript{233}$

304. The Committee, while fully supportive of the proposals for integration, recognises the potential for progress to be hindered as a result of staffing issues. While detailed staffing arrangements are a matter for negotiation between the local authorities, the health boards and the relevant trades unions, there may well be matters of principle, such as some of those mentioned by UNISON and others, that could best be agreed centrally at a national level.

305. While the Committee has no wish to entrench cultural barriers and reinforce professional boundaries, both of which would limit the potential success of the Bill, there is a need for clarity and consistency on staff issues that may be raised by integration of different staffs working for different employers and coming from different professional backgrounds. These would include issues related to professional standards, codes of conduct and the role of regulatory professional bodies.

306. The Committee therefore calls on the Scottish Government, in its response to this report, to set out the steps that it is taking to identify the relevant issues and the work that it plans to do with the appropriate professional bodies, trades unions and others to resolve them.

Part 2 – shared services

307. This part of the Bill proposes to enable National Services Scotland (also known as the Common Services Agency) to extend its services to other public bodies. The following functions of National Services Scotland have been identified as having the potential to be extended to other public bodies:

- Central Legal Office,
- Counter fraud services,
- National Procurement,
- National Information Systems Group (IT services) and
- Information Services Division.

308. The sharing of these services would be entirely voluntary for either party.

309. The Bill also proposes to extend the NHS’ indemnity scheme (known as CNORIS – the Clinical Negligence and Other Risks Indemnity Scheme). Health boards contribute an annual amount and CNORIS covers the expenses arising from any loss or damage to property and any liabilities to third parties for loss, damage or injury. The Bill proposes to allow local authorities and joint integration Boards to participate in the scheme.

310. In June 2013, the Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013 came into force. This order allowed NSS to share its services with other public bodies. The policy memorandum outlines that:

“Scottish Ministers agreed that the changes to the remit of the Common Services Agency made through the Public Services Reform Act Order would then be reviewed and restated through an updated approach to provisions in the Bill.” (Para 98)

311. The Committee heard from NHS National Services Scotland (NSS) that the above Order was introduced in anticipation of further integration in Scotland and ahead of “the approach then being properly codified in the bill”. NSS told the Committee that the order had provided “a stopgap”, which allowed it to operate and to “start to get to know people beyond the health service.” It was, it said, intended to provide “the room for manoeuvre that enables us to give support more broadly.”

312. In oral evidence, NSS explained that the capacity of NSS to provide additional services was dependent on the service in question: some areas, legal services for example, would require additional resource at a cost; while other facilities could be shared beyond health care services at no cost. The Committee heard that NSS already provides assistance to local authorities on IT contracting.

313. The Committee notes this part of the Bill, which provides for the ability of NHS National Services Scotland to extend its services to other public bodies and appears to be an entirely sensible development.

Part 3 – Health service functions

314. According to the Policy Memorandum, this part of the Bill is intended “to facilitate opportunities brought about by integration and…ensure the most effective use of resources”. It seeks to address two issues: “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.”

315. The ability of health boards to form companies is restricted under the Companies Act 1985. The policy memorandum indicates that the Scottish Government wants health boards “to be able to form corporate structures other than companies for joint ventures purposes, such as the management and disposal of property and assets.”

316. The Scottish Futures Trust outlined the benefits of this approach under questioning—

234 Available at: http://www.legislation.gov.uk/sdsi/2013/9780111020623
235 Policy Memorandum, paragraph 98.
237 Scottish Parliament Health and Sport Committee. Official Report, 3 September 2013, Col 4167
238 Policy Memorandum, paragraph 144.
it can be the case that, for historic reasons, different bits of the public sector own parcels of land that are next to each other, such as where a health centre is situated next to a council office. If we find that those become surplus because of a reorganisation in a town or village, the ability for a local authority and health board to enter into a joint venture with a private development partner for the disposal of those assets could increase their value and be of benefit to the public sector.  

317. Under current legislation, whereas local authorities can enter into limited liability partnerships, health boards are unable to do so. However, were such a partnership approach to be designated as a company, health boards would be able to be part of that. According to the Scottish Future’s Trust—

“relieving that anomaly and allowing bodies to work better together in an LLP structure, which is recognised as being a good corporate form for this sort of thing, would be a useful enhancement of what health boards are allowed to do.”

318. As noted above, the Bill provides for a health board to be able to exercise its functions out with its own area. The Committee heard that this was expected to be particularly beneficial in relation to procurement. It would allow for a single health board to lead on the procurement of facilities, for example multiple health centres, both for itself and on behalf of neighbouring health boards under a single procurement agreement, known as the ‘hub model’. The Scottish Futures Trust outlined its view that, as the model allows for local public bodies to procure and occupy facilities together, “shared facilities and co-location can be a catalyst for integration”.

319. The Committee notes that the Bill provides health boards with the ability to form companies (under the National Health Service (Scotland) Act 1978) for joint ventures purposes, such as the management and disposal of property and assets.

320. The Committee also notes the provision in the Bill which would allow health boards to exercise functions beyond their own territories.

321. The Committee considers that these are entirely appropriate and sensible proposals.

Delegated Powers and Law Reform Committee scrutiny

322. Under Rule 9.6.2 of Standing Orders, where a bill contains provisions conferring powers to make subordinate legislation, the Delegated Powers and Law Reform Committee (DPLR) must consider and report to the lead committee on those provisions.
323. A copy of the DPLR report\(^{242}\) is attached as an annexe.

324. The DPLR Committee report drew the attention of the Health and Sport Committee, as lead committee, to a number of points, as follows:

- The power contained in section 12(1)(a). This proposes to enable Scottish Ministers by order to make provision about the membership of integration joint boards, without any limitations as to the number of members of a particular board that may be prescribed, or as to who may be prescribed as members.

- In relation to Section 15 – (Transfer of staff where functions delegated to local authority or Health Board), it was highlighted that the exercise of this power would not be subject to Parliamentary scrutiny.

325. The DPLR Committee understands that the current power to make provision for any transfer or secondment of staff contained in the Community Care and Health (Scotland) Act 2002, where arrangements may be entered between local authorities and NHS bodies for the delegation of functions, is exercisable by Regulations which are subject to Parliamentary scrutiny by the negative procedure (sections 15(4)(c) and 23 of that Act).

326. In contrast, the power in section 15 of the Bill to make provision about the transfer of staff, where functions are delegated to a local authority or Health Board, is proposed to be exercisable by a scheme which would not be published as a Scottish statutory instrument, nor subject to Parliamentary scrutiny.

327. The Committee understands therefore that section 15 proposes to remove scrutiny by the Parliament, in comparison with the similar power in the 2002 Act which would be repealed by the Bill.

328. Similarly, the DPLR report also highlighted section 36(c) which would also have the effect of removing parliamentary scrutiny in the exercise of this power.

329. Section 16(1) provides that the Scottish Ministers may, by order, make provision about the establishment of, membership of, and the proceedings of, integration joint monitoring committees, and any other matter relating to the operation of integration joint monitoring committees that the Scottish Ministers think fit.

330. The DPLR report drew the attention of the Health and Sport Committee to this provision.

331. The Committee thanks the Delegated Powers and Law Reform Committee for its report and draws it to the attention of the Scottish Government.

Local Government and Regeneration Committee scrutiny

332. The Local Government and Regeneration Committee (LGRC) considered this Bill alongside stage one of the Children and Young People (Scotland) Bill, in relation to the delivery of local government services. Both bills include proposals for joint working between local government and public bodies. LGRC was interested in how the bills complement each other and work together to help deliver and support the public sector reform agenda.

333. LGRC considered written evidence from a range of organisations and held an oral evidence session with NHS Ayrshire and Arran, GPs at the Deep End, East Ayrshire Council, North Ayrshire Council and the Housing Coordinating Group.

334. The main points made by Local Government and Regeneration Committee have been incorporated into the body of the report, where appropriate. The Committee thanks the Local Government and Regeneration Committee for its report.

Consultation

335. Part of the function of Stage 1 of the parliamentary scrutiny of bills is to consider whether any consultation carried out by the bill’s promoter has been adequate.

336. The Policy Memorandum reports that in May 2012, the Scottish Government published its consultation on proposals for the integration of adult health and social care. It goes on to record that over the period of the consultation, Scottish Government officials held a number of consultation events across Scotland, providing the opportunity for professionals, patients, service users and carers, as well as providers of services, to hear about the consultation proposals and to ask questions and discuss the proposals. Officials, it says, met a broad range of stakeholders at events and meetings organised by local partnerships to provide further opportunities to discuss the consultation proposals.  

337. The Policy Memorandum also reports that 315 responses to the consultation were received. An analysis of written responses to the consultation was published on 19 December 2012.

338. In as far as any of the submissions received by the Committee mentioned the consultation, most appeared content that it was appropriate and thorough, though there were a few comments that the Bill had changed more than expected from what had been discussed in consultation events.

339. Overall, the Committee considers that the consultation carried out by the Scottish Government was adequate and appropriate.

CONCLUDING REMARKS

340. The Committee fully supports the principles of integration of health and social care, which should provide better outcomes for patients and service.

243 Policy Memorandum, paragraph 26.
users as well as delivering better value for the investment made in health, local government and support to the third and independent sectors.

341. While the Committee accepts that legislation, in itself, does not guarantee successful integration of services and that cultural change and quality leadership are also vitally important, it recognises that the statutory footing that the Bill will bring is essential in cementing and reinforcing the progress that has already been made.

342. It is clear that much work is being carried out across the country through a range of working groups and this should help to ease practical difficulties that may arise as implementation of the Bill, when passed, progresses.

343. This report has identified a number of issues that have arisen in evidence where further clarification or, in some cases, reassurances from the Scottish Government would be welcome before the Parliament has the opportunity to debate the Bill at stage 1. There are also a number of areas where the Bill could potentially be strengthened by amendment, and some of these have been drawn to the attention of the Scottish Government in the report.

344. The Committee has already stated its broad support for the Bill. Notwithstanding the comments it has made in the report, the Committee supports the general principles and recommends to the Parliament that they be approved.
ANNEXE A: EXTRACT FROM MINUTES OF THE HEALTH AND SPORT COMMITTEE

24th Meeting, 2013 (Session 4)

Tuesday 3 September 2013

2. Public Bodies (Joint Working) (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Ian Crichton, Chief Executive, Simon Belfer, Director of Finance and Business Services, and Professor Marion Bain, Medical Director, NHS National Services Scotland;

Peter Reekie, Director of Finance, The Scottish Futures Trust.

25th Meeting, 2013 (Session 4)

Tuesday 10 September 2013

3. Public Bodies (Joint Working) (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Andrew Eccles, Glasgow School of Social Work;

Alison Petch, Director, Institute for Research and Innovation in Social Services (IRISS);

Duncan Mackay, Head of Social Work Development, North Lanarkshire Council;

Soumen Sengupta, Head of Strategy, Planning and Health Improvement, West Dunbartonshire Community Health and Care Partnership;

Peter Gabbitas, Director of Health and Social Care, and Susanne Harrison, Integration Programme Manager, City of Edinburgh Council;

Ron Culley, Chief Officer, Health & Social Care, and Councillor Peter Johnston, Spokesperson for Health and Well-being, COSLA;

Ritchie Johnson, Director of Housing and Social Work, Aberdeenshire Council.

26th Meeting, 2013 (Session 4)

Tuesday 17 September 2013

2. Public Bodies (Joint Working) (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Dr Allan Gunning, Executive Director – Policy, Planning and Performance, NHS Ayrshire and Arran;

Jeff Ace, Chief Executive, NHS Dumfries and Galloway;

Susan Manion, Chair, Association of Community Health Partnerships;

Alan Gray, Director of Finance, NHS Grampian;

Ranald Mair, Chief Executive, Scottish Care;

Nigel Henderson, Convener, Coalition of Care and Support Providers in Scotland;

Martin Sime, Chief Executive, Scottish Council for Voluntary Organisations.

27th Meeting, 2013 (Session 4)

Tuesday 24 September 2013

2. **Public Bodies (Joint Working) (Scotland) Bill**: The Committee took evidence on the Bill at Stage 1 from—

Claire Cairns, Network Coordinator, The Coalition of Carers in Scotland;

Pam Duncan, Policy Officer, Independent Living in Scotland (ILiS);

Ian Welsh, Chief Executive, Health and Social Care Alliance Scotland, (the ALLIANCE);

Karen Hamilton, Borders Public Partnership Forum;

Dr John Gillies, Chair, Royal College of General Practitioners Scotland;

Rachel Cackett, Policy Advisor, Royal College of Nursing Scotland;

Ruth Stark, Social Worker and Manager, Scottish Association of Social Work;

Gabrielle Stewart, Member, Allied Health Professions Federation Scotland;

Dr John Taylor, Consultant Psychiatrist, Associate Medical Director NHS Ayrshire and Arran and Vice Chair of the RCPsych in Scotland, Royal College of Psychiatrists in Scotland;

Dr Christine McAlpine, Consultant Physician, Member BGS (Scotland) Council, British Geriatric Society (Scotland);

Dave Watson, Scottish Organiser (Bargaining and Campaigns), Unison.
28th Meeting, 2013 (Session 4)

Tuesday 1 October 2013

3. **Public Bodies (Joint Working) (Scotland) Bill:** The Committee took evidence on the Bill at Stage 1 from—

Claire Sweeney, Portfolio manager, Performance Audit and Best Value Group, Audit Scotland;

Annette Bruton, Chief Executive, and Paul Edie, Chair, Care Inspectorate;

Dr Denise Coia, Chairman, and Robbie Pearson, Director of Scrutiny and Assurance, Healthcare Improvement Scotland;

Maureen Falconer, Senior Policy Officer, Information Commissioner’s Office;

Jim Martin, Ombudsman, and Paul McFadden, Head of Complaints Standards, Scottish Public Services Ombudsman.

6. **Public Bodies (Joint Working) (Scotland) Bill:** The Committee took evidence on the Bill at Stage 1 from—

Alex Neil, Cabinet Secretary for Health and Well-being, Kathleen Bessos, Deputy Director, John Paterson, Divisional Solicitor, and Alison Taylor, Team Leader, Scottish Government.

31st Meeting, 2013 (Session 4)

Tuesday 5 November 2013

2. **Public Bodies (Joint Working) (Scotland) Bill (in private):** The Committee considered a draft report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at its meeting on 12 November.

32nd Meeting, 2013 (Session 4)

Tuesday 12 November 2013

3. **Public Bodies (Joint Working) (Scotland) Bill (in private):** The Committee considered a revised draft Stage 1 report. Various changes were agreed to, and the report was agreed for publication.
ANNEXE B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

24th Meeting, 2013 (Session 4) Tuesday 3 September 2013

Written Evidence

Oral Evidence
NHS National Services Scotland
The Scottish Futures Trust

25th Meeting, 2013 (Session 4) Tuesday 10 September 2013

Written Evidence

North Lanarkshire Council
West Dunbartonshire Community Health and Care Partnership
City of Edinburgh Council
COSLA
Aberdeenshire Council

Oral Evidence
Glasgow School of Social Work
Institute for Research and Innovation in Social Services (IRISS)
North Lanarkshire Council
West Dunbartonshire Community Health and Care Partnership
City of Edinburgh Council
COSLA
Aberdeenshire Council

26th Meeting, 2013 (Session 4) Tuesday 17 September 2013

Written Evidence

NHS Ayrshire and Arran
NHS Dumfries and Galloway
Scottish Care
Coalition of Care and Support Providers in Scotland
Scottish Council for Voluntary Organisations

Oral Evidence
NHS Ayrshire and Arran
NHS Dumfries and Galloway
Association of Community Health Partnerships
NHS Grampian
Scottish Care
Coalition of Care and Support Providers in Scotland
Scottish Council for Voluntary Organisations
27th Meeting, 2013 (Session 4) Tuesday 24 September 2013

Written Evidence

The Coalition of Carers in Scotland
Independent Living in Scotland (ILiS)
Health and Social Care Alliance Scotland, (the ALLIANCE)
Borders Public Partnership Forum
Royal College of Nursing Scotland
Scottish Association of Social Work
NHS Ayrshire and Arran
Unison

Oral Evidence

The Coalition of Carers in Scotland
Independent Living in Scotland (ILiS)
Health and Social Care Alliance Scotland, (the ALLIANCE)
Borders Public Partnership Forum
Royal College of General Practitioners Scotland
Royal College of Nursing Scotland
Scottish Association of Social Work
Allied Health Professions Federation Scotland
NHS Ayrshire and Arran and Vice Chair of the RCPsych in Scotland, Royal College of Psychiatrists in Scotland
British Geriatric Society (Scotland)
Unison

28th Meeting, 2013 (Session 4) Tuesday 1 October 2013

Written Evidence

Audit Scotland
Care Inspectorate
Healthcare Improvement Scotland
Information Commissioner’s Office
Scottish Public Services Ombudsman

Oral Evidence

Audit Scotland
Care Inspectorate
Healthcare Improvement Scotland
Information Commissioner’s Office
Scottish Public Services Ombudsman
Scottish Government
ANNEXE C: LIST OF OTHER WRITTEN EVIDENCE

Rev Donald Prentice (Individual)
North Ayrshire Council
NSPCC Scotland
British Heart Foundation Scotland
Heather Locke and Catherine Murray
Voluntary Health Scotland
British Psychological Society
NHS North Lanarkshire
Carers Scotland
YouthLink Scotland
Dumfries and Galloway Council
Children in Scotland
Company Chemists Association
Community Pharmacy Scotland
Scottish Independent Advocacy Alliance
Falkirk Council
HIV Scotland
Alex Stobart (the Alliance)
College of Occupational Therapists
Chartered Society of Physiotherapy Scotland
Macmillan Cancer
Society of Chiropodists & Podiatrists
MS Society
Citizens Advice Scotland
Scottish Health Council
Inverclyde CHCP
Royal Pharmaceutical Society
Royal College of Speech and Language Therapists
NHS Education for Scotland
Scottish Association for Mental Health
BMA Scotland
MND Scotland
Voices of Experience Scotland
Carers Trust in Scotland
Barnardo’s Scotland
Leonard Cheshire Disability
Quarriers Scotland
ENABLE Scotland
National Pharmacy Association
British Red Cross
Capability Scotland
British Dietetic Association
Parkinsons UK
Midlothian Council
Dr Jenny Ure (Individual)
GMC
South Lanarkshire Council
British Healthcare Trades Association
South Ayrshire Council
Equality and Human Rights Commission
Chartered Institute of Public Finance and Accountancy
East Renfrewshire Community Health and Care Partnership
Marie Curie Cancer Care
Council of Deans of Health
Scottish Social Services Council
East Lothian Council
NHS Lothian
City of Edinburgh Council
Glasgow City Council
Housing Coordinating Group
Association of Directors of Social Work
Alliance Boots Submission
COSLA Submission
NHS Highland
Scottish Health Council
ANNEXE D: NOTE OF VISITS TO NHS HIGHLAND, WEST LOTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP AND LOTHIAN CENTRE FOR INDEPENDENT LIVING (LCIL)

The note of the visit to NHS Highland, Inverness can be found on the Scottish Parliament website at the following webpage:

The note of the visit to West Lothian Community Health and Care Partnership, Livingston can be found on the Scottish Parliament website at the following webpage:
http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Public%20Bodies%20Joint%20Working%20Scotland%20Bill/Note_of_a_Visit_to_West_Lothian_CHCP.pdf

The note of the visit to Lothian Centre for Independent Living, Livingston can be found on the Scottish Parliament website at the following webpage:
http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Public%20Bodies%20Joint%20Working%20Scotland%20Bill/Note_of_a_Visit_to_Lothian_Centre_for_Inclusive_Living.pdf
ANNEXE E: REPORT FROM THE FINANCE COMMITTEE

The Finance Committee report on the Public Bodies (Joint Working) (Scotland) Bill can be found on the Scottish Parliament’s website at the following webpage: http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/68001.aspx.
ANNEXE F: REPORT FROM THE DELEGATED POWERS AND LAW REFORM COMMITTEE

The Delegated Powers and Law Reform Committee report on the Public Bodies (Joint Working) (Scotland) Bill can be found on the Scottish Parliament’s website at the following webpage: http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/68001.aspx.
ANNEXE G: MEMORANDUM FROM THE LOCAL GOVERNMENT AND REGENERATION COMMITTEE

The Local Government and Regeneration Committee Memorandum on the Children and Young People (Scotland) Bill and the Public Bodies (Joint Working) (Scotland) Bill can be found on the Scottish Parliament’s website at the following webpage:
http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/LGR_Committee_memorandum_on_SP_Bill_27_and_SP_Bill_32.pdf.
Members who would like a printed copy of this *Numbered Report* to be forwarded to them should give notice at the Document Supply Centre.