Passage of the

Public Bodies (Joint Working) (Scotland) Bill 2013

SPPB 200
Passage of the

Public Bodies (Joint Working) (Scotland) Bill 2013

SP Bill 32 (Session 4), subsequently 2014 asp 9

SPPB 200

EDINBURGH: APS GROUP SCOTLAND
Contents

Foreword

Introduction of the Bill

Bill (As Introduced) (SP Bill 32) 1
Explanatory Notes (and other accompanying documents) (SP Bill 32-EN) 27
Policy Memorandum (SP Bill 32-PM) 79
Delegated Powers Memorandum (SP Bill 32-DPM) 112

Stage 1

Stage 1 Report, Health and Sport Committee 133
Oral evidence and associated written evidence to the Health and Sport Committee 208
Other written evidence to the Health and Sport Committee 477
Notes of visits by the Health and Sport Committee 731
Scottish Government policy statements relating to the Bill 739
Memorandum from the Local Government and Regeneration Committee 779
Official Report, Local Government and Regeneration Committee, 4 September 2013 795
Written evidence to the Local Government and Regeneration Committee 815
Report by the Finance Committee at Stage 1 905
Official Report, Finance Committee, 11 September 2013 925
Written evidence to the Finance Committee 945
Report by the Delegated Powers and Law Reform Committee at Stage 1 1029
Extract from the Minutes, Delegated Powers and Law Reform Committee, 3 September 2013 1065
Official Report, Delegated Powers and Law Reform Committee, 3 September 2013 1066
Scottish Government response to the Health and Sport Committee’s Stage 1 Report, 22 November 2013 1071
Papers for the meeting of the Delegated Powers and Law Reform Committee, 26 November 2013, incorporating Scottish Government response to the Committee’s report at Stage 1 1099
Extract from the Minutes of the Parliament, 26 November 2013 1108
Official Report, Meeting of the Parliament, 26 November 2013 1109

After Stage 1

Extract from the Minutes of the Parliament, 3 December 2013 1128

Stage 2

1st Marshalled List of Amendments for Stage 2 (SP Bill 32-ML1) 1129
1st Groupings of Amendments for Stage 2 (SP Bill 32-G1) 1163
Extract from the Minutes, Health and Sport Committee, 21 January 2014 1165
Official Report, Health and Sport Committee, 21 January 2014

2nd Marshalled List of Amendments for Stage 2 (SP Bill 32-ML2)
2nd Groupings of Amendments for Stage 2 (SP Bill 32-G2)
Extract from the Minutes, Health and Sport Committee, 28 January 2014
Official Report, Health and Sport Committee, 28 January 2014

Bill (As Amended at Stage 2) (SP Bill 32A)
Revised Explanatory Notes (SP Bill 32A-EN)
Supplementary Delegated Powers Memorandum (SP Bill 32A-DPM)

After Stage 2
Report on the Public Bodies (Joint Working) (Scotland) Bill as amended at Stage 2, Delegated Powers and Law Reform Committee

Stage 3
Papers for the meeting of the Delegated Powers and Law Reform Committee, 25 February 2014, incorporating correspondence relating to Scottish Government amendments at Stage 3
Extract from the Minutes, Delegated Powers and Law Reform Committee, 25 February 2014

Marshalled List of amendments selected for Stage 3 (SP Bill 32A-ML)
Groupings of Amendments for Stage 3 (SP Bill 32A-G)
Extract from the Minutes of the Parliament, 25 February 2014
Official Report, Meeting of the Parliament, 25 February 2014

Bill (As Passed) (SP Bill 32B)
Foreword

Purpose of the series

The aim of this series is to bring together in a single place all the official Parliamentary documents relating to the passage of the Bill that becomes an Act of the Scottish Parliament (ASP). The list of documents included in any particular volume will depend on the nature of the Bill and the circumstances of its passage, but a typical volume will include:

- every print of the Bill (usually three – “As Introduced”, “As Amended at Stage 2” and “As Passed”);
- the accompanying documents published with the “As Introduced” print of the Bill (and any revised versions published at later Stages);
- every Marshalled List of amendments from Stages 2 and 3;
- every Groupings list from Stages 2 and 3;
- the lead Committee’s “Stage 1 report” (which itself includes reports of other committees involved in the Stage 1 process, relevant committee Minutes and extracts from the Official Report of Stage 1 proceedings);
- the Official Report of the Stage 1 and Stage 3 debates in the Parliament;
- the Official Report of Stage 2 committee consideration;
- the Minutes (or relevant extracts) of relevant Committee meetings and of the Parliament for Stages 1 and 3.

All documents included are re-printed in the original layout and format, but with minor typographical and layout errors corrected. An exception is the groupings of amendments for Stage 2 and Stage 3 (a list of amendments in debating order was included in the original documents to assist members during actual proceedings but is omitted here as the text of amendments is already contained in the relevant marshalled list).

Where documents in the volume include web-links to external sources or to documents not incorporated in this volume, these links have been checked and are correct at the time of publishing this volume. The Scottish Parliament is not responsible for the content of external Internet sites. The links in this volume will not be monitored after publication, and no guarantee can be given that all links will continue to be effective.

Documents in each volume are arranged in the order in which they relate to the passage of the Bill through its various stages, from introduction to passing. The Act itself is not included on the grounds that it is already generally available and is, in any case, not a Parliamentary publication.

Outline of the legislative process

Bills in the Scottish Parliament follow a three-stage process. The fundamentals of the process are laid down by section 36(1) of the Scotland Act 1998, and amplified by Chapter 9 of the Parliament’s Standing Orders. In outline, the process is as follows:
• Introduction, followed by publication of the Bill and its accompanying documents;
• Stage 1: the Bill is first referred to a relevant committee, which produces a report informed by evidence from interested parties, then the Parliament debates the Bill and decides whether to agree to its general principles;
• Stage 2: the Bill returns to a committee for detailed consideration of amendments;
• Stage 3: the Bill is considered by the Parliament, with consideration of further amendments followed by a debate and a decision on whether to pass the Bill.

After a Bill is passed, three law officers and the Secretary of State have a period of four weeks within which they may challenge the Bill under sections 33 and 35 of the Scotland Act respectively. The Bill may then be submitted for Royal Assent, at which point it becomes an Act.

Standing Orders allow for some variations from the above pattern in some cases. For example, Bills may be referred back to a committee during Stage 3 for further Stage 2 consideration. In addition, the procedures vary for certain categories of Bills, such as Committee Bills or Emergency Bills. For some volumes in the series, relevant proceedings prior to introduction (such as pre-legislative scrutiny of a draft Bill) may be included.

The reader who is unfamiliar with Bill procedures, or with the terminology of legislation more generally, is advised to consult in the first instance the Guidance on Public Bills published by the Parliament. That Guidance, and the Standing Orders, are available free of charge on the Parliament’s website (www.scottish.parliament.uk).

The series is produced by the Legislation Team within the Parliament’s Chamber Office. Comments on this volume or on the series as a whole may be sent to the Legislation Team at the Scottish Parliament, Edinburgh EH99 1SP.

Notes on this volume

The Bill to which this volume relates followed the standard 3 stage process described above.

The Health and Sport Committee’s Stage 1 Report did not include in full the oral and written evidence received by the Committee. This was also the case for the reports to the Health and Sport Committee by the Local Government and Regeneration Committee, Finance Committee and Delegated Powers and Law Reform Committee. This material was originally published on the web only, and is now included in full in this volume.

This volume also includes in full notes of fact-finding visits made by the Health and Sport Committee, and policy statements on a variety of issues relevant to the Bill that were provided by the Scottish Government to assist the Committee’s consideration of the Bill.

The Scottish Government made a written response to the report of the Delegated Powers and Law Reform Committee at Stage 1, in addition to the Government’s
The Delegated Powers and Law Reform Committee noted the general response to the Stage 1 Report of the lead committee. At its meeting on 26 November 2013, the Delegated Powers and Law Reform Committee noted the response without debate. No extracts from the minutes or the Official Report of that meeting are, therefore, included in this volume. Relevant papers for that meeting, including the Scottish Government’s response, are, however, included.

The motion for a financial resolution for the Bill was not considered by the Parliament on the same day as the Stage 1 debate, but the following week on 3 December 2013. The motion was moved and agreed without debate or division and so no Official Report extract is included in this volume. The relevant extract from the Minutes of the Parliament is, however, included in this volume in the After Stage 1 section.

The Delegated Powers and Law Reform Committee considered the delegated powers in the Bill after Stage 2 and reported to the Parliament. That report is included in this volume. However, the Committee agreed its report without debate and no extracts from the minutes or the Official Report of the relevant meeting of the Committee are, therefore, included.

At its meeting on 25 February 2014, the Delegated Powers and Law Reform Committee also considered the delegated powers aspects of Scottish Government amendments at Stage 3. The relevant papers, along with extracts from the minutes and the Official Report of the meeting, are included in this volume.
Public Bodies (Joint Working) (Scotland) Bill

[AS INTRODUCED]

CONTENTS

Section

PART 1

FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

Integration plans

1 Integration plans: same local authority and Health Board area
2 Integration plans: two or more local authorities in Health Board area
3 Considerations in preparing integration plan
4 Integration planning principles
5 Power to prescribe national outcomes
6 Consultation
7 Approval of integration plan
8 Publication of integration plan

Implementation of integration plan

9 Functions delegated to integration joint board
10 Chief officer of integration joint board
11 Other staff of integration joint board
12 Integration joint boards: further provision
13 Payments to integration joint boards in respect of delegated functions
14 Functions delegated to local authority or Health Board
15 Transfer of staff where functions delegated to local authority or Health Board
16 Integration joint monitoring committees: further provision
17 Payments to Health Boards in respect of delegated functions
18 Payments to local authorities in respect of delegated functions
19 Transfer of staff: effect on contract of employment
20 Co-operation

Carrying out of delegated functions

21 Effect of delegation of functions
22 Further powers of persons to whom functions are delegated

Strategic planning etc.

23 Requirement to prepare strategic plans
24 Considerations in preparing strategic plan
25 Integration delivery principles
26 Establishment of consultation group
27 Steps following establishment of consultation group
28 Requirement for agreement to certain strategic plans
29 Publication of strategic plans
30 Significant decisions outside strategic plan: public involvement

Carrying out of integration functions

31 Carrying out of integration functions: general
32 Carrying out of integration functions: localities
33 Integration authority: performance report

Change of integration plan

34 Revised integration plan
35 New integration plan
36 Power to make provision in consequence of new integration plan

Supplementary

37 Information-sharing
38 Grants to local authorities
39 Default power of Scottish Ministers
40 Directions
41 Guidance
42 Meaning of “integration authority”
43 Meaning of “integration functions”

PART 2

SHARED SERVICES

44 Shared services
45 Extension of schemes for meeting losses and liabilities of health service bodies

PART 3

HEALTH SERVICE: FUNCTIONS

46 Scottish Ministers: power to form companies etc.
47 Health Boards: carrying out of functions

PART 4

GENERAL

48 Interpretation
49 Subordinate legislation
50 Ancillary provision
51 Repeals
52 Commencement
53 Short title
Public Bodies (Joint Working) (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

PART 1

FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

Integration plans

1 Integration plans: same local authority and Health Board area

(1) Subsection (2) applies where the area of a local authority is the same as the area of a Health Board.

(2) The local authority and the Health Board must jointly prepare an integration plan for the area of the local authority.

(3) An integration plan is a plan setting out—

(a) which integration model mentioned in subsection (4) is to apply,

(b) the functions that are to be delegated in accordance with that model,

(c) where functions are to be delegated in accordance with the model mentioned in subsection (4)(b), (c) or (d), the functions of the person to whom functions are to be delegated which are to be carried out in conjunction with the delegated functions,

(d) a method of calculating payments that are to be made in respect of a delegated function by the person delegating the function to the person to whom the function is delegated,

(e) prescribed information about such other matters as may be prescribed.

(4) The integration models are—

(a) delegation of functions by the local authority to a body corporate that is to be established by order under section 9 (an “integration joint board”) and delegation of functions by the Health Board to the integration joint board,

(b) delegation of functions by the local authority to the Health Board,
(c) delegation of functions by the Health Board to the local authority,

(d) delegation of functions by the local authority to the Health Board and delegation of functions by the Health Board to the local authority.

(5) A function may not be set out under subsection (3)(c) if it is a function which by virtue of regulations under subsection (6)(a) or (b) may not be delegated under an integration plan.

(6) The Scottish Ministers may by regulations prescribe—

(a) functions of local authorities that must, may or may not be delegated under an integration plan,

(b) functions of Health Boards that must, may or may not be delegated under an integration plan,

(c) functions of local authorities or Health Boards—

(i) that must be delegated under an integration plan other than in prescribed circumstances,

(ii) that may be delegated under an integration plan only in prescribed circumstances,

(iii) that may not be delegated under an integration plan in prescribed circumstances,

(d) functions of local authorities or Health Boards that may be delegated under an integration plan only if other prescribed functions are also delegated to the same person under the plan.

(7) In this section, “Health Board” means a Health Board constituted under section 2(1)(a) of the National Health Service (Scotland) Act 1978 (c.29).

2 Integration plans: two or more local authorities in Health Board area

(1) This section applies where the areas of two or more local authorities fall within the area of a Health Board.

(2) Each local authority and the Health Board must comply with subsection (3) or (4) as respects each local authority area.

(3) Each local authority and the Health Board must jointly prepare an integration plan for the area of the local authority.

(4) Two or more local authorities and the Health Board must jointly prepare an integration plan for the areas of those local authorities.

(5) In preparing an integration plan under subsection (3) or (4), a local authority must take into account—

(a) any other integration plan that has been, or is being, prepared in relation to the area of the same Health Board, and

(b) the likely effect on the Health Board of both or all the plans prepared under this section.
3 Considerations in preparing integration plan
   (1) This section applies where a local authority and a Health Board are preparing an integration plan.
   (2) The local authority and the Health Board must have regard to—
      (a) the integration planning principles (see section 4), and
      (b) the national health and wellbeing outcomes (see section 5).

4 Integration planning principles
   (1) The integration planning principles are—
      (a) that the main purpose of services which must or may be provided in pursuance of functions which must or may be delegated under an integration plan is to improve the wellbeing of recipients,
      (b) that, in so far as consistent with the main purpose, those services should be provided in the way which, so far as possible—
         (i) is integrated from the point of view of recipients,
         (ii) takes account of the particular needs of different recipients,
         (iii) takes account of the particular needs of recipients in different parts of the area in which the service is being provided,
         (iv) is planned and led locally in a way which is engaged with the community and local professionals,
         (v) best anticipates needs and prevents them arising, and
         (vi) makes the best use of the available facilities, people and other resources.
   (2) In subsection (1), “recipients” means persons to whom or in relation to whom the services are provided.

5 Power to prescribe national outcomes
   (1) The Scottish Ministers may by regulations prescribe outcomes in relation to health and wellbeing.
   (2) Such outcomes are to be known as “the national health and wellbeing outcomes”.
   (3) Before making regulations under subsection (1), the Scottish Ministers must consult—
      (a) each local authority,
      (b) each Health Board,
      (c) each integration joint board at the time established,
      (d) in respect of each group mentioned in subsection (4), such persons appearing to be representative of the group as the Scottish Ministers think fit.
   (4) The groups mentioned in subsection (3)(d) are—
      (a) health professionals,
      (b) users of health care,
      (c) carers of users of health care,
Part 1—Functions of local authorities and Health Boards

(d) commercial providers of health care,
(e) non-commercial providers of health care,
(f) social care professionals,
(g) users of social care,
(h) carers of users of social care,
(i) commercial providers of social care,
(j) non-commercial providers of social care.

6 Consultation

(1) This section applies where a local authority and a Health Board are required by section 1(2) or 2(2) to prepare an integration plan.

(2) Before submitting the integration plan for approval under section 7, the local authority and the Health Board must jointly consult—

(a) such persons or groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed, and

(b) such other persons as the local authority and the Health Board think fit.

(3) In finalising the integration plan, the local authority and the Health Board must take account of any views expressed by virtue of subsection (2).

7 Approval of integration plan

(1) After complying with section 6 and before the prescribed day, a local authority and a Health Board must jointly submit an integration plan to the Scottish Ministers for approval.

(2) Any information included in an integration plan by virtue of section 1(3)(e) need not be approved by the Scottish Ministers but may be taken into account by them in deciding whether to approve the plan.

(3) The Scottish Ministers may—

(a) approve the plan submitted under subsection (1),

(b) refuse to approve it.

(4) If the Scottish Ministers refuse to approve the plan, the local authority and the Health Board must jointly modify the plan and submit it for approval under subsection (1).

(5) The Scottish Ministers may, on their own account or on the request of the local authority and the Health Board, specify that subsection (1) applies as if the prescribed day were such later day as the Scottish Ministers may specify.

(6) A request under subsection (5) must be made in writing and must include the reasons for the request.

(7) A day specified under subsection (5) is to be treated as if it were the prescribed day for the purposes of the other provisions of this Act.
8 Publication of integration plan

As soon as practicable after an integration plan is approved under section 7, the local authority and the Health Board must publish it.

Implementation of integration plan

9 Functions delegated to integration joint board

(1) This section applies where the Scottish Ministers approve under section 7 an integration plan setting out that the integration model in section 1(4)(a) is to apply.

(2) The Scottish Ministers may by order establish the integration joint board to which the functions are to be delegated.

(3) The functions are to be delegated before the prescribed day.

10 Chief officer of integration joint board

(1) An integration joint board is to appoint, as a member of staff, a chief officer.

(2) Subsection (3) applies where the person to be appointed is an existing member of staff of a constituent authority.

(3) The person is to be seconded to the board by that authority.

(4) Where subsection (3) does not apply, the person to be appointed—

(a) is to be appointed as a member of staff of a constituent authority, and

(b) is then to be seconded to the board by that authority.

(5) The Scottish Ministers may in relation to any integration joint board by order—

(a) disapply the requirements of subsections (2) to (4), and

(b) make provision enabling the board to employ a chief officer on such terms and conditions as the board determines.

(6) Before appointing a person as chief officer an integration joint board is to consult the constituent authorities.

(7) The responsibilities of a chief officer are subject to the agreement of the Scottish Ministers.

(8) The references in this section to constituent authorities are to the local authority and the Health Board which prepared the integration plan in pursuance of which the integration joint board was established.

11 Other staff of integration joint board

(1) The Scottish Ministers may by order make provision enabling integration joint boards to appoint staff other than a chief officer.

(2) Such an order may include such further provision as regards such staff as the Scottish Ministers think fit, including in particular provision as to—

(a) the appointment of staff,

(b) the numbers of staff,

(c) the terms and conditions of staff.
(3) Provision as to a matter mentioned in subsection (2)(a), (b) or (c) may include provision making the matter subject to the determination, direction or agreement of any person.

(4) Without prejudice to section 49(1)(a), an order under this section may make different provision in relation to different integration joint boards.

12 **Integration joint boards: further provision**

(1) The Scottish Ministers may by order make provision—

(a) about the membership of integration joint boards,

(b) about the proceedings of integration joint boards,

(c) giving integration joint boards general powers (such as powers to contract, acquire or dispose of property or rights or borrow money or incur other liabilities) in connection with the carrying out of their functions,

(d) about the supply of services or facilities to integration joint boards by a local authority or Health Board,

(e) about any other matter relating to the establishment or operation of integration joint boards that the Scottish Ministers think fit.

(2) Without prejudice to section 49(1)(a), an order under this section may make different provision in relation to different integration joint boards.

(3) The Scottish Ministers may by scheme make provision about the transfer to an integration joint board of staff, property, rights, liabilities or obligations of a local authority or a Health Board.

13 **Payments to integration joint boards in respect of delegated functions**

(1) Subsections (2) and (3) apply where—

(a) an integration plan sets out that the integration model in section 1(4)(a) is to apply, and

(b) the plan is approved by the Scottish Ministers under section 7.

(2) The local authority must make a payment to the integration joint board of the amount calculated in accordance with the method of calculation set out in the plan in relation to each function delegated by it.

(3) The Health Board must make a payment to the integration joint board of the amount calculated in accordance with the method of calculation set out in the plan in relation to each function delegated by it.

14 **Functions delegated to local authority or Health Board**

(1) This section applies where the Scottish Ministers approve under section 7 an integration plan setting out that the integration model in section 1(4)(b), (c) or (d) is to apply.

(2) Before the prescribed day—

(a) the local authority and the Health Board must jointly establish a committee (an “integration joint monitoring committee”) for the purpose of monitoring the carrying out of the integration functions for the area of the local authority,

(b) the functions are to be delegated.
15 Transfer of staff where functions delegated to local authority or Health Board
(1) The Scottish Ministers may by scheme make provision about the transfer of staff from a person who is to delegate functions under an integration plan falling within subsection (2) to the person to whom the functions are to be delegated.
(2) An integration plan falls within this subsection if it sets out that the integration model in section 1(4)(b), (c) or (d) is to apply.

16 Integration joint monitoring committees: further provision
(1) The Scottish Ministers may by order make provision about—
   (a) the establishment of integration joint monitoring committees,
   (b) the membership of integration joint monitoring committees,
   (c) the proceedings of integration joint monitoring committees,
   (d) any other matter relating to the operation of integration joint monitoring committees that the Scottish Ministers think fit.
(2) Without prejudice to section 49(1)(a), an order under subsection (1) may make different provision in relation to different integration joint monitoring committees.

17 Payments to Health Boards in respect of delegated functions
(1) Subsection (2) applies where—
   (a) an integration plan sets out that the integration model in section 1(4)(b) or (d) is to apply, and
   (b) the plan is approved by the Scottish Ministers under section 7.
(2) The local authority must make a payment to the Health Board of the amount calculated in accordance with the method of calculation that is set out in the plan in relation to each function delegated to the Health Board.

18 Payments to local authorities in respect of delegated functions
(1) Subsection (2) applies where—
   (a) an integration plan sets out that the integration model in section 1(4)(c) or (d) is to apply, and
   (b) the plan is approved by the Scottish Ministers under section 7.
(2) The Health Board must make a payment to the local authority of the amount calculated in accordance with the method of calculation that is set out in the plan in relation to each function delegated to the local authority.

19 Transfer of staff: effect on contract of employment
(1) This section applies where by virtue of section 12(3) or 15(1) a person is to be transferred from the employment of one person (“the original employer”) to another (“the new employer”).
(2) If, before the day of the transfer, the person informs the original employer that the person does not wish to become an employee of the new employer, the person’s contract of employment is terminated on the day before the day of the transfer.

(3) Otherwise—

(a) the contract of employment between the person and the original employer has effect on and after the day of the transfer as if originally made between the person and the new employer,

(b) the rights, powers, duties and liabilities of the original employer under or in connection with the contract of employment are by virtue of this section transferred to the new employer on the day of the transfer, and

(c) anything done before the day of the transfer by or in relation to the original employer in respect of the contract of employment or the person is to be treated on and after that day as having been done by or in relation to the new employer.

(4) A person is not to be treated for any purpose as being dismissed by reason of the operation of any provision of this section in relation to the person.

(5) Nothing in this section affects any right of a person to terminate the person’s contract of employment if a substantial detrimental change in the person’s working conditions is made.

(6) No such right arises by reason only that, by virtue of this section, the identity of the person’s employer changes.

20 Co-operation

(1) This section applies where the Scottish Ministers approve under section 7 one or more plans prepared by virtue of section 2(3) or (4) in relation to the same Health Board.

(2) The persons mentioned in subsection (3) must co-operate with each other in relation to the efficient and effective use of buildings, staff and equipment to which the plan or plans relate.

(3) The persons are—

(a) each local authority,

(b) the Health Board.

Carrying out of delegated functions

21 Effect of delegation of functions

(1) This section applies where a function is delegated in pursuance of an integration plan.

(2) The person to whom the function is delegated—

(a) is subject to the same duties in connection with the carrying out of the function as the person who delegated the function would have been subject in the event that the function had not been delegated,

(b) has the same rights and powers (including in particular powers to make payments or impose charges) in connection with the carrying out of the function as the person who delegated the function would have had in the event that the function had not been delegated,

(c) is in all respects as if the person who delegated the function—
(i) entitled to enforce any rights acquired in the carrying out of the function,
(ii) liable in respect of any liabilities incurred (including in particular liability in damages for wrongful or negligent acts or omissions) in the carrying out of the function.

5 (3) In subsection (2)—

(a) the reference in paragraph (a) to duties includes duties imposed after the delegation takes place,
(b) the reference in paragraph (b) to rights and powers includes rights or powers conferred after the delegation takes place.

10 (4) All proceedings for the enforcement of rights or liabilities mentioned in subsection (2)(c) are to be brought by or against the person to whom the function is delegated in the person’s own name.

(5) The Scottish Ministers may by order provide that an integration joint board must or must not exercise a power conferred by virtue of subsection (2)(b).

22 Further powers of persons to whom functions are delegated

(1) In addition to the powers conferred by section 21(2)(b)—

(a) an integration joint board may by direction specify that a function delegated to it in pursuance of an integration plan is to be carried out on its behalf by the local authority or Health Board which prepared the integration plan,

(b) a local authority or Health Board to which a function is delegated in pursuance of an integration plan may by direction specify that the function is to be carried out on its behalf by the local authority or Health Board which delegated the function in pursuance of the plan.

(2) A direction under subsection (1)—

(a) may include provision—

(i) about the manner in which the function is to be carried out,
(ii) about the rights, powers, duties or liabilities of the person who is to carry out the function,

(b) must set out, or set out a method of calculating, payments that are to be made by the person giving the direction to the person who is to carry out the function.

(3) A person giving a direction under subsection (1) must make payments in accordance with the provision included in the direction by virtue of subsection (2)(b).

(4) Where a person is carrying out a function by virtue of a direction under subsection (1), subsections (2) to (4) of section 21 apply as if—

(a) the person were a person to whom the function had been delegated under those subsections,
(b) the person who gave the direction were a person who had delegated the function under those subsections.

(5) Subsection (4) is subject to any provision included in the direction by virtue of subsection (2)(a)(ii).
(6) A person to whom a direction under subsection (1) is given must comply with the direction.

(7) A direction under subsection (1)—
   (a) may vary or revoke any earlier direction under this section,
   (b) must be in writing.

(8) The Scottish Ministers may by order provide that an integration joint board must or must not give a direction under subsection (1).

Strategic planning etc.

23 Requirement to prepare strategic plans

10 (1) The integration authority for the area of a local authority must prepare strategic plans in accordance with this section.

(2) A strategic plan is a document—
   (a) setting out the arrangements for the carrying out of the integration functions for the area of the local authority over the period of the plan,
   (b) setting out how those arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes, and
   (c) including such other material as the integration authority thinks fit.

(3) The provision required to be included in a strategic plan by virtue of subsection (2)(a) is to include provision—
   (a) dividing the area of the local authority into two or more localities, and
   (b) setting out separately arrangements for the carrying out of the integration functions in relation to each such locality.

(4) The first strategic plan of an integration authority is—
   (a) to be prepared before the prescribed day, and
   (b) to relate to the period of 3 years beginning with the prescribed day.

(5) Subsequent strategic plans of an integration authority are—
   (a) to be prepared before each anniversary of the day prescribed under subsection (4)(b), and
   (b) to relate to the period of 3 years beginning with the anniversary mentioned in paragraph (a) by reference to which the plan is to be prepared.

24 Considerations in preparing strategic plan

In preparing a strategic plan, the integration authority for the area of a local authority must have regard to—
   (a) the integration delivery principles (see section 25), and
   (b) the national health and wellbeing outcomes (see section 5).

25 Integration delivery principles

(1) The integration delivery principles are—
that the main purpose of services which must or may be provided in pursuance of the integration functions for the area of the local authority is to improve the wellbeing of recipients,

(b) that, in so far as consistent with the main purpose, those services should be provided in the way which, so far as possible—

(i) is integrated from the point of view of recipients,

(ii) takes account of the particular needs of different recipients,

(iii) takes account of the particular needs of recipients in different parts of the area in which the service is being provided,

(iv) is planned and led locally in a way which is engaged with the community and local professionals,

(v) best anticipates needs and prevents them arising, and

(vi) makes the best use of the available facilities, people and other resources.

(2) In subsection (1), “recipients” means persons to whom or in relation to whom the services are provided.

26 Establishment of consultation group

(1) For the purpose of preparing a strategic plan, an integration authority in relation to the area of a local authority is to establish a group comprising—

(a) where the integration authority is an integration joint board, one person nominated by each of the local authority and the Health Board which prepared the integration plan in pursuance of which the integration authority was established,

(b) where the integration authority is a Health Board, one person nominated by the local authority with which the integration authority prepared the integration plan in pursuance of which the integration authority acquired its functions,

(c) where the integration authority is a local authority, one person nominated by the Health Board with which the integration authority prepared the integration plan in pursuance of which the integration authority acquired its functions,

(d) one person in respect of each of the groups mentioned in subsection (2), being a person who the integration authority considers to be representative of that group, and

(e) such other persons as the integration authority considers appropriate.

(2) The groups referred to in subsection (1)(d) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

(3) The procedure of the group is to be such as the authority determines.

(4) The integration authority may pay to members of the group such expenses and allowances as the authority determines.

27 Steps following establishment of consultation group

(1) Having established a group under section 26, an integration authority in relation to the area of a local authority is to—

(a) prepare proposals for what the strategic plan should contain, and
(b) seek the views of the group on the proposals.

(2) Taking account of any views expressed by virtue of subsection (1)(b), the integration authority is then to—
   (a) prepare a first draft of the strategic plan, and
   (b) seek the views of the group on the draft.

(3) Taking account of any views expressed by virtue of subsection (2)(b), the integration authority is then to—
   (a) prepare a second draft of the strategic plan,
   (b) send a copy to—
       (i) the persons mentioned in subsection (4), and
       (ii) such other persons as it considers appropriate, and
   (c) invite the recipients to express views (within such period as the integration authority considers appropriate) on the draft.

(4) The persons referred to in subsection (3)(b)(i) are—
   (a) where the integration authority is an integration joint board, the local authority and the Health Board which prepared the integration plan in pursuance of which the integration joint board was established,
   (b) where the integration authority is a local authority, the Health Board with which the local authority prepared the integration plan in pursuance of which the integration authority acquired its delegated functions,
   (c) where the integration authority is a Health Board, the local authority with which the Health Board prepared the integration plan in pursuance of which the integration authority acquired its delegated functions, and
   (d) persons who the integration authority considers to be representative of each of the groups mentioned in subsection (5).

(5) The groups referred to in subsection (4)(d) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

(6) In finalising the strategic plan, the integration authority must take account of any views expressed by virtue of subsection (3)(c).

28 Requirement for agreement to certain strategic plans

(1) This section applies in relation to a strategic plan prepared by an integration authority which is a Health Board or a local authority.

(2) After finalising the plan, the integration authority must submit it to the person mentioned in subsection (3) for approval.

(3) That person is—
   (a) where the integration authority is a local authority, the Health Board with which the integration authority prepared the integration plan in pursuance of which the integration authority acquired its delegated functions,
   (b) where the integration authority is a Health Board, the local authority with which the integration authority prepared the integration plan in pursuance of which the integration authority acquired its delegated functions.
(4) If that person does not approve the plan, the integration authority must modify the plan and submit it for approval under subsection (2).

29 **Publication of strategic plans**

(1) As soon as practicable after the occurrence of the event mentioned in subsection (2), an integration authority must publish its strategic plan.

(2) That event is—

   (a) where the integration authority is an integration joint board, the finalisation of the plan under section 27,

   (b) where the integration authority is a local authority and a Health Board acting jointly, the finalisation of the plan under section 27,

   (c) where the integration authority is a Health Board or a local authority, the agreement of the plan under section 28.

(3) At the same time as publishing a strategic plan, an integration authority must also publish a statement of the action which it took in pursuance of section 27.

30 **Significant decisions outside strategic plan: public involvement**

(1) This section applies where the integration authority for the area of a local authority—

   (a) proposes to take a significant decision about the arrangements for the carrying out of the integration functions for the area of the authority, and

   (b) intends the decision to take effect other than in its next strategic plan.

(2) In subsection (1)(a), “significant decision” means a decision which the integration authority considers might significantly affect the provision of a service provided in pursuance of the integration functions in the area of the local authority.

(3) The integration authority must take such action as it thinks fit with a view to securing that persons mentioned in subsection (4) are involved in and consulted on the decision.

(4) Those persons are users of the service which is being or may be provided.

**Carrying out of integration functions**

31 **Carrying out of integration functions: general**

In carrying out an integration function for the area of a local authority, a person must have regard to—

   (a) the integration delivery principles (see section 25), and

   (b) the national health and wellbeing outcomes (see section 5).

32 **Carrying out of integration functions: localities**

(1) This section applies where a person carrying out an integration function for the area of a local authority proposes to take a decision which the person considers might significantly affect the provision in a locality of the area of a service provided in pursuance of the function.

(2) In subsection (1), “locality” means a locality of an area as set out in the strategic plan in pursuance of section 23(3)(a).
(3) The person must take such action as the person thinks fit with a view to securing that the groups mentioned in subsection (4) are involved in and consulted on the decision.

(4) The groups referred to in subsection (3) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

5 Integration authority: performance report

(1) Each integration authority must prepare and publish a performance report for the reporting year.

(2) A performance report is a report setting out an assessment of performance during the reporting year in carrying out the integration functions for the area of the local authority.

(3) The Scottish Ministers may by regulations prescribe—

- the form and content of performance reports,
- the period during which performance reports must be published.

(4) In this section, “reporting year”, in relation to an integration authority, means—

- the period beginning with the date prescribed under section 23(4)(b) and ending on the first anniversary of that date, and
- each subsequent period of a year.

Change of integration plan

34 Revised integration plan

(1) This section applies where an integration plan has been approved by the Scottish Ministers under section 7.

(2) The local authority and the Health Board may vary the plan by jointly preparing a revised integration plan.

(3) A revised integration plan may—

- set out additional functions that are to be delegated under the plan as mentioned in section 1(3)(b),
- set out functions that are delegated by virtue of the integration plan approved under section 7 that are no longer to be delegated,
- if the integration plan delegates functions in accordance with the integration model mentioned in section 1(4)(b), (c) or (d), set out functions that are to be carried out in conjunction with the delegated functions,
- if the integration plan delegates functions in accordance with the integration model mentioned in section 1(4)(b), (c) or (d), set out functions that are no longer to be carried out in conjunction with the delegated functions,
- change the method of calculating payments as mentioned in section 1(3)(d).

(4) The local authority and the Health Board must jointly submit the revised plan to the Scottish Ministers for approval under section 7.

(5) A revised integration plan takes effect on such day as may be specified by the Scottish Ministers.
35  **New integration plan**

(1) This section applies where an integration plan has been approved by the Scottish Ministers under section 7.

(2) If the local authority and the Health Board wish to change any of the matters mentioned in subsection (3) they must prepare a new integration plan under section 1.

(3) The matters are—

(a) the local authority which prepared the integration plan,  
(b) the integration model.

36  **Power to make provision in consequence of new integration plan**

(1) This section applies where the Scottish Ministers approve an integration plan which has been prepared by virtue of section 35.

(2) In consequence of the replacement of an integration plan by a new integration plan, the Scottish Ministers may by order provide for the winding-up of an integration joint board.

(3) In consequence of the replacement of an integration plan by a new integration plan, the Scottish Ministers may by scheme make such provision about the transfer of staff, property, rights, liabilities or obligations of an integration joint board, a local authority or a Health Board as they consider necessary.

**Supplementary**

37  **Information-sharing**

(1) Where a local authority and a Health Board are jointly preparing an integration plan, each of them may disclose information to the other for or in relation to the purpose of preparing the plan.

(2) Where two or more local authorities and a Health Board are jointly preparing an integration plan, each of them may disclose information to any of the others for or in relation to the purpose of preparing the plan.

(3) A person mentioned in subsection (4) may disclose information to any other person mentioned in that subsection for or in relation to any of the purposes mentioned in subsection (5).

(4) The persons are—

(a) a local authority,  
(b) a Health Board,  
(c) an integration joint board.

(5) The purposes are—

(a) functions that are delegated by virtue of an integration plan approved under section 7,  
(b) functions that are to be carried out in conjunction with delegated functions,  
(c) the preparation of a strategic plan.
(6) Subsections (1) to (3) apply despite any duty of confidentiality owed to any person in respect of the information by the person disclosing the information.

38 Grants to local authorities

(1) The Scottish Ministers may make a grant to a local authority in respect of costs incurred by the authority by virtue of this Part.

(2) The payment of a grant under subsection (1) may be made subject to such conditions (including conditions as to repayment) as the Scottish Ministers may determine.

39 Default power of Scottish Ministers

(1) Subsection (2) applies where a local authority and a Health Board fail before the day prescribed for the purposes of section 7 to submit an integration plan for the approval of the Scottish Ministers under that section.

(2) The Scottish Ministers may—

(a) specify functions of the local authority and the Health Board which are to be delegated to an integration joint board,

(b) by order establish the integration joint board to which the functions are to be delegated,

(c) require the local authority and the Health Board to delegate the specified functions to the integration joint board before the prescribed day,

(d) require the local authority and the Health Board to make such payments to the integration joint board as the Scottish Ministers may specify, and

(e) require the local authority and the Health Board to comply with such other requirements in relation to the functions as the Scottish Ministers may specify.

40 Directions

(1) The Scottish Ministers may give directions to a local authority in relation to the carrying out of—

(a) functions conferred on it by this Act,

(b) functions delegated to it in pursuance of an integration plan,

(c) functions specified in the plan that are to be carried out in conjunction with those functions.

(2) The Scottish Ministers may give directions to a Health Board in relation to the carrying out of—

(a) functions conferred on it by this Act,

(b) functions delegated to it in pursuance of an integration plan,

(c) functions specified in the plan that are to be carried out in conjunction with those functions.

(3) The Scottish Ministers may give directions to an integration joint board in relation to the carrying out of—

(a) functions conferred on it by this Act,

(b) functions delegated to it in pursuance of an integration plan.
(4) A local authority, a Health Board or an integration joint board must comply with a direction given to it under this section.

(5) Directions under this section—
   (a) may vary or revoke earlier directions under this section,
   (b) must be in writing.

41 Guidance

Each local authority, Health Board and integration joint board must have regard to any guidance issued by the Scottish Ministers about their functions under or in relation to this Act.

42 Meaning of “integration authority”

For the purposes of this Part, the “integration authority” for the area of a local authority is—

(a) where in pursuance of the integration plan for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(a), the integration joint board established in pursuance of the plan,

(b) where in pursuance of the integration plan for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(b), the Health Board to which the functions are delegated,

(c) where in pursuance of the integration plan for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(c), the local authority to which the functions are delegated,

(d) where in pursuance of the integration plan for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(d), the local authority and the Health Board to which the functions are delegated, acting jointly.

43 Meaning of “integration functions”

(1) For the purposes of this Part, the “integration functions” for the area of a local authority are—

(a) where in pursuance of the integration plan for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(a), the functions delegated to the integration joint board in pursuance of the plan,

(b) where in pursuance of the integration plan for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(b)—
   (i) the functions delegated to the Health Board in pursuance of the plan, and
   (ii) the functions to be carried out in conjunction with those functions,

(c) where in pursuance of the integration plan for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(c)—
   (i) the functions delegated to the local authority in pursuance of the plan, and
   (ii) the functions to be carried out in conjunction with those functions,
(d) where in pursuance of the integration plan for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(d)—

(i) the functions delegated to each of the Health Board and the local authority in pursuance of the plan, and

(ii) the functions to be carried out in conjunction with those functions.

(2) In subsection (1), the references to the functions which are to be carried out in conjunction with delegated functions are to the functions set out in the integration plan in pursuance of section 1(3)(c).

**PART 2**

**SHARED SERVICES**

44 **Shared services**

(1) The Common Services Agency for the Scottish Health Service (the “Agency”) may, with the consent of the Scottish Ministers, enter into arrangements with a person mentioned in subsection (2) under which the Agency provides, or secures the provision of, any goods or services for the person.

(2) The persons are—

(a) the Scottish Ministers,

(b) any other office-holder in the Scottish Administration,

(c) any Scottish public authority,

(d) any Scottish public authority with mixed functions or no reserved functions,

(e) any government department,

(f) any cross-border public authority.

(3) Services which may be provided under subsection (1) include in particular—

(a) administrative services,

(b) technical services,

(c) legal services.

(4) The power to make arrangements under subsection (1) is without prejudice to any other power of the Agency to provide goods or services to other persons.

(5) In this section—

“cross-border public authority” has the meaning given by section 88(5) of the Scotland Act 1998 (c.46),

“government department”, and “Scottish public authority” have the meanings given by section 126(1) of that Act,

“office-holder in the Scottish Administration” is to be construed in accordance with section 126(7) of that Act,

“Scottish public authority with mixed functions or no reserved functions” is to be construed in accordance with paragraphs 1 and 2 of Part 3 of Schedule 5 to that Act.
45  **Extension of schemes for meeting losses and liabilities of health service bodies**

(1) Section 85B of the National Health Service (Scotland) Act 1978 (schemes for meeting losses and liabilities of health service bodies) is amended as follows.

(2) In subsection (2)—
   
   (a) the word “and” immediately after paragraph (ea) is repealed,
   
   (b) after paragraph (f) add—
      
      “(g) local authorities; and

      (h) integration joint boards established by order under section 9(2) of the 2014 Act,”.

(3) After subsection (2A) insert—

“(2B) The reference—

   (a) in paragraph (a) of subsection (1) to property of a local authority is to be construed as a reference to property held by a local authority in connection with the exercise of its relevant functions;

   (b) in paragraph (b) of that subsection to the functions of a local authority is to be construed as a reference to the relevant functions of a local authority.

(2C) In subsection (2B), “relevant functions” means—

   (a) integration functions; and

   (b) such other functions as the Scottish Ministers may by order specify.

(2D) In subsection (2C)(a), “integration functions” means functions which in pursuance of an integration plan under the 2014 Act are—

   (a) delegated to the authority;

   (b) to be carried out in conjunction with functions delegated to the authority (that is, functions set out in the integration plan in pursuance of section 1(3)(c) of that Act); or

   (c) to be carried out by the authority by virtue of a direction under section 22 of the 2014 Act.”.

(4) After subsection (4) insert—

“(4A) Subsection (4)(a) does not apply in relation to a local authority.”.

(5) After subsection (5) insert—

“(6) In this section, “the 2014 Act” means the Public Bodies (Joint Working) (Scotland) Act 2014.”.

---

**PART 3**

**HEALTH SERVICE: FUNCTIONS**

46  **Scottish Ministers: power to form companies etc.**

In section 84B of the National Health Service (Scotland) Act 1978 (joint ventures)—
(a) in subsection (1), for “companies”, wherever it occurs, substitute “bodies corporate”,

(b) in subsection (2), for “company” substitute “body corporate”, and

(c) in subsection (3), the definition of “companies” is repealed.

47 Health Boards: carrying out of functions

After section 12J of the National Health Service (Scotland) Act 1978, insert—

"12K Power of Health Board to carry out other Health Board’s functions

A Health Board may, with the agreement of another Health Board and the Scottish Ministers, carry out on behalf of that other Health Board any function of that other Health Board.”.

PART 4

GENERAL

48 Interpretation

(1) In this Act—

“Health Board” has the meaning given by section 1(7),

“health care” has the same meaning as in section 10A(1)(b) of the National Health Service (Scotland) Act 1978,

“health professionals” means persons of such description engaged in the provision of health care as may be prescribed,

“integration joint board” has the meaning given by section 1(4)(a),

“integration joint monitoring committee” has the meaning given by section 14(2)(a),

“integration plan” has the meaning given by section 1(3),

“prescribed” means prescribed by the Scottish Ministers by regulations,

“social care” means—

(a) social services (having the same meaning as in Part 5 of the Public Services Reform (Scotland) Act 2010), and

(b) such functions of local authorities relating to the provision of accommodation for persons who are homeless as may be prescribed,

“social care professionals” means persons of such description engaged in the provision of social care as may be prescribed,

“strategic plan” has the meaning given by section 23(2).

(2) For the purposes of this Act, a provider of a service is a “commercial” provider if the aim of the person in providing the service is or includes making a profit.

(3) References in this Act (other than sections 2(3) and 37(1))—

(a) to a local authority include, in the case where the integration plan is being or has been jointly prepared under section 2(4), references to both or all the authorities which are preparing or have prepared the plan, acting jointly,
(b) to the area of a local authority mean, in a case where the integration plan is being
or has been jointly prepared under section 2(4), the combined area of the local
authorities which are preparing or have prepared the plan.

(4) References in this Act to a function include references to a function so far as exercisable
in relation to persons or matters of a particular class or description.

49 Subordinate legislation

(1) Regulations and orders under this Act may—
(a) make different provision for different purposes,
(b) include such supplementary, incidental, consequential, transitional or transitory
    provision, or savings, as the Scottish Ministers consider appropriate.

(2) Regulations under section 5(1) are subject to the affirmative procedure.

(3) An order under section 50 containing provision which adds to, replaces or omits any
    part of the text of an Act is subject to the affirmative procedure.

(4) Otherwise, regulations and orders under this Act are subject to the negative procedure.

(5) This section does not apply to an order under section 52(2).

50 Ancillary provision

(1) The Scottish Ministers may by order—
(a) make such supplementary, incidental or consequential provision as they consider
    appropriate for the purposes of, in consequence of, or for giving full effect to, any
    provision of this Act,
(b) make such transitional or transitory provision or savings as they consider
    appropriate for the purposes of, or in connection with, the coming into force of
    any provision of this Act.

(2) An order under this section may modify any enactment (including this Act).

51 Repeals

(1) Sections 4A and 4B of the National Health Service (Scotland) Act 1978 (c.29) (which
    make provision about community health partnerships) are repealed.
(2) Sections 15 to 17 of the Community Care and Health (Scotland) Act 2002 (asp 5)
    (which make provision about joint working among local authorities and certain health
    bodies) are repealed.
(3) Section 2 of the National Health Service Reform (Scotland) Act 2004 (asp 7) (which
    inserts sections 4A and 4B into the National Health Service (Scotland) Act 1978) is
    repealed.
(4) Section 20 of the Social Care (Self-directed Support) (Scotland) Act 2013 (asp 1)
    (which amends section 15(4) of the Community Care and Health (Scotland) Act 2002) is
    repealed.

52 Commencement

(1) This Part (other than sections 48 and 51) comes into force on the day after Royal Assent.
(2) The other provisions of this Act come into force on such day as the Scottish Ministers may by order appoint.

(3) An order under subsection (2) may contain transitory or transitional provision or savings.

53  **Short title**

The short title of this Act is the Public Bodies (Joint Working) (Scotland) Act 2014.
Public Bodies (Joint Working) (Scotland) Bill
[AS INTRODUCED]

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

Introduced by: Alex Neil
Supported by: Derek Mackay
On: 28 May 2013
Bill type: Government Bill
These documents relate to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

PUBLIC BODIES (JOINT WORKING) (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

As required under Rule 9.3 of the Parliament’s Standing Orders, the following documents are published to accompany the Public Bodies (Joint Working) (Scotland) Bill introduced in the Scottish Parliament on 28 May 2013:

- Explanatory Notes;
- a Financial Memorandum;
- a Scottish Government Statement on legislative competence; and
- the Presiding Officer’s Statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 32–PM.
EXPLANATORY NOTES

INTRODUCTION

1. These Explanatory Notes have been prepared by the Scottish Government in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

2. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

THE BILL

3. The Bill provides the framework which will support the improvement of the quality and consistency of health and social care services in Scotland. This framework permits the integration of local authority services with health services. In addition, the Bill provides for the Common Services Agency commonly known as NHS National Services Scotland to provide goods and services to public bodies including local authorities; for the Scottish Ministers to form a wider range of joint venture structures than at present in order to make the most effective use of resources; and to extend the Clinical Negligence and Other Risks Scheme (CNORIS) indemnity scheme run by the Scottish Ministers.

Outline of the Bill

4. In summary the Bill:
   - Provides for national outcomes for health and wellbeing, and for delivery of which Health Boards and local authorities will be accountable to the Scottish Ministers and the public (note that the provisions of the Bill apply to area Health Boards and not Special Health Boards)
   - Sets out principles for planning and delivery of integrated functions, which local authorities, Health Boards and joint integration boards will be required to have regard to. They set out that the main purpose of integrated services is to improve the wellbeing of recipients, as well as an expectation that planning and delivery will take account of key principles relating to integrated delivery; the requirement to balance the needs of individuals with the overall needs of the population; anticipation and prevention of need; and effective use of resources.
   - Establishes integration joint boards and integration joint monitoring committees as the partnership arrangements for the governance and oversight of health and social care services. The Bill will remove Community Health Partnerships from statute.
   - Requires Health Board and local authority partners to enter into arrangements (the integration plan) to delegate functions and appropriate resources to ensure the effective delivery of those functions. The Bill provides two options for integrating budgets and functions. First, delegation to an integration joint board established as a body corporate - in this case the Health Board and the local authority agree the
amount of resources to be committed by each partner for the delivery of services to support the functions delegated. Second, delegation between partners. In this case the Health Board and/or local authority delegates functions and the corresponding amount of resource, to the other partner.

- Requires integration joint boards to appoint a chief officer, who will through the board be jointly accountable to the constituent Health Board and local authorities, responsible for the management of the integrated budget and the delivery of services for the area of the integration plan. The chief officer will also lead the development and delivery of the strategic plan for the joint board.

- Requires integration joint boards, and Health Boards or local authorities to whom functions are delegated acting in the capacity of “integration authority” to prepare a strategic plan for the area, which sets out arrangements for delivery of integration functions and how it will meet the national health and wellbeing outcomes. The integration authority will be required to involve a range of partners in the development of the plan and consult widely. In addition, locality planning duties will require the integration authority to make suitable arrangements to consult and plan locally for the needs of its population.

- Delivers opportunities for more effective use of public services and resources by allowing for Health Boards to be able to contract on behalf of other Health Boards for contracts which involve providing facilities, and by allowing the Scottish Ministers to form a wider range joint ventures structures to collaborate effectively with local authorities and enable a joint approach to asset management and disposal.

- Provides for the extension of the Common Services Agency’s ability to deliver shared services to public bodies including local authorities.

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

COMMENTARY ON SECTIONS

Part 1

FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

Integration plans

Section 1 – Integration plans: same local authority and Health Board area

5. Section 1 makes provision about integration plans and sets out the four models of integration from which local authorities and Health Boards are to choose for the purposes of integration planning and integrated delivery of services in accordance with the Bill.
6. Integration planning is predicated on the delegation of local authority and/or Health Board functions using one of the four models of delegation set out in subsection (4): (a) the local authority and the Health Board delegate functions to an integration joint board established as a body corporate by order by the Scottish Ministers; (b) the local authority delegates functions to the Health Board; (c) the Health Board delegates functions to a local authority, and (d) the local authority delegates functions to the Health Board and the Health Board delegates functions to the local authority.

7. By virtue of subsections (1) and (2), where the area of a local authority is the same as the area of a Health Board i.e. there is a single local authority within the Health Board area, the local authority and the Health Board are required to jointly prepare an integration plan for the area of the local authority.

8. Subsection (3) sets out what the integration plan must include. The required information is: (a) which model of integration is to be used, (b) the functions which are to be delegated in the way identified, (c) where functions are delegated to a Health Board, local authority or both, the functions of that body which are to be carried out in conjunction with the delegated functions, (the functions which may be set out in this part of the plan are described in subsection (5)), (d) a method of calculating payments which are to be made with respect to the delegated functions, and (e) any additional information that may be required by the Scottish Ministers by regulations.

9. Subsection (6) enables the Scottish Ministers to make provision in regulations about functions of local authorities and Health Boards which may, may not or must be delegated under integration plans. If no regulations are made local authorities and Health Boards will be free to choose which of their functions to delegate under the Bill. This provision will however give the Scottish Ministers flexibility to set parameters, including minimum requirements, for the delegation of functions.

10. Subsection (7), read with section 48(1)(Interpretation) defines what is meant by “Health Board” for the purposes of the Bill. Its effect is that the provisions of the Bill apply to area Health Boards only, not Special Health Boards.

Section 2 - Integration plans: two or more local authorities in Health Board area

11. Section 2 sets out integration planning requirements where more than one local authority sits within the boundary of a single Health Board area (in contrast to the requirements in section 1(2) which apply where there is a single local authority in a Health Board area).

12. By virtue of subsection (2), each local authority and the Health Board are to agree which of the alternative duties in subsections (3) and (4) they will comply with in respect of the local authority area (compliance with one or the other is mandatory). The options are for a local authority to jointly prepare an integration plan with that Health Board, for its own area only (subsection (3)), or for the local authority to join together with one or more other local authorities to, with the Health Board, jointly prepare an integration plan for the areas of those local authorities (subsection (4)). The result is that within a single Health Board area which houses more than one local authority there may be any number of single local authority plans and/or multiple local authority plans. For example, in an area with 3 local authorities there may...
be a plan for a single area plus a plan covering the other two areas; or in an area with 6 local authorities there could be a plan covering three areas, plus a plan covering two areas, plus a plan for a single area. The effect is to provide flexibility so that planning decisions can be taken on the basis of what is appropriate for the areas in question i.e. multiple local authorities, within the area of the same Health Board, can plan together, where appropriate or they may choose to plan separately.

13. Subsection (5) sets out that when preparing an integration plan, whether between an individual local authority and Health Board, or multiple local authorities and a Health Board, a local authority must (a) take into account any other integration plan that is currently or has been prepared for the same Health Board area, and (b) the potential impact on the Health Board of any plans prepared in relation to that Health Board. This provision establishes the importance of different integration plans within a single Health Board area paying due regard to their combined effect, and inter-operability, in relation, in particular, to the effective running of the Health Board.

Section 3 – Considerations in preparing integration plan

14. Section 3 requires the local authority and Health Board to consider the integration principles and the national health and wellbeing outcomes when preparing their integration plan. This provides the link with the national outcomes for health and wellbeing from the outset and underpins the purpose of integrating services, to ensure integration arrangements which embed a preventative, anticipatory and person-centred approach to the planning and delivery of services. Section 4 provides further information on integration principles and section 5 provides further information on national health and wellbeing outcomes.

Section 4 – Integration planning principles

15. Section 4 establishes the integration planning principles that must be taken into account when preparing an integration plan.

16. The effect of subsection (1)(a) is to ensure that decisions about integration of functions take account of the principle that services, for the purposes of carrying out functions that must or may be delegated, are to improve the wellbeing of users of that service.

17. Subsection (1)(b) supplements this by setting out principles for delivery which must also be taken into account in taking decisions about how functions will be integrated. The effect is to ensure a focus on integrated delivery, consideration of the needs of different individuals and different areas, local planning and leadership, anticipation and prevention, and effective use of resources.

Section 5 – Power to prescribe national outcomes

18. This section provides for the Scottish Ministers to set out in regulations, national outcomes that relate to health and wellbeing. The national outcomes will provide for improved experience of services and outcomes that services achieve. The intention is for the national
outcomes on health and wellbeing to be reflected in the Single Outcome Agreements, which the national outcomes expressed within the National Performance Framework.

19. Before doing so, the Scottish Ministers are required to consult persons set out in subsections (3) and (4). The effect of the provision is to involve the groups identified in the development of the national outcomes on health and wellbeing.

**Section 6 – Consultation**

20. Section 6 sets out consultation requirements in relation to the preparation of integration plans.

21. The local authority and Health Board, before submitting the integration plan for approval, are required to consult (a) those persons or groups of person, set out by the Scottish Ministers, by regulations, and (b) any other persons as the local authority and Health Board think fit. The consultation must be carried out jointly by the local authority and the Health Board. The local authority and Health Board are required to take account of views expressed as part of the consultation, when finalising the integration plan.

**Section 7 - Approval of integration plan**

22. This section requires a local authority and Health Board to jointly submit the integration plan to the Scottish Ministers for approval, before a date that will be set by the Scottish Ministers by regulations.

23. Subsection (5) gives Ministers a discretionary power to grant an extension for submission of a plan for approval. The Scottish Ministers may grant an extension on their own initiative or on the request of the local authority and the Health Board. Where the request comes from the local authority and the Health Board it must be made jointly and reasons must be given. The effect is to enable a plan to be accepted after the statutory deadline for submission, where there is good reason.

24. The Scottish Ministers may decide either to approve an integration plan submitted to them, or to refuse to approve it. Although any information that may be included by virtue of section 1(3)(e) does not form part of the information to be approved, it may be taken into account by Ministers in coming to their decision.

25. If the Scottish Ministers refuse to approve the submitted integration plan, the local authority and Health Board must jointly amend the plan and resubmit it for approval.

**Section 8 – Publication of integration plan**

26. Section 8 requires the local authority and Health Board to publish the approved integration plan, as soon as practicable after it has been approved.
Implementation of integration plan

Section 9 – Functions delegated to integration joint board

27. This section provides that, where the Scottish Ministers approve an integration plan which sets out that functions will be delegated to an integration joint board under section 1(4)(a), Ministers may by order establish the integration joint boards, which will have the functions specified in the integration plan delegated to it.

28. Subsection (3) provides for the functions in the integration plan to be delegated before a date set, by the Scottish Ministers, by regulations.

Section 10 – Chief officer of integration joint board

29. Section 10 requires the integration joint board to appoint a member of staff to be its chief officer. The integration joint board will not necessarily be given powers to employ its own staff. Section 11 provides for the Scottish Ministers to give the ability to joint boards to appoint staff. In the absence of an order being made under section 11 to allow for the appointment of staff, subsections (2), (3) and (4) set out the default position that the chief officer is to be seconded to it from one of its constituent local authorities or Health Board. In the event that there is a wish in future for the chief officer to be employed directly by the joint integration board, Ministers have powers to make an order under subsection (5) to enable this.

30. Subsection (4) provides that where the person to be appointed is not an existing member of staff of a local authority or Health Board by which the integration joint board was established, the person is first to be appointed to the local authority or the Health Board and then seconded to the integration joint board.

31. Subsection (6) requires the integration joint board to consult the Health Board and local authority, before appointing the chief officer of the integration joint board.

32. Subsection (7) provides for the Scottish Ministers to approve the responsibilities of the chief officer.

Section 11 – Other staff of integration joint board

33. This section provides for the Scottish Ministers, by order, to give integration joint boards the ability to appoint staff other than a chief officer and to make further provision in relation to the staffing of integration joint boards (generally or making different provision in relation to different joint boards) as the Scottish Ministers think fit, including; (a) the appointment of staff, (b) the numbers of staff, (c) the terms and conditions of staff. The Scottish Ministers may make provision for these matters to be subject to the determination, direction or agreement of any person. This allows the Scottish Ministers to permit other persons, such as integration joint boards, to decide these matters.
Section 12 – Integration joint boards: further provision

34. This section enables the Scottish Ministers to make further provision about integration joint boards.

35. Subsection (1) gives the Scottish Ministers powers to make provision by order (either generally or making different provision about different joint boards) about the membership, proceedings and general powers of integration joint boards; the supply of services or facilities to integration joint boards by a local authority or Health Board; and any other matter as the Scottish Ministers think fit in relation to the establishment or operation of integration joint boards.

36. Subsection (3) provides for the Scottish Ministers to make schemes for the transfer to an integration joint board of staff, property, rights, liabilities, or obligations of a local authority or a Health Board. This power may be exercised to support the delivery of delegated functions by the integration joint board, where that is considered appropriate.

Section 13 - Payments to integration joint boards in respect of delegated functions

37. Section 13 provides for the allocation of resources by the local authority and Health Board in relation to functions delegated by them to an integration joint board, to support the effective carrying out of the functions.

38. The duty requires payments to be made of the amount calculated in accordance with the method set out in the integration plan as approved by the Scottish Ministers.

Section 14 – Functions delegated to local authority or Health Board

39. Section 14 applies where the Scottish Ministers approve an integration plan under section 7 and that plan contains provision about the delegation of functions by a local authority to a Health Board or functions delegated by a Health Board to a local authority, or both, as the case may be, under section 1(4)(b), (c) or (d).

40. Subsection (2) requires the local authority and Health Board to set up, before a date set by the Scottish Ministers by regulations, an integration joint monitoring committee to monitor the operational delivery of the functions set out in the integration plan. It also requires that the local authority and the Health Board must delegate the functions in accordance with the integration plan before that date.

Section 15 – Transfer of staff where functions delegated to a local authority or Health Board

41. Section 15 provides that the Scottish Ministers may make provision by scheme about the transfer or secondment of staff from the body responsible for delegating the functions in the integration plan as set out in 1(4)(b), (c) or (d), to the body the functions are delegated to. This provision therefore relates to transfers to local authorities or Health Boards, as opposed transfers to integration joint boards which are dealt with by section 12(3).
Section 16 – Integration joint monitoring committees: further provision

42. Section 16 confers a power on the Scottish Ministers to make provision by order about the establishment, membership and proceedings of integration joint monitoring committees (either generally or making different provision about different committees), as well as any about any other matter relating to their operation as Ministers think fit.

Section 17 – Payments to Health Boards in respect of delegated functions

43. Section 17 requires that where a local authority delegates a function to the Health Board, in accordance with an approved integration plan, the local authority must make payment to the Health Board of an amount calculated in accordance with the method set out in the integration plan.

Section 18 – Payments to local authorities in respect of delegated functions

44. Section 18 requires that where a Health Board delegates a function to a local authority, in accordance with an approved integration plan, the Health Board must make payment to the local authority of an amount calculated in accordance with the method set out in the integration plan.

Section 19 – Transfer of staff: effect on contract of employment

45. Section 19 makes provision about the effect on an individual’s contract of employment on the transfer (or proposed transfer in the case of subsection (2)) of that individual’s employment by scheme under section 12 or 15.

46. Subsection (2) provides that where, before the day of transfer, a person who is to be transferred informs their original employer that they do not wish to transfer employment, the person’s contract of employment is terminated on the day before the day of transfer. The effect of this is that a person who does not wish to transfer does not have to do so but instead his or her contract will end immediately before the transfer would have taken place.

47. Subsection (3) sets out the effects of a transfer on an employee’s contract. In effect, the contract continues as it was before the transfer, except that the new employer takes the place of the previous employer. This means that the rights, powers, duties and liabilities of the original employer under or in connection with the contract of employment are transferred to the new employer and anything done by or in relation to the original employer in respect of the contract of employment is treated as having been done by or in relation to the new employer.

48. Subsection (4) makes provision to put beyond doubt that a person is not to be treated as being dismissed as a result of any provision of this section.

49. Subsection (5) protects any right that a person may have under general employment law to terminate their contract where there is a substantial detrimental change to his or her working conditions.
50. Subsection (6) makes clear that the change in employer as a result of the transfer of a person under this section does not constitute a substantial detrimental change to a person’s working conditions. This has the effect that the transfer of a person by scheme under section 12 or 15 cannot be considered a substantial detrimental change such as to give rise to any right protected by subsection (5).

Section 20 - Co-operation

51. Section 20 operates where two or more local authorities have joined together to prepare an integration plan under section 2(4), or there is otherwise more than one integration plan in relation to a Health Board’s area. It puts a duty on the local authorities involved and the Health Board to cooperate with each other in relation to the efficient and effective use of buildings, staff and equipment relevant to the plan or plans.

Carrying out of delegated functions

Section 21 – Effect of delegation of functions

52. Section 21 sets out the effect the delegation of functions, by one body to another, on the rights, powers, duties and liabilities of those bodies. Where a function is delegated from one body to another, the body to whom the function is delegated (referred to here as the “receiving” body) will be subject to the duties, rights and powers of the delegating body, that is the integration joint board, Health Board and/or the local authority as the case may be. This extends to duties imposed and rights and powers conferred after the function is delegated.

53. The receiving body is also entitled to enforce any rights acquired, and is liable in respect of any liabilities incurred, in the carrying out of the delegated functions. Any proceedings in relation to the enforcement of relevant rights and liabilities must be brought by or against the receiving body in its own name and not in the name of the body which has delegated the function.

54. This section, at subsection (6), also confers a power on the Scottish Ministers, by order, to require an integration joint board to exercise or not exercise a right or power, conferred by subsection (2)(b), in relation to a delegated function.

Section 22 – Further powers of persons to whom functions are delegated

55. This section (at subsection (1)(a)) enables integration joint boards to direct the local authorities or the Health Board that have delegated functions to it in accordance with an integration plan, to carry out a function on its behalf.

56. It also (at subsection (1)(b)) enables a local authority or Health Board which has had functions delegated to it in accordance with an integration plan to direct the local authority or Health Board which delegated the function to it to carry out the functions on its behalf.

57. Directions by local authorities, Health Boards and joint integration boards under subsection (1) must set out the payment or calculation method for payments to the person
directed to carry out the function. The person making the direction is required by subsection (3) to make payments accordingly.

58. A direction may also include further detail such as how the delegated functions are to be delivered operationally, or about the rights, powers, duties or liabilities of the body carrying out the function. By virtue of subsections (4) and (5), unless different provision is made in the direction about such rights, powers, duties and liabilities, section 21(2) to (5) will apply as though the person carrying out the function was the person to whom it was delegated under the integration plan.

59. Subsection (6) requires local authorities and Health Boards to comply with any direction given to them under this section.

60. Subsection (7) provides for directions made under this section to revoke or vary any earlier direction and that a direction made under subsection (1) must be made in writing.

61. Subsection (8) confers a power on the Scottish Ministers, by order, to require an integration joint board to give or not give a direction under subsection (1). This will enable the Scottish Ministers to determine whether the integration joint board carries out the delegated functions itself or to require the functions delegated to the integration joint board to be carried out on its behalf.

Strategic planning etc.

Section 23 – Requirement to prepare strategic plans

62. Section 23 requires the integration authority for the area of each local authority to prepare a strategic plan. This section sets out what a strategic plan is and the period the plan relates to. Section 39 sets out who is the integration authority for a local authority area, depending on the integration model adopted in the integration plan.

63. The integration authority can include such material as it thinks fit in the strategic plan, however there are two mandatory elements:

- A strategic plan must set out the arrangements for carrying out the integration functions (defined in section 40) in the local authority area over the period of the plan (subsection (2)(a)). The area must be divided into localities for this purpose, and the arrangements for each locality must be set out separately (subsection (3)).
- A strategic plan must also set out the way in which the arrangements for carrying out the functions are intended to achieve or contribute towards achieving the national health and wellbeing outcomes.

64. The first strategic plan of an integration authority must be prepared before a date set by the Scottish Ministers by regulations, and must cover the three year period starting with a date also to be set by the Scottish Ministers by regulations (subsection (4)).
These documents relate to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

65. Subsequent strategic plans must be prepared on an annual basis, before each anniversary of the start date of the first strategic plan, and cover a three year period beginning with the date of that anniversary (subsection (5)).

Section 24 – Considerations in preparing strategic plan

66. Section 24 requires the integration authority to take into account to the integration delivery principles (set out in section 25) and the national health and wellbeing outcomes (prescribed under section 5) in preparing a strategic plan. The effect of section 24 is to ensure the principles and national outcomes are at the heart of planning for the population and embeds a person centred approach, alongside anticipatory and preventative care planning.

Section 25 – Integration delivery principles

67. Section 25 sets out the integration delivery principles that must be taken into account in preparation of the strategic plan and in the actual carrying out of integration functions (as required by section 31).

68. The effect of subsection (1)(a) is to ensure that in making arrangements for the carrying out of integration functions, the integration authority takes account of the principle that the purpose of the services provided in pursuance of those functions is to improve the wellbeing of users of the service.

69. Subsection (1)(b) supplements this by setting out principles for delivery which must also be taken into account in making arrangements for delivery of integration functions. The effect is to ensure a focus on integrated delivery, consideration of the needs of different individuals and different areas, local planning and leadership, anticipation and prevention, and effective use of resources.

Section 26 – Establishment of consultation group

70. Section 26 puts an obligation on integration authorities to establish a consultation group for each local authority area, for the purposes of preparing the strategic plan for that area.

71. Depending on the model of integration chosen, the group must involve members nominated by the local authority or the Health Board, or both, as set out in subsection (1)(a), (b) and (c). In effect, this provides for the partners who prepared the integration plan and are party to the integrated arrangements to be involved in the development of the strategic plan. In addition, the integration authority will be required by subsection (1)(d) and (e) to involve a range of relevant stakeholders.

72. The group must also include representatives of groups prescribed by the Scottish Ministers by regulations under subsection (2) as having an interest, and other persons as the integration authority considers appropriate.

73. The integration authority is to determine the procedure of the group, and may pay members of the group expenses and allowances.
Section 27 – Steps following establishment of consultation group

74. Section 27 sets out the process for the involvement of the range of stakeholders on the consultation group in the development of the strategic plan, assuring their engagement in the process from the start.

75. The integration authority is required to prepare proposals about matters the strategic plan should contain, and consult the group on the proposals (subsection (1)) and then to prepare a first draft of the strategic plan, taking into account the views of the group expressed during the consultation. The integration authority must then consult the group on the draft (subsection (2)).

76. Taking account of the views in response to the consultation on the first draft, the integration authority is required to prepare a second draft of the strategic plan and send a copy of it for comment to persons mentioned in subsection (4), and any other persons the integration authority considers appropriate (subsection (3)).

77. The persons mentioned in subsection (4) include the local authority and the Health Board or both (depending on the model of integration chosen) as well as representatives of any groups prescribed by the Scottish Ministers under subsection (5). The effect of this is to ensure that any others with an interest will have an opportunity to comment on the draft plan.

78. Subsection (6) requires the integration authority to take into account the views obtained through consultation on the second draft of the strategic plan when finalising the strategic plan.

Section 28 – Requirement for agreement to certain strategic plans

79. Section 28 applies where a strategic plan is prepared by an integration authority that is a local authority or a Health Board.

80. It ensures that the body who has delegated functions to the integration authority is in agreement with the arrangements for delivery of those functions set out in the plan. This is achieved by duties on the integration authority to submit the finalised strategic plan for approval to the delegating Health Board, where the integration authority is a local authority; or the delegating local authority, where the integration authority is a Health Board.

81. Subsection (4) requires the integration authority to modify the plan where it is not approved and submit the modified plan for approval.

Section 29 – Publication of strategic plans

82. Section 29 places a duty on integration authorities to publish strategic plans.

83. Where the integration authority is an integration joint board or the strategic plan relates to an integration plan in which functions are delegated to both the local authority and the Health Board, the plan must be published as soon as it has been finalised. Where the integration
authority is a local authority or a Health Board and approval is required under section 28, the plan must be published as soon as it has been approved.

84. Subsection (3) requires an integration authority to publish a statement at the same time it publishes its strategic plan, which describes the consultation it undertook under section 27.

Section 30 – Significant decisions outside strategic plan: public involvement

85. Section 30 makes provision for where an integration authority plans on making a decision that would have a significant effect on the arrangements for provision of a service in pursuance of integrated functions outwith the context of the strategic planning cycle.

86. The integration authority is required to take appropriate action in order to involve and consult users or potential users of the service which is being or may be provided in relation to the decision.

Carrying out of integration functions

Section 31 – Carrying out of integration functions: general

87. Section 31 obliges integration joint boards, local authorities and Health Boards to have regard to the national health and wellbeing outcomes and the integration delivery principles set out in section 25, when carrying out an integration function. The effect is to embed the principles in delivery as well as in planning to ensure a shift towards preventative and anticipatory care and that the services delivered meet the different needs of different individuals and are ‘person centred’.

Section 32 – Carrying out of integration functions: localities

88. Section 32 requires person carrying out an integration function for the area of a local authority (which may be the local authority, the Health Board or the integration joint board depending on the integration model adopted and any directions made under section 22) to involve and consult interested persons prescribed by the Scottish Ministers by regulations where it proposes to take a decision that it considers might significantly affect the service provision in a locality of the area of the local authority.

Section 33- Integration authority: performance report

89. This section requires each integration authority to prepare and publish a performance report for each reporting year.

90. The report must set out an assessment of performance in carrying out the integrated functions during the reporting year.

91. Subsection (3) enables the Scottish Ministers to make regulations that set out the form and content of performance reports, and the period within which performance reports must be published.
92. In accordance with subsection (4) the “reporting year” is the period of one year starting on the start date set by the Scottish Ministers for the first strategic plan (under section 23(4)(b)) and each subsequent year.

*Change of integration plan*

**Section 34 – Revised integration plan**

93. This section sets out the process for varying the integration plan after it has been approved by the Scottish Ministers.

94. Any variation must be made jointly by the local authority and the Health Board and is to be achieved by the preparation of a revised integration plan.

95. Subsection (3) establishes the scope of variation that may apply to the integration plan. A revised integration plan may include further functions that are to be delegated, set out functions that are no longer to be delegated, amend the functions that are to be carried out in conjunction with the delegated functions when delegating to a Health Board only or a local authority only or to both, and make adjustments to the method of calculating payments.

96. A revised integration plan must be jointly submitted by the local authority and the Health Board to the Scottish Ministers for approval, who will set the date on which the revised integration plan will take effect.

**Section 35 – New integration plan**

97. Section 35 sets out that a local authority and Health Board must prepare a new integration plan under section 1 where they wish to change the local authorities that are party to the plan or the integration model. The new plan is subject to all the same requirements including as to consultation and the requirement for Ministerial approval as the originally prepared plan.

**Section 36 – Power to make provision in consequence of replacement of integration plan**

98. This section confers powers on the Scottish Ministers to take steps in consequence of a new integration plan approved under section 35. They are empowered to provide by order for the winding-up of any integration joint board that was established in pursuance of the original plan. They can also provide by scheme for the transfer of staff, property, rights, liabilities or obligations of an integration joint board, local authority or Health Board as may be necessary in light of the new plan.

*Supplementary*

**Section 37 – Information-sharing**

99. Section 37 allows for the disclosure of information between local authorities, Health Boards and integration joint boards for the purpose of preparing an integration plan, carrying out the functions that are delegated, the functions that are to be carried out in conjunction with delegated functions and the preparation of a strategic plan. The sharing of information for these
purposes can take place without breaching any duty of confidentiality that may be owed by a Health Board or local authority to any person.

**Section 38 – Grants to local authorities**

100. Section 38 provides for the Scottish Ministers to make grant payments to local authorities in respect of costs incurred by virtue of Part 1 of the Bill, and to set conditions in relation to grants made.

**Section 39 – Default power of Scottish Ministers**

101. Section 39 provides for the Scottish Ministers to take action where a local authority and Health Board have failed to submit an integration plan to them for approval by the deadline set under section 7.

102. In such circumstances the Scottish Ministers may require the local authority and Health Board to adopt the integration joint board model of integration and may decide the functions to be delegated to it. They may also establish the integration joint board by order, set a deadline by which the local authority and Health Board must delegate the specified functions to the integration joint board, specify payments to be made by the local authority and Health Board to the integration joint board and impose other requirements in relation to the delegated functions.

**Section 40 – Directions**

103. Section 40 confers a power on the Scottish Ministers to give directions to integration joint boards, Health Boards and local authorities.

104. Directions given to a local authority or Health Board under this section may relate to the functions conferred on them by this Bill, the carrying out of functions delegated to them in pursuance of an integration plan, and the functions to be carried out in conjunction with the delegated functions (subsections (1) and (2)).

105. Directions to an integration joint board may relate to the functions conferred on it by this Bill and the carrying out of functions delegated to it in pursuance of an integration plan (subsection (3)).

106. Integration joint boards, Health Boards and local authorities are required to comply with a direction given to them by the Scottish Ministers under this section.

107. Subsection (5) provides that directions made under this section may vary or revoke earlier directions made under this section and are to be made in writing.

**Section 41 – Guidance**

108. Section 41 requires every local authority, Health Board and integration joint board to take account of any guidance issued by the Scottish Ministers about their functions, under or in relation to the Bill.
Section 42 – Meaning of “integration authority”

109. Section 42 sets out who is the integration authority for a local authority area for the purposes of Part 1 of the Bill. This depends on the model of integration adopted, so that the integration authority is: the integration joint board, where the integration plan provides for functions to be delegated to an integration Joint Board; the Health Board, where in accordance with the integration plan functions are delegated to the Health Board only; the local authority where, in accordance with the integration plan, functions are delegated to the local authority only; or both the local authority and the Health Board acting jointly where, in accordance with the integration plan, functions are delegated to both the local authority and the Health Board.

Section 43 – Meaning of “integration functions”

110. Section 43 sets out what the integration functions for the area of a local authority are for the purposes of Part 1 of the Bill. Where the integration plan provides for functions to be delegated to an integration joint board, the integration functions are those delegated to the board in pursuance of the plan. Where the integration plan provides for functions to be delegated to either a local authority or to a Health Board or to both a local authority and a Health Board, the integration functions are those delegated in pursuance of the plan, as well as the functions specified in the plan as ones which are to be exercised in conjunction with the delegated functions.

PART 2

SHARED SERVICES

Section 44 - Shared services

111. Section 44(1) provides for the Common Services Agency for the Scottish Health Service to provide, or arrange the provision of, goods and services to the bodies listed in subsection (2). The Common Services Agency may only provide, or arrange the provision of, goods and services to those bodies with the consent of the Scottish Ministers.

112. Subsection (3) provides an illustrative list of the services which may be provided. The list comprises administrative, technical and legal services.

113. The Common Services Agency also has powers under the National Health Service (Scotland) Act 1978 (“the 1978 Act”) to provide goods and services to certain persons. For example, under section 15, the Common Services Agency may provide goods to doctors, dentists and ophthalmologists who are providing primary medical services under a contract with a Health Board. Subsection (4) sets out that the power of the Common Services Agency to provide goods and services under subsection (1) of this section sits alongside and does not compromise any other power of the Common Services Agency to provide goods or services to other persons.
Section 45 – Extension of schemes for meeting losses and liabilities of health service bodies

114. Section 45 amends section 85B of the National Health Service (Scotland) Act 1978 (the “1978 Act”) to permit local authorities and integration joint boards to participate in the scheme established under that section for the purposes of meeting losses and liabilities incurred in the exercise of relevant functions.

115. Subsection (3) inserts references into the 1978 Act, which have the effect of restricting the functions of local authorities that can be covered by a scheme made under section 85B of the 1978 Act. It restricts the functions to integration functions and to functions that a local authority carries out in accordance with a direction from an integration joint board. The Scottish Ministers are given the power to specify by order other functions of local authorities that can be covered by a scheme under section 85B of the 1978 Act “Integration functions” are defined for the purposes of this section in relation to local authorities as functions which are: delegated to the authority under an integration plan; to be carried out in conjunction with delegated functions; or to be carried out by the local authority in pursuance of a direction by a Health Board or integration joint board under section 22.

116. Subsection (4) amends the existing power in the 1978 Act so that the Scottish Ministers are not able to direct local authorities to participate in a scheme made under section 85B of the 1978 Act.

PART 3

HEALTH SERVICE: FUNCTIONS

Section 46 – Scottish Ministers: power to form companies etc.

117. Section 46 provides for amendments to section 84B (Joint ventures) of the 1978 Act. Currently, the Scottish Ministers may only form or participate in companies as defined by section 1(1) of the Companies Act 2006. The amendment permits the Scottish Ministers to form and participate in any type of body corporate. This includes limited liability partnerships and Scottish Charitable Incorporated Organisations.

Section 47 – Health Boards: carrying out of functions

118. Section 47 amends the 1978 Act to permit Health Boards to exercise any function of another Health Board where the other Health Board and the Scottish Ministers give their consent.

PART 4

GENERAL

Section 48 – Interpretation

119. Section 48 provides various definitions that apply to this Act.
Section 49 - Subordinate legislation

120. The Bill contains various powers for the Scottish Ministers to make regulations and orders. This section makes further provision about regulations and orders under the Bill in particular enabling them to make different provision for different purposes, and to include supplementary, incidental, consequential, transitional or transitory provision. It also provides that regulations under section 5(1) and any order under section 50 which amends the text of another Act is subject to the affirmative procedure. Other regulations and orders under the Bill are subject to the negative procedure.

Section 50 - Ancillary provision

121. This section provides powers for the Scottish Ministers to make supplementary, incidental or consequential provision by order, as they consider appropriate for the purposes of, or in connection with, or for the purposes of giving full effect to, any provision made by, or by virtue of, this Act. Such an order may also make such transitional, transitory or savings provision as the Scottish Ministers consider appropriate for the purposes of, or in connection with, the coming into force of any provision.

Section 51 – Repeals

122. Subsection (1) and (3) repeal sections 4A and 4B of the National Health Service (Scotland) Act 1978 (c.29) and section 2 of the National Health Service Reform (Scotland) Act 2004 (asp 7), thereby removing Community Health Partnerships from statute.

123. Subsection (2) repeals sections 15 to 17 of the Community Care and Health (Scotland) Act 2002 (asp5) which provide the current mechanism for Health Boards and local authorities to delegate functions and make payments in relation to those functions, and for the transfer of staff in relation to the delegated functions.

124. Subsection (4) repeals section 20 of the Social Care (Self-directed Support) (Scotland) Act 2013 (asp1) which amends section 15 of the Community Care and Health (Scotland) Act 2002 (which is itself repealed by subsection (2)).

Section 52 – Commencement

125. Section 52 establishes that sections 49, 50, 52 and 53 of the Bill come into force on the day after Royal Assent. Powers are conferred on the Scottish Ministers to commence the other provisions of the Act on dates appointed by order and to make transitory, transitional or savings provisions in connection with commencement.

Section 53 – Short title

126. Section 53 states that the short title of this Act is the Public Bodies (Joint Working) (Scotland) Act 2014.
FINANCIAL MEMORANDUM

INTRODUCTION

1. This document relates to the Public Bodies (Joint Working) (Scotland) Bill introduced in the Scottish Parliament on 28 May 2013. It has been prepared by the Scottish Government to satisfy Rule 9.3.2 of the Parliament’s Standing Orders. It does not form part of the Bill and has not been endorsed by the Parliament.

2. The purpose of this Financial Memorandum is to set out:
   • the best estimates of the administrative, compliance and other costs to which the provisions of the Bill will give rise, as well as likely efficiency savings;
   • the best estimates of the timescales over which the costs and savings are expected to arise; and
   • an indication of the margins of uncertainty in these estimates.

3. The Bill sets out different models for Health Boards and local authorities to integrate health and social care services. The Financial Memorandum summarises the cost implications of each model.

4. The Bill provides the framework which will support improvement of the quality and consistency of health and social care services through the integration of health and social care in Scotland. This framework permits integration of other local authority services with health services. The Scottish Ministers intend to use the framework to integrate adult health and social care services as a minimum, and for statutory partners to decide locally whether to include other functions in their integrated arrangements. The Financial Memorandum, therefore, only gives consideration to costs in relation to integration of adult health and social care functions.

5. The Financial Memorandum draws upon a variety of evidence sources to present general modelling of the costs of the different models of integration for which the Bill provides. It does not provide a blueprint for how individual Health Boards and local authorities will integrate adult health and social care locally. Minimum functions that must be included in local integrated arrangements will be prescribed in regulations and statutory guidance.

6. The Financial Memorandum is structured as follows:

   Part One
   Cost implications to the Scottish Government from provisions in the Bill:
   Transitional costs

   Part Two
   2.1 Recurrent cost implications to Health Boards and local authorities from provisions in Part 1 of the Bill
2.2 Cost implications to Health Boards and local authorities from provisions in Part 2 of the Bill

2.3 Cost implications to Health Boards and local authorities from provisions in Part 3 of the Bill

2.4 Consequential cost implications to Health Boards and local authorities from provisions in Part 1 of the Bill

Part Three
Cost implications to other Public Bodies from provisions in the Bill

Part Four
Consequential cost implications to other bodies, individuals and businesses from provisions in the Bill.

7. The following terms are used in this Financial Memorandum:

- **Community Health Partnerships (CHPs)**, as constituted under the NHS Reform (Scotland) Act 2004 and The Community Health Partnership (Scotland) Regulations 2004. Two forms of CHP have evolved, as follows: a health only structure, and a health structure that incorporates aspects of social care alongside health. For the purposes of this Financial Memorandum, the term “Community Health Partnership” refers to both types of structure.

- **Section 33 bodies**, which are bodies identified by that section in the Value Added Tax Act 1994 that are funded by local taxation and are able to reclaim, except for minor exceptions, all of the VAT they incur in the purchasing of goods and services. Local authorities have section 33 VAT status.

- **Section 41 bodies**, which are bodies identified by that section in the Value Added Tax Act 1994 that are able to reclaim VAT on certain services. Health Boards have section 41 VAT status.

**BACKGROUND**

**Summary of Health Board and local authority health and social care expenditure**

8. The policy intention of the Scottish Ministers is to prescribe in regulations that adult health and social care functions must be integrated as a minimum. The following material provides information by way of context for expenditure in this area and with regard to the financial challenges that Health Boards and local authorities face in relation to health and social care services for adults.

9. In 2011/12, estimated total expenditure by Health Boards on the provision of services for adults was almost £9bn. Table 1 sets out the spend by category of care.
Table 1: Health Board expenditure by sector, £m, 2011/12.

<table>
<thead>
<tr>
<th>Sector</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>3,853</td>
</tr>
<tr>
<td>Mental health and learning difficulty</td>
<td>1,127</td>
</tr>
<tr>
<td>Maternity and care of the elderly</td>
<td>540</td>
</tr>
<tr>
<td>Community</td>
<td>1,054</td>
</tr>
<tr>
<td>Family health sector</td>
<td>2,248</td>
</tr>
</tbody>
</table>

(Source: ASD analysis of Scottish Health Service Costs R100\(^1\))

10. The figures in Table 1 include £332m of resources transferred to local authorities in 2011-12 to fund jointly planned community care services, which have resulted in long-stay hospital closures and bed reductions over the last 20 years.

11. In 2011/12, net expenditure by local authorities on adult social care was £2.1bn, 43% of which was spent on residential care.

Table 2: Net adult social care expenditure by care group, £m, 2011/12.

<table>
<thead>
<tr>
<th>Care Group</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older persons</td>
<td>1,264</td>
</tr>
<tr>
<td>Adults with learning difficulties</td>
<td>484</td>
</tr>
<tr>
<td>Adults with physical or sensory disabilities</td>
<td>183</td>
</tr>
<tr>
<td>Adults with mental health needs</td>
<td>94</td>
</tr>
<tr>
<td>Adults with addictions/substance misuse</td>
<td>39</td>
</tr>
</tbody>
</table>

(Source: Annex A Scottish Local Government Finance Statistics 2011/12\(^2\)).

12. These are figures net of the resource transfer received from Health Boards noted above and also income received from charging, which was £43m for adults.

13. In 2010/11, nearly two thirds of health and social care expenditure on people aged 75+ was accounted for by spending on care delivered in institutional settings (care homes and hospitals). Emergency admissions to hospital accounted for nearly 70% of total hospital expenditure for people aged 75+, equating to one third of total health and social care expenditure on this age group – approximately £900m. The cost of all inpatient and day cases (planned and unplanned) for people aged 75+ was £1,200m, which represents 44% of total expenditure on occupied bed days in hospital.

14. The number of people whose discharge from hospital is delayed, once their clinical care is complete, and the length of time for which they are delayed, are symptoms of disjointed care pathways. In the nine months to December 2012, the number of occupied bed days accounted for by delayed discharge totalled 366,311, suggesting an annual total of 488,000 days. This is

---

\(^1\) SG ASD analysis of information provided in Executive Summary 100, [http://www.isdscotland.org/Health-Topics/Finance/Publications/2012-11-27/Costs_R100_2012.xls](http://www.isdscotland.org/Health-Topics/Finance/Publications/2012-11-27/Costs_R100_2012.xls)

\(^2\) [http://www.scotland.gov.uk/Publications/2013/02/4659 - Annex A](http://www.scotland.gov.uk/Publications/2013/02/4659 - Annex A)
equivalent to 44 hospital wards, an estimated fully absorbed cost to the NHS of £120m, and a direct cost estimated at £88m. Most people affected by delayed discharge are older people.

15. As of 31 March 2012, there were 916 care homes in Scotland for older people. Despite increases in the numbers of older people in the population, the total care home population has been relatively stable for the past decade because of the Scottish Government’s policies to enable more vulnerable people to be cared for at home.

16. Over the same period, a trend has emerged in the number of local authority funded elderly care home residents reducing annually by around 2%. This is due to an overall decrease in the number of placements in residential care, resulting from policy aims to provide more care at home, and is also a result of a growing proportion of self-funders in care homes. The current average contribution to care home fees from clients recently increased to £144 per week; based on the average national contract (2012/13 rate) of £527, the current average local authority contribution per resident is £383.

17. Expenditure on health and social care services is projected to increase, both because of demographic change – more people living for longer – and because more people are living with multiple co-morbidities. The Registrar General has projected that the number of people in Scotland aged over 75 will grow by around 10,000 every year, over the decade ahead. Changes in demography will vary in scale, depending on location. Around one quarter of Scotland’s population will be aged 65 and over by 2033; for some of our more rural areas the proportion is predicted to rise to nearly one third.

18. The Finance Committee\(^3\) noted that, taking current patterns of utilisation of health and social care services as a starting point, demand for health and social care could increase by between 18.4% and 28.7% between 2010 and 2030, depending on the trajectory of healthy life expectancy. These estimates do not take account of increased numbers of adults with learning or physical disabilities due to improvements in life expectancy at all ages\(^4\).

**Integrated care**

19. Reform needs to deliver care that is better joined up and delivers better outcomes for patients, service users and carers, wherever they live. By improving the continuity and person-focus of care, some efficiencies may be achievable where it is possible to deliver care within the community setting rather than an institutional setting. Any such efficiencies must be taken within the context of the overall growing population of people with multiple support needs.

20. As noted above, the challenge and associated opportunities for improvement are particularly relevant to the provision of care and support for older people, a growing group within the population, who are frequently admitted to expensive institutional care – hospitals and

---


care homes – for long periods, when a package of support in the community might have served their needs better, with better outcomes and at equal or lower cost per person.

21. Evidence from the UK\(^5\) and further afield, shows that better outcomes for people, better use of resources (money and people’s time) and better experience of care can all flow when services are planned and delivered in an effectively integrated way – between GPs, hospitals and community based health and social care teams. Integration of health and social care will enable partners to redesign services and use resources across sectors differently to shift the balance of care away from reactive institutional based care to preventive and community based care that better meets the needs of adults with complex needs\(^6\).

22. Despite the presence of some confounding factors, an initial comparison of unplanned bed days for people aged 75+ between Torbay Care Trust, (one of the most successful examples of integration in England\(^7\)) and Scottish partnerships shows that the levels achieved in Torbay are lower than those in Scotland\(^8\).

23. It is possible to estimate some of the potential efficiencies that may be achieved through integration, as described below:

**Delayed discharge**

24. Delayed discharge occurs when patients are unnecessarily delayed in a hospital setting when their needs could more appropriately be met in the community. Reducing delayed discharge therefore provides both a better outcome for the individual and a reduced cost to the public purse.

25. Local authorities and Health Boards have worked hard over the last 10 years to reduce unnecessary delays in getting people out of hospital. However, progress has been more difficult in recent years, as can be seen in chart 1 below.

---


\(^8\) ISD Comparison of Occupied Bed Days for 65+, 75+ and 85+ between Scottish partnerships and Torbay Care Trust. Unpublished analysis. ISD can provide this information on request: [http://www.isdscotland.org/](http://www.isdscotland.org/)
Chart 1: NHS Delayed Discharges by length of delay (excluding code 9s (complex cases) and delays of 3 days or less): Scotland; Historical Trend April 2001 to January 2013

26. It is projected that 488,000 bed days will be used in 2012/13 by patients awaiting discharge from hospital. Delayed discharge happens for a variety of reasons. ISD published data shows that 96% of delayed patients were delayed for reasons of community care assessment or community care arrangements. Health Boards and local authorities will be required to ensure that the maximum delay is no longer than 14 days by April 2015; requirements on Health Boards and local authorities to put in place strategic planning arrangements will enable better allocation of resources to achieve this target. The public expenditure implications of moving to a 14 day limit on delays can be estimated by comparing the current cost of service provision with the costs of alternative (more appropriate) community based health and social care services.

27. For this estimate, the bed days used by delayed patients (excluding those who are complex cases) were converted into bed weeks. For the baseline expenditure the bed weeks used by delayed discharge patients were costed at an adjusted cost per bed day, and for the projected expenditure post integration, those bed weeks were costed at a weighted average rate of residential care, home care, and care at home. These estimates suggest that reducing delayed discharge by reallocating expenditure from hospital to community based health and social care to

---

facilitate timely departure from hospital and provide alternatives to admission to hospital, could generate potential efficiencies of around £22m per annum for a maximum 14 day delay. If partnerships wish to be more ambitious and move beyond the target, a further £41m of potential efficiencies may be generated for a 72 hour limit for delays.

**Anticipatory care plans**

28. Anticipatory care plans (ACP) are produced for an identified population, which has been assessed as at risk of admission to hospital, using a risk assessment tool. The benefit of the plan is that it allows individuals who are at risk of unplanned admission to have a plan for their care that will help to avoid unnecessary admission to hospital. Effective anticipatory care planning depends on two factors: accurate identification of people at risk of admission, and deployment of an integrated multi-disciplinary team working with the care group to plan their care. Many unplanned admissions to hospital for older people would be avoidable if alternative care options were available to local care professionals, patients and carers. This is desirable because unnecessary time spent in hospital by older people can lead to rapidly diminishing life skills and further avoidable institutional care. It is expensive, both in terms of the human cost of accelerating dependence and diminishing independence, and in financial terms.

29. The potential implications of anticipatory care plans for the cost of health and social care in Scotland have been estimated based on the findings of the Nairn study. By extrapolating the results to a Scotland-wide level using an estimate of the potential number of patients with similar risk characteristics as were included in the Nairn study, it is estimated that potential efficiencies of approximately £12m may be generated.

**Reducing variation**

30. There is variation in per capita expenditure on health and social care across partnerships. For healthcare, the variation cannot be explained by differences in need across partnership populations or in input costs and may be due to inefficiencies. For adult social care expenditure, the picture is less clear and we are unable to determine whether the variation is due to differences in local democratic decisions, input costs, prevalence of unpaid care, the relative size of the voluntary sector or inefficiencies. Furthermore, some of the variation in per capita expenditure by one partner may be required to compensate for variation in per capita expenditure by the other partner.

31. The requirement on Health Boards and local authorities to delegate resources to the integration joint board or the lead agency, will highlight the extent of variation and will enable them to understand more clearly the underlying causes. Over time, it is anticipated that Health Boards and local authorities may respond to greater clarity regarding variation in their allocations to the integration joint board or the lead agency by moving to a more equitable allocation of resources to partnerships thereby driving efficiencies in their use of integrated

---


resources. Such an effect would probably be most immediately apparent in those partnerships within the same Health Board area, where local comparisons will most readily be made. In the longer term such an effect could be observed across Scotland, particularly if there is an appetite for benchmarking and sharing good practice.

32. The potential for efficiencies from reducing variation in allocations to partnerships with the same Health Boards has been estimated by comparing the expenditure per person between partnerships. Due to the confounders for variation in per capita social care expenditure noted above, this estimate is limited to the variation in costs per head for healthcare expenditure.

33. The costs per head are adjusted for local population need, using the resource allocation formula weightings, to ensure that it does not include variation that is driven by differences in local population need. If costs per head in the higher cost partnerships are reduced to the average cost per head for the partnerships with the relevant Health Board, this could generate potential efficiencies of around £104m per annum.

34. The Bill will enable Health Boards and local authorities to plan and deliver holistic integrated health and social care services and to improve efficiency in allocation and utilisation of their joint resources. In summary, it is estimated that the potential efficiencies for partnerships from the combined effect of Anticipatory Care Plans, reducing Delayed Discharge and reducing variation, to be between £138m and £157m. These potential efficiencies should be considered in the context of the scale of the projected increase in expenditure attributable to demographic change, noted in paragraph 17, and will need to be reinvested within the partnerships in order to help meet demand.

35. It is important to note that there is considerable uncertainty around these estimates and the eventual outcome and phasing will be dependent on local decisions taken by partners on resource allocation and utilisation through their strategic plans. Nevertheless, these estimates provide a reasonable indication of the potential scale of efficiencies. Any actual realisation of efficiencies from reduced demand for care in institutional settings will be contingent on the scale of the planned change and on cost behaviour, i.e., how costs are affected by a change in an organisation’s volume and pattern of activity.

36. All of these factors will need to be taken into account by integration authorities in developing their strategic plans and this level of understanding will be important if partnerships are to maximise the value of their integrated resources in addressing the demographic challenges over the longer term.

PART ONE

COST IMPLICATIONS TO THE SCOTTISH GOVERNMENT FROM PROVISIONS IN THE BILL: TRANSITIONAL COSTS

37. The Bill sets out a number of key provisions described further in the Explanatory Notes. Table 3 summarises transitional non-recurrent costs to the Scottish Government associated with Bill implementation:
### Table 3 - Summary of Scottish Government investment (£m)

<table>
<thead>
<tr>
<th>Costs directly associated with Bill implementation</th>
<th>Non-recurrent Overall Total (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transitional costs</strong></td>
<td></td>
</tr>
<tr>
<td>Para 37 Transition team</td>
<td>0</td>
</tr>
<tr>
<td>Para 44 Displacement of CHP leadership staff</td>
<td>0</td>
</tr>
<tr>
<td>Para 50 Strategic workforce and organisational development</td>
<td>0.085</td>
</tr>
<tr>
<td>Para 56 Developing VAT guidance with HMRC</td>
<td>0</td>
</tr>
<tr>
<td>Para 59 Support to develop strategic plans</td>
<td>0</td>
</tr>
<tr>
<td>Para 60 Support to third sector – national partnership initiative</td>
<td>0</td>
</tr>
<tr>
<td>Para 63 Financial governance (included in organisational development and transition team)</td>
<td>0</td>
</tr>
<tr>
<td>Para 64 Capital and assets (included in transitional costs)</td>
<td>0</td>
</tr>
<tr>
<td>Para 65 ISD data activity information sets</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.085</td>
</tr>
</tbody>
</table>

38. The following sections provide further information on the costs listed above.

**Transition team**

39. In NHS Highland (and also in Torbay Care Trust and North East Lincolnshire Care Trust, which have established similar arrangements) a transition team was set up for the purpose of leading and overseeing the transition arrangement in moving to a delegation between partners model of integration. NHS Highland delegated functions in relation to children’s community
health services to Highland Council and Highland Council delegated functions relating to adult social care services to NHS Highland.

40. The Highland Partnership, between NHS Highland and Highland Council, in taking forward the delegation between partners model of integration, received £450k from the Scottish Government, over the period 2010-2012 to support a programme of change management necessary to achieve the model of integration permissible within the current legislation and the specifications of their integration plan.

41. For the purpose of the estimates of the potential costs of transition, the costs of the Highland transition team have been used. These have been adjusted to exclude the sums that relate to the children’s services aspect of the Highland arrangements. In addition, Highland were able to prioritise existing resources to carry out some of these tasks so that some of the costs were opportunity costs. There is uncertainty whether this could be replicated in other partnerships and this is reflected in the scenarios considered at paragraph 45.

42. There are also likely to be economies of scale in cases where Health Boards are developing partnerships with more than one local authority, and this has also been considered in the estimates.

43. The scale and volume of the transition tasks noted above is different for the two main models of integration permitted in the Bill, delegation to a body corporate and delegation between partners; the second model can operate in a number of ways, as described in the Bill. The volume of transition tasks required for delegation between partners, especially in the cases where provision of services is delegated and staff are transferred, being greater than for delegation to a body corporate or delegation between partners, with no staff transfers. The Bill sets out that partnership arrangements will be formed between one local authority and one Health Board and provides for flexibility for more than one local authority to join together to form partnership arrangements with the same Health Board.

44. Given that the costs of transition are contingent on whether partners choose delegation to a body corporate or delegation between partners and the extent that they are able to offset some of the costs through prioritising existing capacity and through economies of scale for multiple partner Boards, a range for the potential total transition cost is possible. In order to provide an overview of this potential, a number of scenarios are set out below, each of which have different assumptions regarding the main variables. Note that in considering scenarios, the likely case is based on the assumption that all partners, with the exception of Highland, will opt for delegation to a body corporate; this reflects feedback on the preference of partnerships between the two main models.

45. Three scenarios have been considered, each of which is based on the Bill receiving Royal Assent and commencement of provisions to establish partnership arrangements being enacted in the financial year 2014/15:

- A prudent likely case, where all partnerships (except Highland) opt for delegation to a body corporate and are able to realise economies of scale. Under this scenario the
These documents relate to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

non-recurrent cost of establishing transition arrangements will be £9.8m, with £7.4m incurred in 2014/15 and the balance in 2015/16;

- A lowest cost case where all partnerships opt for delegation to a body corporate and are able to realise opportunity costs and economies of scale. Under the second scenario the non-recurrent cost of establishing transition arrangements will be £6.4m with £4.8m incurred in 2014/15 and the balance in 2015/16;

- A highest cost case, where all partnerships opt for delegation between partners and do not achieve opportunity costs or economies of scale. This scenario would require £22.6m, with £16.9m in 2014/15 and the balance in 2015/16.

Displacement of staff in Community Health Partnership roles

46. There are a number of roles, as described above, which support the current arrangements in Community Health Partnerships. Some staff employed by Health Boards will be displaced with the removal of Community Health Partnerships. In addition, there are staff employed by local authorities who carry out similar roles in respect of adult social care services that are currently aligned with Community Health Partnerships. It is reasonable to assume that most of these will be transferred to posts in support of the new partnership arrangements. The possible exception to this may be staff currently occupying Community Health Partnership Director/General Manager posts, who may or may not be in competition for the new chief officer post in those partnerships which choose the body corporate model of integration.

47. It is acknowledged that local authorities have committees established to provide governance, with responsibility for delivery arrangements for social care services, including adult social care functions. The Bill does not prescribe the removal of such committees; however, it is reasonable to expect that some of these arrangements may no longer be necessary given the proposed responsibilities of the partnership arrangements (integration joint board or lead agency). In any case, it would be for individual local authorities to determine, and therefore no costs have been included.

48. There are currently 25.6 WTE Community Health Partnerships leadership posts in Scotland (and 28 post holders) at a recurrent annual cost of £2.6m. Health Boards will offer a range of options to displaced staff in leadership posts including voluntary redundancy terms. If such options are not accepted by the individuals involved, they will be enrolled in Health Board re-deployment registers on protected salaries. It should be noted that in the event of the latter, the non-recurrent cost of the protected salary of these staff may be incurred for several years until the individual gives notice or a suitable vacancy arises.

49. The specific criteria and guidance for the recruitment and appointment of chief officer posts is being developed jointly by the Scottish Government and relevant stakeholders. The cost of displaced staff will vary depending on the proportion that are successful in applications for chief officer posts and also on whether displaced staff accept voluntary redundancy or move to the redeployment register; and so a potential range exists for the cost of displacement. To illustrate this potential range three scenarios are set out below. Two are at the extremes in which either all the displaced Community Health Partnership leadership staff are appointed to the new chief officer posts or none are appointed; and one in which half of the staff are appointed to the posts.
50. No estimates are made for any displaced local authority staff as the Bill does not prescribe the removal of any local authority post and, in any case, it will be for individual local authorities to determine such matters. The Bill will not remove the requirement for existing local authority or Health Board statutory posts with the exception of Community Health Partnerships director posts.

51. For the purposes of this estimate, it has been assumed that half of the displaced staff accept voluntary redundancy, and half move on to redeployment registers for a period of three years:

- If all of the 28 displaced Community Health Partnership leadership staff that move to redeployment are successful in securing the post of chief officer, then there will be no non-recurrent cost incurred.
- If none of the 28 displaced Community Health Partnership leadership staff that move to redeployment are successful in securing the post of chief officer, the non-recurrent cost would be £3.5m incurred in 2014/15 and £1.3m incurred in each year thereafter until 2016/17.
- If half of the 28 displaced Community Health Partnership leadership staff that move to redeployment are successful in securing the post of chief officer, the non-recurrent cost would be £1.8m incurred in 2014/15 and £0.7m incurred in each year until 2016/17.

**Strategic workforce and organisational development**

52. The duties placed on statutory partners by the proposals will require a sustained and integrated approach by partners to organisational and professional/management development, in addition to effective, on-going education and training for a wide range of staff groups.

53. Support will be necessary at all levels in the new partnerships, including the establishment of new integration joint boards, or integration joint monitoring committees, through to education and training for frontline practitioners, working in new ways to support service users. Supporting partnerships to understand and build the conditions for change and improvement will be necessary for sustained success in delivering better outcomes for people and communities. Statutory partners will need to ensure that their organisational development plans reflect the integration agenda and offer a comprehensive, systematic and practical approach to improving individual and organisational effectiveness. This shared endeavour will be necessary to support the culture change that will be required to underpin greater multi-disciplinary and multi-agency joint working and to reflect the move towards a greater community focus for service planning and delivery.

54. Significant support for professionals and staff is already available locally and via a range of innovative national programmes of work delivered by NHS Education Scotland and Scottish Social Services Council, as part of the Scottish Government’s Reshaping Care of Older People Programme, e.g. dementia and palliative care training. Locally, Community Health Partnerships are continuing to develop their workforce to enable delivery of local Change Fund Plans for Older People, supported by a range of improvement bodies to support care pathway development and joint working with third and independent sector partners.
55. Support for leadership development will also be important; for Health Board and local authority Chief Executives, the new arrangements will change their relationship and they will be jointly and equally accountable for the delivery of agreed national outcomes; the role of the chief officers will require a high level of skill, expertise and experience and the ability to lead change and system wide improvement in a highly complex working environment. More widely, professional leadership will be essential to create the right conditions for the development of a flexible and adaptive workforce, particularly in the context of locality planning.

56. An organisational development programme that integrates the existing partnership organisational development capacity with national support will be required to provide:

- Integration joint board and integration joint monitoring committees development sessions, including work locally on the development of a shared set of values, purpose and vision for the Board and its members;
- Development sessions for Health Board non-executive directors and local authority elected members;
- Supporting the development of skills and behaviours needed for the chief officer posts;
- Targeted programme of support for Health Board and local authority chief executives and chief officers;
- The Scottish Government will work with national partners via public sector leaders forum to support development for key groups of staff and professional;
- Development support for senior professional teams, including GPs and Chief Social Work Officers to lead change within localities and as part of the strategic commissioning process locally;
- Support for staff working in non-statutory organisations.

57. The Scottish Government is working with stakeholders through the Workforce Development Strategic Group to support developments in workforce and organisation development and model approaches to collaborative working, which will support the effective integration of health and social care and locality planning arrangements. The Scottish Government has provided £85k in 2012-13 to support this work and anticipates providing further funding of £1m in 2013-14 and £0.685m in 2014-15 to support implementation of the Bill.

VAT

58. Health Boards and/or local authorities will be required to delegate resources and functions, under delegation between partners arrangements, to the host organisation, that is the partner that will be responsible for the delivery and management of functions on behalf of the other partner, or to the body corporate. Health Boards and local authorities will incur a number of non-recurrent and recurrent costs associated with financial governance of the delegated functions and resources.

13http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/WorkforceDevelopmentGroup
59. Different VAT arrangements pertain in Health Boards and local authorities. Health Boards are section 41 bodies (VAT Act 1994) for VAT purposes, such that they can only reclaim VAT on certain specified services. In contrast, local authorities are section 33 bodies (VAT Act 1994) and, with a few minor exceptions, have full VAT recovery. The different VAT status of the partners complicates the recovery of VAT on goods and services purchased through the resources in an integrated budget and this introduces risks for recurrent resources. This is considered in detail in the recurrent costs section below. There is existing HM Revenue and Customs (HMRC) guidance for the delegation between partners model, and the Scottish Government will work with HMRC to tailor this to the Scottish context and to develop new guidance for the delegation to a body corporate model. Professional advisors have been appointed by Scottish Government at a non-recurrent cost of £35k.

60. In addition, each partnership will have to obtain agreement from HM Revenue and Customs on a case-by-case basis, which will involve preparation of financial statements. Based on experience in Highland, this will be marginal and is covered by the non-recurrent transitional costs outlined above. There will be a cost to HM Revenue and Customs for the process of application and approval of the integrated VAT arrangements for each partnership. Scottish Government officials are working with HM Revenue and Customs on these matters.

**Strategic planning**

61. Investment is required in Health Boards and local authorities to ensure that strategic planning is taken forward with maximum effectiveness. This issue has been recognised for some time and a programme of development has been established. A Local Learning Development Framework has been produced by the Institute of Public Care (IPC). Building on that, the Scottish Government is working with IPC and the Joint Improvement Team (JIT) to develop an accredited course on strategic commissioning, aimed at the statutory, independent and third sectors. This will cost £100k over two years. In addition, the JIT is undertaking a two year national improvement and support programme, working directly with local partnerships at a cost of £150k a year for two years from 2013/14.

**Support to the third sector**

62. It is intended, through secondary legislation, that integration authorities will be required to fully involve the third sector as key partners in strategic commissioning, locality planning and service delivery activity. The Scottish Government recognise the key role non-statutory, not-for profit providers of health and social care services play in the provision of care, working in partnership with statutory partners. It is expected that there will be a degree of overlap between these activities and those currently required for third sector participation in community planning and in developing change fund commissioning plans.

63. However, initial scoping work with third sector partners has identified a number of levels at which additional resources might be required to ensure sufficient knowledge and capacity to enable third sector partners to fully participate. These include:

- Strategic involvement at integration joint board and integration joint monitoring committee level;
• Bringing together and contributing on a co-production basis, the full extent of the third sector’s knowledge, expertise, and information, both in relation to communities and the sector itself, to strategic commissioning and locality planning; and

• Development of local capacity, including workforce development, partnership working and facilitation, to ensure a focus on prevention and upstream interventions, essential to delivering the full benefits of health and social care integration.

64. Scottish Government officials, with third sector partners, are scoping out a range of these estimated costs, which will be attributable to statutory partners. However, it is also anticipated that, in addition, some initial transitional cost for this function will be provided by the Scottish Government as part of the transitional costs to third sector partners in the partnership. Transitional costs of £360k will be made available to the third sector over 2013/14 and 2014/15 to support a national partnership initiative which will aid local change work. This will be alongside and complement local discussions between the third sector and statutory partners about how other transitional support available locally is utilised, including support to the sector locally. Third sector partners will also be expected to consider efficient and effective use of current resources and funding streams to enhance their capability and capacity.

Other financial governance

65. Delegating resources in a delegation between partners model to create the integrated budget in the host partner will require changes to financial recording and reporting in both partners, as well as preparation of the statements in support of the integrated budget and development of the finance sections of the integration plan. In addition, in the delegation to a body corporate model, Financial Procedure Notes and Standing Orders will need to be developed in the new bodies. The non-recurrent costs associated with this are based on the Highland experience and are included in the transition costs to the Scottish Government noted above.

Capital and assets

66. There are likely to be non-recurrent costs associated with carrying out due diligence reviews on assets and liabilities transferred to the host partner in the delegation between partners model. The estimate for these, based on the Highland experience, is included in the transition costs noted above. Under delegation to a body corporate, it is not intended that the new bodies will own capital assets, so there is no need to provide for costs associated with carrying out due diligence reviews on transferred assets and liabilities as is the case for delegation between partners model. This will result in a small reduction in the cost required for the transition team, but this will be offset by the small additional cost required for developing the Standing Orders etc. for the new body.

Health and social care activity information

67. To provide partnerships with information for developing their strategic plans and to inform performance management, a linked patient/client level health and social care dataset and information system will be required. It is likely to be more efficient that this be developed as a national solution by Information Services Division and for partnerships to access their data.
remotely. Non-recurrent estimates for the development of this, based on a preliminary assessment by ISD, are £250k in 2013/14 and £500k in 2014/15.

Summary - overall transitional costs to the Scottish Government

68. The Scottish Government will provide approximately £16.7m, which will be available to Health Boards and local authorities as partners in integration joint boards or lead agency arrangements, on a proportional basis for transitional costs, to implement the organisational development and other change management functions necessary, as set out above, to meet the requirements set out in the Bill. In moving to these arrangements, it is reasonable to assume that Health Boards and local authorities will realise opportunity costs, which will be expected to be used to support transitional arrangements.

PART TWO

2.1 – RECURRENT COST IMPLICATIONS TO HEALTH BOARDS AND LOCAL AUTHORITIES FROM PROVISIONS IN PART 1 OF THE BILL

Table 4 provides a summary of the recurrent costs to Health Boards and local authorities associated with delegation between partner model of integration set out in the Bill.

<table>
<thead>
<tr>
<th>Costs directly associated with Bill Implementation</th>
<th>2014/15 (£m)</th>
<th>2015/16 – recurrent (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Para 85 Financial costs teams</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Para 87 Clinicians’ involvement in locality planning</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Para 92 Health and social care dataset and information system</td>
<td>0</td>
<td>0.25</td>
</tr>
<tr>
<td>Para 93 Economist and analytical support for health and social care activity information</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Total</td>
<td>4.3</td>
<td>4.55</td>
</tr>
</tbody>
</table>

Table 4 - Summary of costs to Health Boards and local authorities – Delegation between partner model (£m)
Table 5 provides a summary of the recurrent costs to Health Boards and local authorities associated with delegation to a body corporate model of integration set out in the Bill.

<table>
<thead>
<tr>
<th>Costs directly associated with Bill Implementation</th>
<th>2014/15 (£m)</th>
<th>2015/16 (£m) recurrent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recurrence costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Para 68 Appointment of chief officer</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>Para 83 Financial recording and reporting</td>
<td>0.15</td>
<td>0.15</td>
</tr>
<tr>
<td>Para 85 Financial costs teams</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Para 87 Clinicians’ involvement in locality planning</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Para 92 Health and social care dataset and information system</td>
<td>0</td>
<td>0.25</td>
</tr>
<tr>
<td>Para 93 Economist and analytical support for health and social care activity information</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5.35</strong></td>
<td><strong>5.6</strong></td>
</tr>
</tbody>
</table>

**Establishment of an integration joint board or integration joint monitoring committee**

69. The partnership will be required to establish a joint board or joint committee, depending on the model of integration used, and its membership will be determined by the Health Board and local authority that are partners in the partnership arrangements within the requirements of the legislation. The cost implications to establish and maintain the joint boards or joint committees are immaterial as they will be mitigated by the removal of Community Health Partnership committees.

**Appointment of a chief officer in a body corporate model**

70. The Bill requires the appointment of a chief officer, where partners delegate functions and resources to the integration joint board within the body corporate model of integration. The chief officer will be responsible for the effective management of the integrated budget to deliver the services set out in the integration plan in order to achieve the nationally agreed outcomes via the strategic plan.

71. It is anticipated that the recurrent cost of a chief officer in each partnership that chooses to integrate via the delegation to a body corporate model of integration will be a maximum of £3.5m p.a. if all partnerships adopt this model; this estimate is based on 30 Whole Time
Equivalent (WTE) posts. This cost will be offset by the existing resource incurred by Health Board and local authority partners used to fund CHP general managers of £2.6m p.a., giving a maximum net additional cost of £900k p.a.. Approximately half of this cost is attributable to increasing the number of WTEs from 23.6 to 30 and the balance is attributable to the likely increased grading of the chief officer posts compared to Community Health Partnership general managers. The Scottish Government will provide guidance to support Partners on the appointment of the chief officer.

Other roles in the partnership

There are other recurrent costs associated with Community Health Partnerships, such as clinical leadership, financial management, HR support and administration functions, which will be required by the new partnerships and, therefore, the changes under the Bill are assumed to be cost neutral.

VAT

The different VAT status of the statutory partners 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 is a recurrent cost of £32m p.a. based on the estimated total VAT recovered by local authorities for adult social care services.

The VAT implications for integration are contingent on whether partners opt for delegation between partners or delegation to a body corporate.

VAT: delegation between partners

The VAT regime of the host partner in the delegation between partners model will apply to the integrated budget and 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.

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. The experience of the Care Trusts in Torbay and North East Lincolnshire, both of which took advantage of the solution in the guidance, was a VAT neutral outcome. Highland Partnership are also following this approach and, although its position is not yet finalised with HMRC, it expects a VAT neutral outcome also. The likely position, therefore, is that there will be no additional cost under the new arrangements for VAT.

VAT: delegation to a body corporate

Unlike with the delegation between partners model, where HMRC guidance allows a VAT neutral solution, there is no guidance available for this model. Consequently, there is a risk that VAT currently reclaimed by local authorities is no longer able to be recovered under the VAT arrangements in the body corporate. However, 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 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 that a VAT neutral position is attainable.

78. Note that should the Scottish Ministers extend, at a future juncture, the remit of the body corporate to be allowed to take advantage of employment and contracting powers, then there is a risk that HMRC will revise their view and conclude that the body corporate is in fact providing services. Under this contingency, the VAT status of the body corporate is less clear and the recovery of VAT is at risk. 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.

79. The Scottish Government is working with its advisors and HMRC to develop new guidance for the delegation to a body corporate model, based on the same principal of VAT neutrality that informs the guidance for delegation between partners. The likely position, therefore, is that there will be no additional cost under the new arrangements for VAT.

Other financial governance

80. In cases where staff and functions are transferred between partners, there is a transfer of risk to the host partner with an associated cost of indemnity to the host partner. Under the body corporate model, it is not intended for the integration joint board to employ staff or provide services, so that there will be no staff transferred to the new body and no associated transfer of risk and need for indemnity.

81. Nevertheless, staff transfers between partners may result from the subsequent commissioning decisions of the partnership, in which case the issues noted above for delegation between partners would apply. Under current arrangements, host partners would be required to obtain cover for risks arising from delegated staff and functions from the market and this may be material, particularly in cases of local authorities hosting health functions.

82. Part two of the Bill makes provision to extend the scope of the CNORIS clinical and other risks self-assurance scheme to allow cover for local authority social care functions and membership of local authorities, such that risks associated with social care services hosted by Health Boards and/or health services hosted by local authorities can be covered under the scheme. Under this arrangement, indemnity is estimated to be cost neutral. In cases where there is no transfer of staff between partners, but where integration results in innovation in the roles of care staff, there may be an increase in indemnity premiums for local authorities; however, given the likely nature of these innovations, this is not considered to be material.

Other financial governance: delegation between partners

83. Internal and external audit of the integrated budget and associated systems will be provided by the host partner auditors and, based on the Highland Partnership experience, is expected to be cost neutral from a partnership (delegation between partners) perspective.
84. Integration will act as a catalyst for consideration of the opportunities for rationalisation of support services. These are likely to be most apparent in Finance and HR due to the delegation of resources and potential of transfer of staff, but can potentially extend to all support services. Highland Partnership are in the early stages of discussions on shared services. Notwithstanding this, the national opportunities for this will depend on the circumstances in each partnership arrangement. As a result, it is difficult to estimate the potential saving and any associated re-organisation costs, and so none are included for this.

Other financial governance: delegation to a body corporate

85. Financial recording and reporting for the body corporate will be provided through a separate domain within the systems of either parent body at marginal on-going cost. The body corporate will require its own audit arrangements, and, whereas these are likely to be provided by the auditors of either of the parent bodies, this will require new work and is estimated at £150k p.a.

86. The potential benefits from rationalisation of support services and the cost of additional capacity in costing teams noted above for recurrent costs of delegation between partners equally apply under this model.

Other financial governance: for both models

87. The inclusion of hospital services in the integrated budget will necessitate a greater emphasis on hospital activity and cost in Health Board financial management and financial planning systems, which will require investment in costing teams. The estimate for this is £800k p.a. based on increasing the capacity of Health Boards costing teams to a proportionately consistent level.

Strategic planning

88. Integration joint boards and the lead agency will be under a duty to produce a strategic plan. The plan will be developed in collaboration with the third and independent sector providers, outlining how the objectives of the integration plan will be delivered using the integrated budget. Partners will be expected to adequately support involvement and consultation of a range of stakeholders in the planning process.

Locality planning

89. The Bill will place a requirement on partnerships to establish effective locality planning arrangements at a level of planning and commissioning for services for an identified population. Local clinicians and care professionals, in particular, will play a greater role in locality planning, which will inform the partnerships’ strategic plans. Carers, patients, service users and their families will also inform locality planning arrangements. Locality planning arrangements currently exist in many Community Health Partnerships and local authorities, though it is expected that these will need to be re-configured and developed to cover the scope of the new proposals. In some areas there will be a need for additional resources to fund clinical involvement. The recurrent costs to fund clinical involvement are estimated as £3m p.a. from 2015/16 and are based on existing good practice in a number of partnerships.
Capital and assets

Capital and assets: delegation between partners

90. Integration of health and social care offers the potential for some rationalisation of Health Board and local authority estate, which may result in non-recurrent receipts from asset disposals and will accrue to the owner of the asset. In the case of the Highland Partnership, property rationalisation is at the heart of the redesign of adult services and has the potential to affect team bases and properties used for in-house care home and day-care services.

91. In addition, rationalisation may result in recurrent savings on revenue property costs. Consideration of this is at an early stage in Highland and figures for potential savings are not available. Moreover, extrapolating from Highland to a national estimate would be difficult given the different asset configurations in each partnership. Accordingly, there is insufficient evidence to estimate the potential benefits from asset rationalisation and no figures are included.

Capital and assets: delegation to body corporate

92. Notwithstanding that the new bodies will not own capital assets; integration under this model still offers the potential for rationalisation of Health Board and local authority estate as that under delegation between partners; this will be through the strategic commissioning process and of recurrent savings on revenue property costs. The same difficulties in estimating the potential benefit of this noted above apply for this model and no figure is included for this.

Health and social care activity information

93. To provide partnerships with information for developing their strategic plans and to inform performance management, a linked patient/client level health and social care dataset and information system will be required.

94. The recurrent running costs and depreciation for the linked patient/client level health and social care information system (outlined above) are estimated as £250k p.a. from 2015/16, based on a preliminary assessment by Information Services Division.

95. In addition, care economists and analyst capacity will be required by partnerships in developing their strategic plans, to analyse and model existing and future needs and activity. Some partnerships have used change fund resource to fund this on a non-recurrent basis and there are also three WTE posts at £150k p.a funded by the Scottish Government currently supporting this work. To provide this capacity across all partnership on a recurrent basis would require an additional £500k p.a.
2.2 – COST IMPLICATIONS TO HEALTH BOARDS AND LOCAL AUTHORITIES FROM PROVISIONS IN PART 2 OF THE BILL

Broadening the remit of the Common Services Agency

96. Current legislation provides that whilst the Common Services Agency (CSA), commonly known as NHS National Services Scotland, may provide goods and services to NHS bodies in Scotland generally, it may only provide a limited range of goods and services to other public bodies, and then only to a limited range of public bodies. It is considered that this acts as a block to the Common Services Agency being as efficient and productive as it might otherwise be, and also prevents a range of public bodies in Scotland working as efficiently and productively as they might.

97. In January 2013, the Scottish Ministers approved laying a Public Services Reform Act Order to enable the Common Services Agency to move from a provider of shared services to NHS bodies only, to a provider of shared services to Scottish public bodies (including local authorities). It is envisaged that there are opportunities for the Common Services Agency to offer services such as legal, procurement, counter fraud and IT support to the wider public sector, which have the potential to produce operating and cost efficiencies.

98. 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.

99. It is difficult to accurately gauge the level of uptake off the Common Services Agency’s shared services across the wider public sector as this is not a mandatory measure - rather it is for public bodies themselves to determine the benefits of using the services provided by the Common Services Agency. However, what is apparent is that the costs to the public sector will be cost neutral. There will be no increase in the level of the Common Services Agency budget as a result of it delivering services to the wider public sector.

Extending the scope of CNORIS indemnity scheme

100. Current legislation (Section 85(B) of The National Health Service (Scotland) Act 1978) enables that a scheme may be created by regulation whereby any of the bodies listed in section 85(B) may make provision to meet:

- (i) expenses arising from any loss of or damage to their property; and
- (ii) liabilities to third parties for loss, damage or injury arising out of the carrying out of the functions of such members.

101. The Clinical Negligence and Other Risks Insurance Scheme (CNORIS) was created on 1 April 2000 pursuant to The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000; the regulations limit membership to all the NHS entities plus the Mental Welfare Commission for Scotland and also define the scope of the functions covered by the scheme. Under these arrangements, local authorities are not permitted to participate in the scheme nor are social work functions permitted to be covered.
102. Consequently, under the lead agency model, cases where local authorities host delegated health functions or where Health Boards host local authority functions, would not be covered by the scheme. In these cases, indemnity cover would need to be obtained from the market and this may be prohibitive.

103. The Bill amends s85(B) of the National Health Service (Scotland) Act 1978 to allow membership by local authorities and to extend cover to social care functions. This provision will allow local authorities and Health Boards to obtain indemnity cover under CNORIS and avoid the potentially material costs of market indemnity.

2.3 – COST IMPLICATIONS TO HEALTH BOARDS AND LOCAL AUTHORITIES FROM PROVISIONS IN PART 3 OF THE BILL

Joint venture structures

104. The Bill also aims to address two barriers to efficient procurement of infrastructure projects and address differences in the approaches available to Health Boards and local authorities to manage and maximise value from surplus assets.

105. In respect of collaborative procurement, there are two elements of cost reduction to Health Boards – development costs/fees for projects and on-going Special Purpose Vehicle costs. By way of an example, several Health Boards who are members of the hub North Territory are proposing to enter into one Design, Build, Finance and Maintain (DBFM) contract with a Special Purpose Vehicle (SPV) formed for this purpose by their hubco. Under this contract, each Health Board will be provided with individual facilities. Bundling the various facilities into one DBFM contract will maximise financial efficiency through economies of scale and avoiding the additional costs of setting up and running SPVs for each facility, and will facilitate funding by aggregating the otherwise individual borrowing requirements. Not having additional powers means that there will be two financial close processes (one for NHS Grampian and one for NHS Highland) required rather than one, and two special purpose vehicles created rather than one.

106. The financial implications of this example would be additional fees of up to £250,000 to get to financial close and additional costs of £75,000 to £100,000 per annum over the life of the agreement (25 years) in respect of the management of the additional Special Purpose Vehicle. These costs are in effect recovered from Health Boards via the unitary payments made in respect of premises developed.

107. In this example alone, having these powers would save NHS Scotland a minimum of £2.125m in revenue costs over 25 years or an average of £85,000 per annum. We can reasonably expect that the requirement for such bundles that cross Health Board boundaries would occur every 2 to 3 years. Financial modelling (using lower end cost estimates) shows in cash terms, over a 25 year period, savings in the order of £15.9m could be made when compared to the existing position of requiring separate financial close and SPV arrangements for such bundled projects.

108. Proposals for flexibility in company structures have no direct financial implications in themselves. These proposals will allow collaboration on an equal basis between partners and,
whilst structures such as LLP’s offer some tax efficiencies, these cannot be quantified at this time, and will be dependent on the application of such structures, which cannot be quantified at this time.

Implications for business

109. The bodies/stakeholders affected by the proposals are Health Boards, local authorities and private sector suppliers contracted to provide community based facilities. The proposals will streamline procurement of facilities and improve efficiency for those bodies developing such facilities.

110. There are no additional regulations or requirements being placed on private sector stakeholders. In respect of collaborative procurement, the powers sought will be used in the context of existing contractual arrangements and documentation. The proposals will not impact on access to public sector markets.

111. For Health Boards, there will be increased flexibility in the procurement of facilities and a consequent reduction in both development and on-going costs. Private Sector Development Partners have already been selected via open procurement in accordance with EU procurement law.

2.4 - CONSEQUENTIAL COST IMPLICATIONS TO HEALTH BOARDS AND LOCAL AUTHORITIES FROM PROVISIONS IN PART 1 OF THE BILL

Harmonisation of terms and conditions

112. The Bill will not require the transfer of staff between Health Boards and local authorities or to the integration joint board. Nevertheless, partners may choose to transfer some staff between them in order to better integrate delivery teams. Where staff transfer, they will do so under TUPE arrangements but there is a risk of a potential cost to partners in terms of harmonisation of terms and conditions, including equality of pay; the risk is different depending on which model of financial integration is chosen.

Harmonisation of terms and conditions: delegation between partners

113. Experience in Highland, Torbay and North East Lincolnshire indicates that transfer of staff is likely under this model; if staff transfer, the risk of harmonisation of terms and conditions depends on which organisation is the host partner:

114. Where staff transfer to the Health Board, the initiative for harmonisation would be with the Board; experience from Torbay and North East Lincolnshire, where staff transferred to the Care Trusts, was that the Trusts encouraged transferred staff to migrate onto the same terms and conditions as their new colleagues and that this helped to establish multi-disciplinary co-located teams and deliver truly integrated services. Although staff would be free to remain on TUPE terms and conditions, it is unlikely because migration of staff onto NHS terms and conditions would be to their individual advantage.
115. Where staff transfer to the local authority, the initiative for harmonisation would be with the local authority in the same way as in the case above, but there would also be a risk of an equal pay claim from the existing local authority staff.

116. In cases where staff transfer from a local authority to a Health Board but remain in the local government pension scheme, the Health Board will be required to recognise in its accounts the proportion of any surplus or deficit on the local authority pension fund that relates to the transferred staff; this may be a charge (in the case of a deficit) or a credit (in the case of a surplus) to the Board Accounts. Statutory mitigation enables local authorities to manage the fluctuations that relate to its employees through its reserves, but this facility is not available to Health Boards and so has the potential for instability in Health Board accounts and, in the case of deficits, creates a potential cost. The Scottish Government is considering options for a solution to this issue and no estimate has been included in the scenarios at paragraph 121.

Harmonisation of terms and conditions: delegation to a body corporate

117. Discussions with stakeholders lead us to think that most partners will use the body corporate model. Under this model, it is not intended that staff will transfer to the body corporate, but partners may nonetheless choose in time to transfer some staff between each other in the same way as under delegation between partners, in order to integrate delivery teams. The risk of cost of harmonisation is therefore contingent on a future decision to transfer staff between partners.

118. In the event of such transfers, the situation would be similar to those under delegation between partners outlined above. Note that there may be an additional theoretical risk that, under this model of integration, future claims may be brought by staff, or groups of staff, on the grounds that they undertake similar duties but work for separate employers on different pay, terms and conditions, within an integrated system. Such situations exist now, but may increase and be more obvious to staff as integration takes effect and is more widely acknowledged. The risk, and scale of any such potential cost pressures, is very difficult to estimate in advance.

119. Given the contingent nature of staff transfers under delegation to a body corporate, in the scenarios for potential costs described below, we have assumed that no staff will transfer under this model and have therefore assumed no harmonisation costs.

120. Costs associated with staff transfer have been scoped on the basis of three scenarios and are dependent on the model of integration agreed by the Health Board and local authority; the estimates are based on the synthesis of a number of analyses: the experience in NE Lincolnshire and Torbay Care Trusts; analysis by Health and Social Care Directorates Analytical Services Division for transfer of adult social care service staff to Agenda for Change; and detailed analysis for a sample of adult NHS Highland adult social care staff. The scenarios assume that transferred staff remain in their original pension schemes, and it includes an estimate of additional employers’ pension contributions due.

121. The following material provides the three estimates for costs associated with staff transfer under the two main models of integration (delegation to a body corporate or delegation between partners).
These documents relate to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

- A likely case, where all partnerships opt for delegation to a body corporate model (except Highland); this is also the lowest cost scenario. The cost under the first scenario is £nil p.a.;
- A mid cost case where half of partnerships opt for delegation to a body corporate model and half opt for delegation between partners model; the cost in this case would be £13.5m.
- A highest cost case, where all partnerships opt for delegation between partners model with functions delegated to Health Boards and adult social care staff transferring to Boards. The cost under the highest cost case is £27m p.a.

PART THREE

COST IMPLICATIONS TO OTHER PUBLIC BODIES FROM PROVISIONS IN THE BILL

Scrutiny of strategic plans and service delivery

122. The Bill places a duty on the Health Board and local authority to achieve the nationally agreed outcomes for health and social care. The outcomes and the performance indicators will be prescribed by the Scottish Ministers. Where other functions beyond adult health and social have been delegated, the Health Board and/or local authority will be required to take account of other relevant outcome measures. The performance of partnerships in achieving the nationally agreed outcomes and other relevant outcomes in relation to the delegated functions will be assessed jointly by Healthcare Improvement Scotland and the Care Inspectorate. Healthcare Improvement Scotland and the Care Inspectorate undertook ‘pilot’ joint inspection of integrated services in early 2013. Estimates based on the pilots from Care Inspectorate and Healthcare Improvement Scotland suggest a cost of £173,362 per joint inspection. It is anticipated that these bodies will undertake six inspections per year.

123. Additional resource, longer term, will also be required to fund the Care Inspectorate and Healthcare Improvement Scotland for scrutiny of strategic commissioning. The scrutiny bodies will review strategic plans as part of joint inspections, assessing whether the plan meets all statutory requirements and has been created within the statutory duties laid out in the Bill. It is anticipated the scrutiny bodies will carry out six joint inspections per year, with a recurrent cost estimated at £670k p.a., some of this work is already underway. This is based on an assessment by Care Inspectorate and Healthcare Improvement Scotland of the additional requirements being placed upon them. It will be incurred from 2015/16.

PART FOUR

CONSEQUENTIAL COST IMPLICATIONS TO OTHER BODIES, INDIVIDUALS AND BUSINESSES FROM PROVISIONS IN THE BILL

124. As discussed above, the Bill will place duties on Health Boards and local authorities, therefore, costs will mainly fall to these statutory bodies. However, providers of social care services, in particular, but also other community services, are provided by third or independent organisations. The Business Regulatory Impact Assessment also explores the potential
consequential impacts of the provisions in the Bill on businesses, though the provisions in the Bill only directly impact on Health Boards and local authorities. The Business Regulatory Impact Assessment is published separately. It is reasonable to anticipate that as a result of the requirement for Health Boards and local authorities to jointly plan and deliver adult health and social care services through the effective use of the integrated budget and resources, that businesses may incur costs in order to support the delivery of services that will shift in the balance of care to community provision.

125. The costs to businesses are anticipated to be the following;

- Costs for delivery of training; to diversify the business to take into account the demand for community provision, increase capacity and support delivery of more community based services and skills to participate in the commissioning and planning process;
- Costs arising from diversification, rationalisation or expansion of business model in response to commissioning of health and social care services;
- Increased costs to business to support and train unpaid carers;
- Costs associated with participation in partnership planning arrangements; and
- Costs associated with compliance with Information Technology, data sharing and data protection protocols.

126. However, given that these will be dependent on the commissioning decisions of the partnerships, no costs are included.
Direct costs resulting from the Bill

127. Table 6 provides a summary of direct costs resulting from the Bill.

<table>
<thead>
<tr>
<th>Table 6 – Summary of direct costs resulting from the Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012/13</strong></td>
</tr>
<tr>
<td>Recurrent</td>
</tr>
<tr>
<td>Transitional costs to the Scottish Government</td>
</tr>
<tr>
<td>Transition team</td>
</tr>
<tr>
<td>Displacement of CHP leadership staff</td>
</tr>
<tr>
<td>Strategic workforce and organisational development</td>
</tr>
<tr>
<td>Developing VAT guidance with HMRC</td>
</tr>
<tr>
<td>Support to develop strategic plans</td>
</tr>
<tr>
<td>Support to third sector – national partnership initiative</td>
</tr>
<tr>
<td>Financial governance (included in organisational development and transition team)</td>
</tr>
<tr>
<td>Capital and assets (included in transitional costs)</td>
</tr>
<tr>
<td>ISD data activity information sets</td>
</tr>
<tr>
<td>Subtotal costs to Scottish Government</td>
</tr>
<tr>
<td>Costs to Health Boards and local authorities</td>
</tr>
<tr>
<td>Appointment of chief officer</td>
</tr>
<tr>
<td>Financial costs teams</td>
</tr>
</tbody>
</table>
Table 6 – Summary of direct costs resulting from the Bill (continued)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recurrent</strong></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Financial recording and reporting</td>
<td>0</td>
<td>0</td>
<td>0.15</td>
<td>0.15</td>
<td>0.15</td>
<td>0.15</td>
</tr>
<tr>
<td>Economist and analytical support for health and social care activity information</td>
<td>0</td>
<td>0</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Health and social care dataset and information system</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>Clinicians’ involvement in locality planning</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Subtotal costs to Health Boards and local authorities</strong></td>
<td>0</td>
<td>0</td>
<td>5.35</td>
<td>5.6</td>
<td>5.6</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>Costs to other public bodies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scrutiny of strategic plans and service delivery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.67</td>
<td>0.67</td>
<td>0.67</td>
</tr>
<tr>
<td><strong>Costs to other bodies, individuals and businesses</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.085</td>
<td>1.63</td>
<td>16.15</td>
<td>9.37</td>
<td>6.97</td>
<td>6.27</td>
</tr>
</tbody>
</table>
ANNEX

Current areas of Scottish Government investment relevant to the scope of the Bill

128. Improved joint working between Health Boards and local authorities, to improve outcomes and the experience of those most in need and their carers, has been a longstanding policy objective of the Scottish Government. This is evident in a range of current and future initiatives. Table 7 provides a summary of the wider financial commitments of the Scottish Government to support the integration agenda. Future funding will be subject to the spending review.

<table>
<thead>
<tr>
<th>Table 7 - Wider Scottish Government financial context (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Para 130</strong> Reshaping Care for Older People Change Fund</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Para 131 Support to Third Sector Interface</td>
</tr>
<tr>
<td>Para 134 Change Fund: Enhancing the Role of the Third Sector</td>
</tr>
<tr>
<td>Para 135 A Stitch in Time</td>
</tr>
<tr>
<td>Para 136 Support to Independent providers in relation to Reshaping Care for Older People</td>
</tr>
<tr>
<td>Para 137 Data Sharing and Information technology integration support</td>
</tr>
<tr>
<td>Para 139 Support for partnerships to develop Health and Social Care Activity data (3xWTE)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

129. The following sections provide further information on the investments listed above.
Reshaping Care for Older People Change Fund

130. The Reshaping Care for Older People Change Fund\(^\text{14}\) represents one of the Scottish Government’s key preventative spend funds (£300 million of the overall £500 million preventative spend budget: £70m/£80m/£80m/£70m across the four financial years from 2011-12 to 2014-15 respectively). Statutory, voluntary and independent sector partners responsible for delivering health and social care across Scotland are using the Fund as bridging finance to make better use of their total combined resources for older people’s services. The Fund is already helping to redesign care services for Scotland’s growing older population - helping to prevent delays, provide more proactive community-based services and better care and support at home. In line with the Scottish Government’s proposals for the integration of adult health and social care, the future Change Fund to 2015 will be explicitly linked to delivery of joint commissioning strategies.

Support to the third sector

131. The Scottish Government is providing £8.2 million for three years from 2012/13 to support the network of 32 third sector interfaces in Scotland. There is a single third sector interface within each local authority area in Scotland. The third sector interface has four key functions:

- Volunteering development;
- Social enterprise development;
- Supporting and developing a strong third sector;
- Building the relationship with community planning.

132. A set of common service standards was developed which ensures a consistent level of service expectation across the interface network in each of the 32 local authorities in Scotland.

133. The Joint Improvement Team (JIT) has a specific remit to support health and social care partnerships to operate more effectively \textit{as partnerships}, across all their services and any other areas of activity. This has traditionally involved Health Boards and local authorities. More recently, the arrangements required by the Reshaping Care for Older People Programme (RCOP) and its attendant Change Fund have brought the third and independent sectors firmly and formally into the partnership relationship.

134. The JIT and the Third Sector Unit of Scottish Government have jointly funded a three year project delivered by the Health and Social Care Alliance (the Alliance) in partnership with other third sector partners, and designed to build the capacity of the third sector to engage with RCOP. The project’s full title is ‘Change Fund: Enhancing the Role of the Third Sector\(^\text{15}\) and has a budget of £180,000 p.a. The project has a focus on supporting Third Sector Interfaces and

\textbf{\textsuperscript{14}} \url{http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Older-People/ReshapingCare}
\textbf{\textsuperscript{15}} \url{http://www.alliance-scotland.org.uk/what-we-do/projects/change-fund-enhancing-the-role-of-the-third-sector-programme/}
national third sector organisations but it also has sufficient locus to work with other third sector organisations as appropriate.

135. A Stitch in Time? is a partnership based National Demonstration Project, facilitated by Evaluation Support Scotland (ESS) in partnership with other third sector partners, and supported by the Scottish Government Third Sector Unit and the JIT providing £0.318m over 3 years from 2012/13. It aims to fully understand the contribution of third sector-delivered interventions to the outcomes of the Reshaping Care for Older People programme in a defined geographical area.

Independent sector

136. The Joint Improvement Team have funded Scottish Care with grant payments of £60,000 in 2011-12 and £90,000 in 2012-13. These grants are to enable support for capacity development in the independent sector in relation to Reshaping Care for Older People and related work. This includes developing and sustaining the independent sector’s capacity to contribute to the Reshaping Care objectives and development and implementation of the Reshaping Care for Older People’s Change Fund plans, along with contributing towards the developing work on health and social care integration and other related government policies.

Data sharing and information technology

137. The Scottish Government eHealth budget currently includes a dedicated budget of £2m p.a. to support Health and Social Care IT integration. The NHS and local authorities have invested significant amounts in previous years to put in place modern IT systems. The focus of future work will be on exploiting the capabilities of these systems to improve information sharing.

138. The eHealth Strategy published in Autumn 2011 included a commitment to produce a Health and Social Care IT strategy (by early 2014) in partnership with local authorities. In addition, a Data Sharing Technology Board (DSTB) has been established under local authority chairmanship and is meeting regularly. This Board is responsible for decisions on the existing infrastructure and the development of consensus on the way forward. The Board undertakes this role in a broader context of co-operation between stakeholders through their role in the development of the Health and Social Care IT Strategy.

Health and social care activity information

139. Analysis of existing population needs and resource allocation and utilisation is a critical stage in the joint commissioning cycle. A number of partnerships have used the Change Fund for Older People’s Services to pay for analyst posts to support the development of their strategic plans. In addition, the Scottish Government has provided £150k p.a. funding to Information Services Division for a further 3 WTE economists and analysts to provide support to other partnerships. These posts have used mapping data from the Integrated Resource Framework to analyse current health and social care expenditure in those partnerships and have carried out

---


cohort analyses on specific care groups, for example, dementia, substance misuse and delayed discharges.

SCOTTISH GOVERNMENT STATEMENT ON LEGISLATIVE COMPETENCE

On 28 May 2013, the Cabinet Secretary for Health and Wellbeing (Alex Neil MSP) made the following statement:

“In my view, the provisions of the Public Bodies (Joint Working) (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

On 28 May 2013, the Presiding Officer (Rt Hon Tricia Marwick MSP) made the following statement:

“In my view, the provisions of the Public Bodies (Joint Working) (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”
INTRODUCTION

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

POLICY OVERVIEW

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

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

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

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

The Christie Commission Report
Commission on the future delivery of public services, June 2011
3. There is a great deal to be proud of in terms of health and social care provision in Scotland. The Healthcare Quality Strategy for NHS Scotland\(^1\) underpins the Scottish Government’s commitment to deliver the highest quality healthcare services to people in Scotland and, in recent years, Scotland has seen significant improvements in terms of standards and outcomes, with improvements in waiting times, patient safety and delayed discharge from hospital. The Scottish Government’s introduction of a Dementia Strategy\(^2\), continuing commitment to Free Personal and Nursing Care and Reshaping Care for Older People\(^3\) programme, which is supported by the Change Fund for older people’s services, all demonstrate determination to assure innovative, high quality care and support services that improve people’s lives. The Scottish Government’s Carers’ Strategy\(^4\) supports unpaid carers, who are themselves essential providers of health and social care, and the Social Care (Self-directed Support) (Scotland) Act 2013\(^5\) seeks to put greater control into the hands of individuals using care and support services.

4. Nevertheless, there is widespread recognition across Scotland that reform needs to go further. Separate – and sometimes disjointed – systems of health and social care can no longer adequately meet the needs and expectations of increasing numbers of people who are living into older age, often with multiple, complex, long-term conditions, and who need joined-up, integrated services. Addressing these challenges will demand commitment, innovation, stamina and collaboration from all of us who are involved, in different ways, in planning, managing, delivering, using and supporting health and social care services.

5. The Scottish Government, its statutory partners in local government and NHS Scotland, and its non-statutory partners in the third and independent sectors, agree that better integration of health and social care services is required in order to ensure the on-going provision of high quality, appropriate, sustainable services. Integration is not an end in itself – it will only improve the experience of people using services when partner organisations work together to ensure that services are being integrated as an effective means for achieving better outcomes.

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

7. There has been very significant progress in improving pathways of care in recent years. The Joint Futures policy, Community Health Partnerships and the work of the Joint Improvement Team have also contributed to development of partnership working across health and social care. Nevertheless, many clinicians, care professionals and managers in health and social care currently describe two key disconnects in Scotland’s system of health and social care. The first disconnect is found within the NHS, between primary care (GPs, community nurses,
This document relates to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

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

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

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

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

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

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

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

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

⁶ Reshaping Care for Older People http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/
to address these barriers and to deliver care that is better joined up and, as a consequence, delivers better outcomes for patients, service users and carers.

13. The goal for integration of health and social care is to tackle these challenges and, in particular, to address the disconnects described above – so that the balance of care shifts from institutional care to services provided in the community, and resources follow people’s needs. This is in line with the Scottish Government’s commitment to a person-centred approach, which builds on the Scottish Government’s policy on Self Directed Support\(^7\) and the principles of the Healthcare Quality Strategy for NHS Scotland.\(^8\)

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

Scope – demographic considerations

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

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

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

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


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

Scope – enabling integration beyond adult health and social care

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

Partnership working – more than statutory partners

20. The Bill is designed to enable locally-implemented integration. It focuses on bringing together the accountability of statutory partners – Health Boards and local authorities – in an equitable way, to deliver better outcomes for patients, service user and carers. The Bill enables, through secondary legislation, Health Boards, local authorities and integration joint boards to fully and appropriately involve non-statutory providers of health and social care with planning and decision-making within the partnership arrangements. This is consistent with principles of co-production\(^9\), which underpin the Government’s vision for mutual and person-centred public services\(^10\), which encourage the utilisation of the talents, capacities and potential of all of Scotland’s people and communities in designing and delivering health and social services\(^11\). In addition, it will be important, and is intended through secondary legislation, to involve and consult carers and users of health and social care services in all aspects of the integrated arrangements.

21. The third and independent sectors, including carers’ organisations, also provide significant levels of care and support and are crucial partners, with the statutory services, in the provision of a wide range of support. As work continues with partners and stakeholders to deliver this agenda for integration of health and social care, it will be particularly important that there is a focus on building on the principles of inter-agency working enshrined in the Change Fund for older people’s services\(^12\). The fundamental purpose of the policy on integration, which underpins the legislation, is to improve people’s wellbeing; the reform will not succeed if, in bringing health and social care together, the need to build upon the progress that has been made in bringing third and independent sector partners to the table when planning delivery of services is overlooked. The contribution of the third and independent sectors in enabling delivery of

\(^9\) Co-production of Health and Wellbeing in Scotland \url{http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/community-capacity-building/community-capacity-building-resources/}


\(^12\) Reshaping Care for Older People \url{http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Older-People/ReshapingCare}
better outcomes is also a crucial factor in the Scottish Government’s wider public service reform\textsuperscript{13} plans.

22. Other areas of service also play a key role in the delivery of better outcomes for people with long term conditions and complex needs, and for older people in particular. Housing is an important example of this. The National Strategy for Housing for Older People\textsuperscript{14} highlights ways in which the right housing and related services (such as adaptions and handyperson services) can help to support independent living, and can contribute to health and social care objectives. It will be important that, in bringing primary and secondary health closer together, and health and social care closer together, partners ensure that housing services (including those provided by housing associations and the third sector, as well as by local authorities) are fully included in the integrated approach to service planning and provision, and that health and social care planning and local housing strategies are mutually supportive.

\textbf{CONSULTATION}

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

24. In May 2012, the Scottish Government published its consultation on proposals for the integration of adult health and social care\textsuperscript{15}. The consultation described the proposals for which the Scottish Ministers intend to legislate, and set the context for the Bill. The consultation closed on 11 September 2012.

25. Over the period of the consultation, Scottish Government officials held a number of consultation events\textsuperscript{16} across Scotland, providing the opportunity for professionals, patients, service users and carers, as well as providers of services, to hear first-hand about the consultation proposals and to have the opportunity to ask questions and discuss the proposals. In addition, officials met with a broad range of stakeholders at events and meetings organised by local partnerships to provide further opportunities to discuss the consultation proposals.

26. Three hundred and fifteen written responses to the consultation were received from a range of different stakeholders and individuals, reflecting the breadth of interest in this area of public service reform. Non-confidential responses\textsuperscript{17} were published on the Scottish Government website. An analysis\textsuperscript{18} of written responses to the consultation was published on 19 December 2012.

\textsuperscript{13} Public Service Reform \url{http://www.scotland.gov.uk/Topics/Government/PublicServiceReform}
\textsuperscript{14} A Strategy for Housing for Scotland’s Older People \url{http://www.scotland.gov.uk/Publications/2011/12/16091323/0}
\textsuperscript{15} Integration of Adult Health and Social Care Consultation on Proposals \url{http://www.scotland.gov.uk/Publications/2012/05/6469}
\textsuperscript{16} Consultation events \url{http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration}
\textsuperscript{17} Responses to the Consultation \url{http://www.scotland.gov.uk/Publications/2012/10/5025}
\textsuperscript{18} Consultation Analysis Report \url{http://www.scotland.gov.uk/Publications/2012/12/1068}
27. The Scottish Ministers and officials considered the consultation responses and continued to work collaboratively with key stakeholders to develop the proposals further.

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

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

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

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

OUTCOME OF THE CONSULTATION

National outcomes for health and wellbeing and scope

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

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

---

19 Bill Advisory Group [http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Meetings](http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Meetings)


21 Scottish Government Response to the Consultation [http://www.scotland.gov.uk/Publications/2013/02/4208](http://www.scotland.gov.uk/Publications/2013/02/4208)
34. Other respondents indicated concerns that, by focusing on ‘older people’ first, an artificial divide may be created that may have a negative impact on other groups of patients and service users, who did not meet the ‘age criteria’.

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

**Governance and accountability**

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

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

38. On proposals regarding committee membership, local authority respondents asked particularly for flexibility regarding the number of councillors who could sit on the Health and social care partnership committee. There was a consistent view that accountability should be to the full council and not the leader of the council or its officers.

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

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

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

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

43. There were mixed views regarding whether Health Boards and local authorities should be free to choose whether to include the budgets for other Community Health Partnership functions (beyond adult services) within the scope of the integration authority. The majority of respondents expressed the view that this should be left to local determination. A few respondents suggested a stepped approach, starting with the minimum and, when integration authorities are able to demonstrate this working, moving to include more services. There were some respondents who expressed the view that the Scottish Ministers should prescribe the extent of the integrated budget in order to assure consistency of approach. Some respondents also expressed the view that budgets for children’s and housing services particularly should be included within the scope of the integrated budget from the start.

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

44. Respondents expressed differing views regarding the appointment of chief officers and expressed a need for further information on the role and remit of the post. Some respondents thought that responsibility for planning and delivery of integrated services should sit with the chief executives of Health Boards and local authorities, and existing Community Health Partnership general managers. Others felt that the role would be necessary in order to manage the integrated budget effectively.

45. There was general agreement that if chief officers are appointed they need to be multi-skilled, experienced, knowledgeable and expert managers, able to operate with autonomy, wield influence and exercise authority within both statutory structures, as well as within the integration authority. Many respondents expressed the view that the chief officer post must be senior enough to reflect these requirements.

Professionally led locality planning and commissioning of services

46. The majority of respondents expressed a desire for locality planning arrangements to be developed locally, supported by Scottish Government guidance. A few respondents expressed the view that the Scottish Government should direct locality planning arrangements to ensure consistency across service delivery areas.
47. The proposal that a duty should be placed upon integration authorities to consult local professionals, including GPs, on how best to put in place local arrangements for planning and implementing service provision was welcomed. However, some respondents asked that the duty be strengthened by using the terms ‘involve’ and ‘engage’ rather than ‘consult’. Reference was also made to the need to make specific mention of other clinical staff, health and social care professionals and service users.

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

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

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

**BILL OUTLINE**

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

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

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

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

53. In summary, the Bill:

- Provides for the Scottish Ministers to specify national outcomes for health and
  wellbeing, and for delivery of which, Health Boards and local authorities will be
  accountable to the Scottish Ministers and the public (note that the provisions of the
  Bill apply to area Health Boards and not Special Health Boards)

- Sets out principles for planning and delivery of integrated functions, which local
  authorities, Health Boards and joint integration boards will be required to have
  regard to. They set out that the main purpose of integrated services is to improve the
  wellbeing of recipients, as well as an expectation that planning and delivery will take
  account of key principles relating to integrated delivery; the requirement to balance
  the needs of individuals with the overall needs of the population; anticipation and
  prevention of need; and effective use of resources.

- Establishes integration joint boards and integration joint monitoring committees as
  the partnership arrangements for the governance and oversight of health and social
  care services. The Bill will remove Community Health Partnerships from statute.

- Requires Health Board and local authority partners to enter into arrangements (the
  integration plan) to delegate functions and appropriate resources to ensure the
  effective delivery of those functions. The Bill provides for two options for
  integrating budgets and functions. First, delegation to an integration joint board
  established as a body corporate - in this case the Health Board and the local authority
  agree the amount of resources to be committed by each partner for the delivery of
  services to support the functions delegated. Second, delegation between partners. In
  this case the Health Board and/or local authority delegates functions and the
  corresponding amount of resource, to the other partner.

- Requires integration joint boards to appoint a chief officer, who will be jointly
  accountable, through the board, to the constituent Health Board and local authorities,
  and responsible for the management of the integrated budget and the delivery of
  services for the area of the integration plan. The chief officer will also lead the
  development and delivery of the strategic plan for the joint board.

- Requires integration joint boards, and Health Boards or local authorities to whom
  functions are delegated acting in the capacity of “integration authority” to prepare a
  strategic plan for the area, which sets out arrangements for delivery of integration
  functions and how it will meet the national health and wellbeing outcomes. The
  integration authority will be required to involve a range of partners in the
  development of the plan and consult widely. In addition, locality planning duties will
  require the integration authority to make suitable arrangements to consult and plan
  locally for the needs of its population.

- Delivers opportunities for more effective use of public services and resources by
  allowing for Health Boards to be able to contract on behalf of other Health Boards
This document relates to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

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

- Provides for the extension of the Common Services Agency’s ability to deliver shared services to public bodies including local authorities.

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

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

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

a) Each Health Board and local authority will be required to establish an integration authority (body corporate or delegation between partners arrangements) to deliver nationally agreed outcomes for health and wellbeing.

b) In the “body corporate” model, the Health Board and the local authority delegate functions and resources to the integration authority, which is a joint board established as a body corporate. In this model, the integration joint board is required to appoint a chief officer who will lead development of the strategic plan, and manage the integrated budget and integrated planning and delivery of services.

c) In the “delegation between partners” model of integration, the Health Board or local authority or both, delegates functions and resources to the other or each other, for delivery of services. This model is sometimes referred to as a “lead agency” model, with the partner to whom functions are delegated becoming the “lead agency”. In this model, the Bill does not require the appointment of a chief officer. The integration plan will establish that the chief executive of the “lead agency” will be jointly accountable to the Health Board and local authority for management of the integrated services, and will lead development of the strategic plan.

d) The terms of the arrangement will be described in an integration plan, the details of which will include the model of integration to be used, functions and resources to be delegated, to the integration authority (integration joint board, Health Board and/ or local authority) and method of calculating money to be delegated to support delivery of the functions.

e) The integration plan will also cover a wide range of other aspects of the arrangement, such as provision for dispute resolution, financial management, staff governance and clinical and care governance. Regulations will be made specifying the required content of the integration plan.

f) Nationally agreed outcomes provide the context for effective joint planning, and the requirement to establish partnership arrangements reinforces the importance of establishing integrated arrangements that span traditional structures. The principle of joint and equal accountability is enshrined in the role of the chief officer in the “body corporate” model, and in the dual accountability of the lead chief executive in the “delegation between partners” model.

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

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

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

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

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

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

**OBJECTIVES OF THE BILL – KEY FEATURES AND PROVISIONS**

62. The Bill responds to the changing shape and needs of Scotland’s population. More people are living longer, some of them with significant, complex needs for support, an effective, sustainable response to which requires better joined up health and social care services.
63. The context for these legislative changes is characterised by complexity; complexity of people’s needs and complexity in the service planning and delivery landscape. As a country, Scotland’s response to such complexity must be driven by strong local leadership and effective local planning based on a strong understanding of local needs and priorities. For all of these reasons, a key objective of this Bill is to enable and require appropriate, local, responses to changing patterns of need, within a national context of accountability for clearly articulated, joint outcomes.

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

Part 1 – Functions of local authorities and Health Boards

Integration plans: principles

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

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

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

National outcomes

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

23 Commission on the future delivery of public services
http://www.scotland.gov.uk/About/Review/publicservicescommission
69. Currently, performance management and reporting frameworks for NHS Scotland and local authorities are considerably different from one another.

70. The introduction of the Concordat\(^24\) between the Scottish Government and COSLA in November 2007 brought with it the end of ring-fencing of local government funding and associated scrutiny by the Scottish Government of local authority spending. Single Outcome Agreements (SOAs) are now agreed between each Community Planning Partnership (CPP) and the Scottish Government.

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

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

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

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

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

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

Integration plans

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

- The purpose of the integration plan is to establish the context and provide the necessary clarity of the arrangements in which the integration authorities will operate. It will set out the governance arrangements for the integration authority, functions and budgets to be delegated, outcomes to be achieved, and the model of financial integration to be implemented. Other aspects of the integrated arrangements, such as dispute resolution, clinical and care governance will also be set out in the integration plan.

- Health Boards and local authorities will be required to involve and consult a wide range of stakeholders including health and social care professionals, representatives of Health Board and local authority employees, carers, and service users. Health Boards and local authorities will be required to take account of the views of the consultees.

- The integration plan will be agreed by the full council and Health Board, approved by the Scottish Ministers, and will be made publicly available.

Models of integration

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

Body corporate model

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

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

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

**Delegation between partners**

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

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

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

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

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

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

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

Integration joint boards and integration joint monitoring committees

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

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

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

Governance

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

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

93. The integration joint board will be accountable to the Health Board and the full council for the delivery of the delegated functions and the national and local outcomes expressed through
the strategic plan. The integration joint board will be a decision-making body and take
responsibility for the delivery of outcomes, the discharge of the integrated budget, and the
performance management of the partnership arrangements. The board will provide direction to
the chief officer in the discharge of his or her duties, which will be to deliver the strategic plan
using the integrated budget.

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

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

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

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

Scope of delegated functions

98. The policy is to require integration of adult health and social care services and the Bill
provides for the Scottish Ministers to establish by regulation the functions that must, may and
may not be delegated. It is to be left to statutory partners to agree locally whether to include
other services, such as children’s or housing services, in the integrated arrangements. The Bill
enables the Scottish Ministers, in the future, to extend the scope of services that must be
integrated. Approval of the integration plan by the Scottish Ministers will ensure that, as a
minimum, adult health and social care functions are included in the integrated arrangements.
99. Functions that can be delegated, and functions that cannot be delegated, are described via regulations and statutory guidance, to provide clarity and flexibility, and to keep pace with future service innovation. Budgets will follow delegated functions.

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

### Integrated budgets and resourcing

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

102. The ability to look at overall expenditure for defined populations and user groups, and to use budgets flexibly, is a hallmark of integrated care. This is important, both to enable efficient allocation of resources and also to ensure that needs are met in the most appropriate and cost-effective way. The experience of integrated partnerships outside Scotland is that pooling resources has resulted in funds that are nominally allocated to one sector being used to increase investment in another, contributing to measurable changes in the location of care over a period of years, including reduced use of hospitals and care homes.\(^25\)

103. Alongside the introduction of this Bill, the Scottish Government continues its work on the Integrated Resource Framework\(^26\) for health and social care, and continues to work with Information Services Division of NHS Scotland and COSLA, in order to develop a database to provide partners with this information at individual client/patient level on a routine basis.

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

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

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

---

\(^25\) Transforming the delivery of health and social care Kings fund 2012

\(^26\) Integrated Resources Framework [http://www.scotland.gov.uk/Publications/2012/07/4786](http://www.scotland.gov.uk/Publications/2012/07/4786)
• In the “delegation between partners” model of partnership, the budgets for the delegated functions are combined with the lead agency’s own resource to form the integrated budget for the population of interest. The lead agency hosts the integrated budget on behalf of both partners, under the management of the chief executive of the lead agency.

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

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

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

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

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

---

27 2010/11 IRF mapping. ISD.
• In **clinical** terms, given pressures in terms of demand resulting from demographic change, existing unscheduled care pathways, which are biased to reactive care in institutional settings, are expanded. The risk here is that the transformational improvements possible through integration, and seen outside Scotland, will not be achieved, to the detriment of patient and service user outcomes. A likely consequence is that the system will increase capacity along current patterns of institutional care – i.e., a vicious cycle of spending more and more money on services that do not support people with multiple complex needs many of whom are frail older people, to best effect.

• In **financial** terms, they do not recognise the reality of the integrated nature of health and social care services, particularly for frail elderly people and those with complex needs. Unless it is recognised that all parts of this system have a direct bearing on the effectiveness of the others, it will not be possible to plan overall expenditure for defined populations and user groups, and to use budgets flexibly, resulting in inefficient use of resources and poor outcomes.

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

• In setting budgets, Health Board and local authority flexibility to allocate their resources across the full range of their budgets may be constrained by “ring-fencing” of their previous allocations to the integration authority (integration joint board, Health Board and/or local authority). This risk will be proportional to the extent of the minimum scope of services to be included in the integrated budget.

• In managing variances on the budget for hospital services due to unforeseen cost pressures; the risk here is that the Health Board is left to manage the overspend whilst being unable to direct under-spends in community health budgets to offset these, a facility that is currently available to Health Boards.

• Both Health Boards and local authorities need to address adverse variances on their out-of-scope budgets. Here, the parent bodies are limited in their options for managing compensating in-year under-spends to those from within the out of scope budgets; under existing arrangements they have greater flexibility and are able to direct under-spends from the in-scope integration authority budgets as well.

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

**Chief officer**

112. In the integrated health and social care environment for which the Scottish Government is legislating, joint accountability at senior level is required, in simple terms, to achieve two objectives:
This document relates to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

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

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

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

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

Health and social care workforce

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

Strategic commissioning of health and social care services

117. Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services, and working in partnership to put these in place.
Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget.

118. Audit Scotland was critical of commissioning skills in Scotland in its report, Commissioning Social Care (March 2012\(^{28}\)), and recommended that local authorities, along with Health Boards and other relevant partners, should develop commissioning strategies. Following that publication, the Public Audit Committee recommended that “it should be a requirement for each of the proposed partnerships to produce a long-term joint social care commissioning strategy”. Furthermore, the Finance Committee\(^ {29}\) recently invited the Scottish Government to respond to the findings that there were few examples of good joint planning, and a slowness to develop strategic commissioning.

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

120. The Bill establishes that integration authorities (integration joint board or Health Board and/or local authority in a lead agency arrangement) are required to produce a strategic plan (strategic commissioning plan), which sets out how they will plan and deliver services for their area over the medium term (3 years). Guidance will set out that strategic plans will also be expected to plan for the longer term (10 years). Further, the role of clinicians and care professionals, along with the full involvement of the third and independent sectors, service users and carers, will be embedded as a mandatory feature of the commissioning and planning process. This will strengthen the cross-sector arrangements that have been established during the first two years of the Change Fund\(^ {30}\).

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

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

Good strategic plans should also:

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

---

\(^{28}\) Audit Scotland: Commissioning Social Care report
[http://wwwaudit-scotlandgovuk/docshealth/2012nr_120301_social_carepdf](http://wwwaudit-scotlandgovuk/docshealth/2012nr_120301_social_carepdf)

\(^{29}\) Demographic change and an ageing population
[http://wwwscottishparliamentuk/parliamentarybusinessCurrentCommittees59613aspnx](http://wwwscottishparliamentuk/parliamentarybusinessCurrentCommittees59613aspnx)

\(^{30}\) Change Fund Plans
This document relates to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

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

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

**Locality planning**

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

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

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

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

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

31 Commission on the Future Delivery of Public Services
http://www.scotland.gov.uk/About/Review/publicservicescommission
localities can genuinely influence how resources are allocated within their communities, within a broadly equitable share of integrated resources, rather than on the basis of historic patterns of resource allocation and service provision.

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

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

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

**Scrutiny**

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

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

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

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

**Part 2 – Shared services**

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

136. A review by the Scottish Government identified that expansion of the remit of the Common Services Agency offered the potential to improve efficiency and productivity across
the public sector by making available to other public bodies the Common Services Agency’s
expertise in the delivery of competitive based shared services.

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

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

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

CNORIS indemnity scheme

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

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

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

141. The Bill amends the 1978 Act to extend the range of bodies that can participate in the
scheme to include local authorities and integration joint boards. It will be a matter for each local
authority and integration joint board as to whether to participate in the CNORIS scheme.
142. Given that the premise of the Bill is that health functions are able to be delegated to local authorities, in the case of delegation between partners, and where there is agreement to do so or delegation to the integration joint board, the Scottish Ministers consider it appropriate to extend the CNORIS indemnity scheme to local authorities and integration joint boards.

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

Part 3 - Health service: functions

Joint ventures structures

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

Ability of Health Boards to form companies

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

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

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

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

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

32 Scottish Futures Trust http://www.scottishfuturestrust.org.uk/
wholly owned by the Scottish Ministers (and accountable through the Board of Non-Executive Directors).

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

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

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

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

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

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

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

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

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

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

- The first option – moving social care from local authority control to the NHS – would have involved considerable upheaval and costs in terms of moving staff between employers, and would also have presented a serious distraction to the need to focus more effectively on improving outcomes and people’s experience of care. In order to work – and address the barriers within health, as well as between health and social care – the outcome would have to be a completely new national health and care service, not “just” an NHS with additional responsibility for social care.

- The second option – moving community health provision to the control of local authorities – would have failed to address the key issue of improving the degree of integrated working between primary and secondary care. This option would also have carried with it the costs, in terms of money and time, of centrally-directed staff transfer noted above.

- The third option – establishing a new “third provider” of health and social care – is a variation on the first, in which social care, along with all of health provision, is transferred to the control of a new body, and the same potential pitfalls would apply.

- The fourth option – placing delivery of health and social care in the hands of Community Planning Partnerships – was rejected because Community Planning Partnerships are not delivery constructs. Instead, they provide an environment for a range of statutory partners in an area to come together to make sure that their individual planning activities add up to an effective whole in terms of local service design and provision.

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

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

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

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

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

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

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

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

164. It was considered necessary to improve the model of integration provided by the Community Care and Health (Scotland) Act 2002 (delegation between partners) because it has not successfully delivered the consistent approach to integrated working that is required. This Bill improves that model of integration by putting strategic planning for person-centred, preventative care, with strong local and professional leadership, at its heart. The Bill also changes the context for local use of this model by requiring all Health Boards and local authorities to engage in integrated working, using either this approach or the body corporate model.
165. The policy intention is to integrate planning and delivery of health and social care functions. The Bill permits delegation of a broader range of local authority functions to the integration authority, although powers are taken to the Scottish Ministers to define in regulations which functions must, may and may not be delegated by either a local authority or Health Board. It is the Scottish Ministers’ intention to use these powers to describe what is meant by the broad term “social care”, which extends beyond social work functions to include, for example, some aspects of housing provision by local authorities. The Scottish Ministers have concluded that, for the purposes of integrating health and social care, it is more appropriate to describe what is meant by social care functions in regulations, rather than in primary legislation, as this will allow for greater flexibility in future as innovative patterns of service provision, which the Scottish Government anticipates will blur traditional lines between “health” and “social care” support, are developed.

EFFECTS ON EQUAL OPPORTUNITIES

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

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

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

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

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

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

EFFECTS ON ISLAND COMMUNITIES

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

EFFECTS ON LOCAL GOVERNMENT

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

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

EFFECTS ON SUSTAINABLE DEVELOPMENT

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

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

1. This memorandum has been prepared by the Scottish Government in accordance with Rule 9.4A of the Parliament’s Standing Orders, in relation to the Public Bodies (Joint Working) (Scotland) Bill. It describes the purpose of each of the subordinate legislation provisions in the Bill and outlines the reasons for seeking the proposed powers. This memorandum should be read in conjunction with the Explanatory Notes and Policy Memorandum for the Bill.

2. The contents of this Memorandum are entirely the responsibility of the Scottish Government and have not been endorsed by the Scottish Parliament.

Overview of the Bill

3. The Bill primarily provides the framework for the improvement of the quality and consistency of health and social care services through the integration of health and social care services in Scotland. In addition, the Bill provides for the Common Services Agency (also known as NHS National Services Scotland) to provide goods and services to public bodies including local authorities; for the Scottish Ministers to form a wider range of joint venture structures in relation to persons providing functions and services under the National Health Service (Scotland) Act 1978 than at present in order to make the most effective use of resources; and to extend the scheme for meeting losses and liabilities of health service bodies which is run by NHS Scotland on behalf of the Scottish Ministers to local authorities and “integration joint boards” established under Part 1.

Outline of Bill provisions

4. In summary the Bill:

- Provides for nationally agreed outcomes for health and social care, and for delivery of which Health Boards and local authorities are equally and jointly accountable to the Scottish Ministers and the public.
Establishes integration joint boards and integration joint monitoring committees as the partnership arrangements for the governance, planning and delivery of health and social care services. The Bill will remove Community Health Partnerships from statute. Health Boards and local authorities will establish functions and resources to be integrated, for the improvement of person-centred care, in an integration plan, which will set out the detail of their integrated arrangements.

Requires Health Board and local authority partners to enter into arrangements (the integration plan) to delegate functions and appropriate resources to ensure the effective delivery of those functions. The Bill provides for two options for integrating budgets and functions. First, delegation to an integration joint board established as a body corporate. In this case the Health Board and the local authority agree the amount of resources to be committed by each partner for the delivery of services to support the functions delegated. Second, delegation between partners. In this case the Health Board and/or local authority delegates functions and the corresponding amount of resource, to the other partner, which then hosts the services and the integrated budget.

Requires integration joint boards to appoint a chief officer who will be responsible for the management of the integrated budget and the delivery of services to meet the outcomes in the integration plans. The chief officer will lead the development and delivery of the strategic plan for the joint board. Where delegation is between partners, these responsibilities fall to the Chief Executive of the host partner.

Requires integration joint boards, and Health Boards or local authorities acting in the capacity of a ‘lead agency’ (the “integration authority”), to prepare a strategic plan for the area, which sets out how it will meet both local and nationally agreed outcomes. The integration authority will involve a range of partners in the development of the plan and will consult widely, taking into account any views expressed. In addition, the integration authority will be required to make suitable arrangements to plan locally for the needs of its population, ensuring the involvement of a range of partners, including clinicians and care professionals, in the development and implementation of local planning arrangements.

Delivers opportunities for more effective use of public services and resources by allowing for Health Boards to be able to contract on behalf of other Health Boards for contracts which involve providing facilities, and by allowing the Scottish Ministers to form a wider range of joint ventures structures to collaborate effectively with local authorities and enable a joint approach to asset management and disposal.

Provides for the extension of the Common Services Agency’s ability to deliver shared services to public bodies including local authorities.

Enables the Scottish Ministers to extend the range of bodies able to participate in the scheme for meeting losses and liabilities of certain health service bodies. The scheme is established under section 85B of the National Health Service (Scotland) Act 1978 for relevant bodies to meet expenses arising from any loss or damage to their property; and liabilities to third parties for loss, damage or injury arising from the carrying out of the
functions of the scheme members. The Bill amends the bodies able to participate in the scheme to include local authorities and integration joint boards.

Rationale for subordinate legislation

5. The Bill contains a number of delegated powers which are explained in more detail below. In deciding whether legislative provisions should be specified on the face of the Bill or left to subordinate legislation, the Scottish Government has had regard to the need to:

- Strike the right balance between the importance of the issue and providing flexibility to respond to changing circumstances with the benefit of experience, without the need for primary legislation;
- Anticipate the unexpected, which might otherwise frustrate the purpose of the provision in primary legislation approved by the Parliament;
- Make proper use of valuable parliamentary time;
- Allow detailed administrative arrangements to be kept up to date with the basic structures and principles set out in the primary legislation; and
- Consider the likely frequency of amendment.

6. The delegated powers provisions are listed below, with a short explanation of what each power allows, why the power has been taken in the Bill and why the selected form of parliamentary procedure has been considered appropriate. Powers that are referred to here as being exercisable by regulations or orders are to be made by Scottish statutory instrument.

Part 1 – Functions of Local Authorities and Health Boards

Integration

Delegated powers

Section 1 – Integration plans: same local authority and Health Board area

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

7. Subsection (3) provides that an integration plan is a plan setting out certain matters including, under subsection (3)(e) prescribed information about such other matters as may be prescribed.

8. Subsection (6) provides that the Scottish Ministers may by regulations prescribe: (a) functions of local authorities that must, may or may not be delegated under an integration plan;
(b) functions of Health Boards that must, may or may not be delegated under an integration plan; 
(c) functions of local authorities or Health Boards that must be delegated under an integration plan other than in prescribed circumstances; functions of local authorities or Health Boards that may be delegated under an integration plan only in prescribed circumstances; functions of local authorities or Health Boards that may not be delegated under an integration plan in prescribed circumstances; and (d) functions of local authorities or Health Boards that may be delegated under an integration plan only if other prescribed functions are also delegated to the same person under the plan.

Reason for taking this power

9. Subsection (3)(a) to (d) sets out the bare bones of an integration plan. The power in subsection (3)(e) allows Ministers to prescribe matters (additional to those specified in subsection (3)(a) to (d)) which are to be set out in an integration plan, and to prescribe information which must be provided in relation to those matters. This will allow Ministers to ensure that integration plans set out a full scheme for integration, and that the requirements can be adapted in light of future developments.

10. The power in subsection (6) allows Ministers to determine which functions must or may be delegated under an integration plan, and which may not. The Scottish Ministers seek innovation in service provision as part of these reforms. This provision enables the Scottish Ministers to take account of changing circumstances across health and social care in future, including in relation to the nature and form of services provided. It also enables Ministers to reconsider the range of functions that may be delegated as integration develops. For example, a function that may currently not be considered appropriate for delegation, may seem entirely appropriate for delegation in a few years’ time. Such an approach will support continuous closer integration and adaptation of services. It is anticipated that any review will be taken forward in consultation with relevant stakeholders with the aim of strengthening and developing the delivery of integrated health and social care services.

Choice of procedure

11. The powers in subsection (3)(e) are subject to negative procedure. This is considered to provide an appropriate level of scrutiny given that the powers allow Ministers only to make detailed provision as to matters which are additional to the core elements of the integration plan.

12. The power in subsection (6) is subject to negative procedure. This is considered to provide an appropriate level of scrutiny given that the power sets the framework within which Health Boards and local authorities will determine which functions to delegate when implementing the integration of health and social care services under the Bill. It is considered therefore that a more detailed level of Parliamentary scrutiny is not required.
Section 5 – Power to prescribe national outcomes

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: affirmative procedure

Provision

13. Subsection (1) provides that the Scottish Ministers may by regulations prescribe outcomes in relation to health and wellbeing, following consultation under subsection (3).

14. This provision allows Ministers to prescribe national health and wellbeing outcomes, but to do so only after consulting with a range of interests across health and social care. It also allows them to amend the prescribed outcomes from time to time in order to recognise progress and to ensure – through updated national health and wellbeing outcomes - that integration authorities focus resources on the areas where Ministers, with the benefit of consultees’ views, consider it is most needed.

Reason for taking this power

15. This provision helps to ensure that integration is taken forward with a focus on its purpose which is improving outcomes. By allowing Ministers to set national outcomes, it provides for a consistent focus nationally. It is appropriate that outcomes are set by regulations as this requires a process of consultation to be followed, contemporaneously with integration plans being prepared, to inform the outcomes. It also provides flexibility for the Scottish Ministers to amend outcomes in the future, in response to innovation locally and changing circumstances, and in order to support continuous improvement.

Choice of procedure

16. This is subject to affirmative procedure as the national outcomes are fundamental to health and social care integration in that they express its practical purpose. Whilst this level of scrutiny involves more parliamentary time, it is considered that the national outcomes are sufficiently important to justify this, and it is not anticipated that they will be regularly amended.
Section 6 – Consultation

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure

17. Subsection (2)(a) provides that before submitting the integration plan for approval under section 7, the local authority and the Health Board must jointly consult such persons of groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed. “Prescribed” means prescribed by regulations.

Reason for taking this power

18. This power will ensure that those who may be affected by the policy are appropriately consulted regarding the content of the integration plan. It is considered appropriate to set out the consultees in legislation, as this will ensure that the full range of persons and groups with an interest in the functions being integrated are consulted consistently throughout Scotland. It is also appropriate that the list be set out in secondary legislation as opposed to in the Bill itself, as this will allow the necessary level of flexibility for the list of consultees to be adjusted in future to reflect changes in service users and service delivery over time, as services adapt to changing needs. It will also enable new groups to be added in response to any future changes to the functions to be integrated (for example if an order under section 1(6) expands the types of functions that may or must be integrated).

Choice of procedure

19. This is subject to negative procedure, which is considered appropriate as the regulations will deal with matters of detail relating to the consultation requirement rather than broad principle. The Scottish Ministers consider that a more detailed level of Parliamentary scrutiny is not required for a provision of this nature.

Section 7 – Approval of integration plan

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

20. Subsection (1) provides that a local authority and a Health Board must submit an integration plan to the Scottish Ministers for approval by the prescribed day.

Reason for taking this power

21. The power in subsection (1) allows Ministers to set the date by which integration plans will be submitted for approval. This provides Ministers with flexibility to set an appropriate date in the circumstances prevailing once the Bill is passed and implementation has commenced.
Choice of procedure

22. This provision subsection (1) is subject to negative procedure. This is considered to provide an appropriate level of parliamentary scrutiny for an essentially administrative matter such as setting the date by which a duty must be complied with.

Section 9 – Functions delegated to integration joint board

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>order /regulations made by Scottish statutory instrument</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>negative procedure</td>
</tr>
</tbody>
</table>

Provision

23. Subsection (2) provides that Ministers may establish an integration joint board by Order.

24. Subsection (3) provides that the Scottish Ministers may by regulations prescribe a day before which functions are to be delegated, where functions are being delegated to an integration joint board.

Reason for taking this power

25. In relation to subsection (2), it would be impractical to create individual integration joint boards in primary legislation, given that integration joint boards require to be created only where the corporate body model is the model of integration chosen locally. It is appropriate that the creation of a new body, such as an integration joint board requires some legislative underpinning, and so an order making power is considered appropriate. The order will establish the joint board for an area or areas.

26. In relation to subsection (3), “prescribed” means prescribed by regulations. This power is necessary to allow flexibility as to the date for delegation to occur in relation to different integration joint boards, recognising and accommodating the fact that there will be some variation in the progress achieved in different areas.

Choice of procedure

27. Negative procedure is considered appropriate in relation to an Order under subsection (2) given the formal nature of the order insofar as it establishes integration joint boards.

28. Regulations under subsection (3) will make provision for, the essentially administrative matter of, setting the date by which functions are to be delegated. Negative procedure is considered to provide an appropriate level of scrutiny for such an administrative matter.
Section 10 – Chief officer of integration joint board

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

29. Subsection (5) provides that the Scottish Ministers may in relation to any integration joint board by order: (a) disapply the requirements of subsections (2) to (4) which require that the chief officer is seconded to the integration joint board from a constituent authority (local authority or Health Board), and (b) make provision enabling the board to employ a chief officer on such terms and conditions as the board determines.

Reason for taking this power

30. If the person appointed as chief officer is an existing member of staff of the local authority or Health Board which has delegated functions to the integration joint board, then the chief officer will be seconded from the Health Board or local authority. If not, then the person will be appointed as a member of staff of either the local authority or the Health Board and will then be seconded to the integration joint board. This provision will allow the Scottish Ministers to disapply these arrangements and gives them the power to enable integration joint boards to employ a chief officer directly. This provision is essentially included as a safeguard – it is anticipated that the option of enabling the direct employment of a chief officer will be exercised only in the event that arrangements agreed locally fail to work.

Choice of procedure

31. This is subject to negative procedure which is considered appropriate. A more detailed level of Parliamentary scrutiny is not required for an administrative provision of this nature which, if used, will simply activate the alternative position (i.e. employment by the board on terms and conditions set by them) already set out in the Bill.

Section 11 – Other staff of integration joint board

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

32. Subsection (1) provides that the Scottish Ministers may by order make provision enabling integration joint boards to appoint staff other than a chief officer. Subsection (2) adds that such an order may include such further provision as regards such staff as the Scottish Ministers think
fit, including in particular provision as to: (a) the appointment of staff; (b) the numbers of staff; and (c) the terms and conditions of staff.

Reason for this power

33. To allow flexibility to appoint staff with appropriate skills and abilities to deliver integration plans. Such provision is not proposed to be made on the face of the Bill as it is envisaged that integration joint boards will not necessarily require to employ staff; delivery of functions is likely to be carried out by the constituent local authorities and Health Board rather than by the board directly. This provision is essentially included as a safeguard – i.e., as with the provision to enable direct employment by the joint board of the chief officer, it is anticipated that the option of enabling direct employment of staff will be exercised only in the event that locally agreed arrangements fail to work. It is considered appropriate to include this power in the Bill to enable a different approach to be taken in light of changing circumstances, if this proves necessary in the future.

Choice of procedure

34. This is subject to negative procedure which is considered appropriate. A more detailed level of Parliamentary scrutiny is not required for a provision of this nature which will set out administrative arrangements relating to the employment of staff.

Section 12 – Integration joint boards: further provision

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

35. Subsection (1) provides that the Scottish Ministers may by order make provision about: (a) the membership of integration joint boards; (b) their proceedings; (c) giving integration joint boards general powers (such as powers to contract, acquire or dispose of property or rights or borrow money or incur other liabilities) in connection with the carrying out of their functions; (d) the supply of services or facilities to integration joint boards by a local authority or Health Board; and (e) about any other matter relating to the establishment or operation of integration joint boards that the Scottish Ministers think fit.

Reason for taking this power

36. It is considered appropriate to enable the Scottish Ministers to establish appropriate parameters for operational arrangements within the new integrated partnerships, whilst leaving scope for future flexibility to respond to progress and innovation. It is also considered necessary as a safeguard to enable integration joint boards to fully transact. It is envisaged that this option will only be exercised in the event arrangements agreed locally fail. It is considered that this level of detail is most appropriately dealt with in secondary legislation. It is also necessary to
allow the flexibility that secondary legislation provides so that the arrangements may take into account the particular circumstances of individual joint boards – for example boards which are delegated a greater number of functions or which intend to carry out delegated functions themselves rather than directing the constituent authorities to do so are likely to require stronger supporting arrangements (e.g. larger membership or more extensive general powers) than boards which have lesser responsibilities.

**Choice of procedure**

37. This power is subject to negative procedure. This is considered appropriate as the order will deal with matters of detail rather than of broad principle. It is considered that a more detailed level of Parliamentary scrutiny would be inappropriate for a provision of this nature.

**Section 14 – Implementation of integration plan where functions delegated to local authority or Health Board**

**Power conferred on:** Scottish Ministers  
**Power exercisable by:** regulations made by Scottish statutory instrument  
**Parliamentary procedure:** negative procedure

**Provision**

38. Subsection (2) provides that the Scottish Ministers may prescribe by regulations a day before which: (a) the local authority and the Health Board must jointly establish a committee (an “integration joint monitoring committee”) for the purpose of monitoring the carrying out of the integration functions for the area of the local authority; and (b) the functions are to be delegated.

**Reason for taking this power**

39. This provision is required in order to allow Ministers to set an appropriate deadline for implementation of integrated arrangements, and to ensure that the monitoring committees which will scrutinise those arrangements are functional from the outset of their operation. The ability to set a timescale for these matters will also support the alignment of statutory planning and reporting periods with the start date of the integrated arrangements.

**Choice of procedure**

40. This is subject to negative procedure which is considered appropriate. A more detailed level of Parliamentary scrutiny is not required for an administrative provision of this nature which simply sets the date by which certain arrangements under the Bill must be put in place.
Section 16 – Provision about integration joint monitoring committees

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

41. Subsection (1) provides that the Scottish Ministers may by order make provision about: (a) the establishment of integration joint monitoring committees; (b) membership of integration joint monitoring committees; (c) the proceedings of integration joint monitoring committees; and (d) any other matter relating to the operation of integration joint monitoring committees that the Scottish Ministers think fit.

Reason for taking this power

42. These provisions enable Ministers to establish appropriate parameters for operational arrangements within the new integrated partnerships, while leaving scope for future flexibility to respond to progress and innovation over time.

Choice of procedure

43. This is subject to negative procedure which is considered appropriate. A higher level of Parliamentary scrutiny is not required for a provision of this nature which will deal with matters of detail rather than of broad principle.

Section 21 – Effect of delegation of functions

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

44. Subsection (5) provides that the Scottish Ministers may by order provide that an integration joint board must or must not exercise a power conferred by virtue of subsection (2)(b) i.e. a power that may be exercised in connection with the carrying out of a delegated function, that would otherwise be a power solely of the delegator.

Reason for taking this power

45. These provisions enable Ministers to establish appropriate parameters for responsibilities of the integration joint board, taking account of whether in practice the board or the constituent authorities will be carrying out the delegated functions, while leaving scope for future flexibility to respond to progress and innovation over time. It is anticipated that an order under this section
may be made in conjunction with an order under section 22(8) so that, for example, if functions are to be carried out directly by the integration joint board the board may be required to exercise the necessary powers to do so; or so that the board may be prevented from exercising powers simultaneously with constituent authorities if those authorities are given responsibility for carrying out the functions by virtue of a direction under section 22.

Choice of procedure

46. This is subject to negative procedure which is considered appropriate. A more detailed level of Parliamentary scrutiny is not required for a provision of this nature. Any order made under this power will constitute technical provision about the practical carrying out of functions delegated under the Bill. It would not add to or modify the powers of integration joint boards and would simply be used to provide that they must or must not be exercised, where appropriate.

Section 22 – Further powers of persons to whom functions are delegated

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

47. Subsection (8) provides that the Scottish Ministers may by order provide that an integration joint board must or must not give a direction under subsection (1).

Reason for taking this power

48. These provisions enable Ministers to establish appropriate parameters for responsibilities of the integration joint board, in light of whether in practice it is considered appropriate for the board to carry out functions directly or whether the constituent authorities should be given responsibility for them. Without this power, the Bill would allow the integration joint board complete discretion as to whether to carry out delegated functions itself or to require others to do so. It is considered appropriate that Ministers are able to influence the mechanisms for delivery of delegated functions within the integration joint board model, if this is considered necessary in light of practical experience and changing circumstances.

Choice of procedure

49. This is subject to negative procedure which is considered appropriate. A more detailed level of Parliamentary scrutiny is not required for a technical provision of this nature which merely allows Ministers to require that a particular delivery mechanism, already set out in the Bill, is used.
Section 23 – Requirement to prepare strategic plans

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

50. Subsection (4) provides that the first strategic plan of an integration authority is: (a) to be prepared before such date as may be prescribed by the Scottish Ministers by order; and (b) to relate to the period of 3 years beginning with such date as may be prescribed by the Scottish Ministers.

Reason for taking this power

51. This provision enables two dates to be prescribed. The first allows the Scottish Ministers flexibility to set the date by which strategic plans are to be prepared. The second allows the Scottish Ministers to prescribe the start date for the 3-year period that the first strategic plan is to cover. Integration of health and social care is an ongoing priority for Health Boards and local authorities; flexibility of this kind will allow the Scottish Ministers to respond to progress locally, and will allow the planning cycle to be synchronised in future, even where the start date for integration varies from place to place. This will allow the Scottish Ministers to align the start date of the strategic plan with the period of the performance report.

Choice of procedure

52. This is subject to negative procedure, which is considered appropriate. A more detailed level of Parliamentary scrutiny is not required for administrative provision of this nature which sets the date by which the duty to prepare a plan under Bill must be complied with and the start date for that plan.

Section 26 – Establishment of consultation group

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure

53. Subsection 2 provides that the groups referred to in subsection (1)(d) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed. “Prescribed” means prescribed by regulations.
Reason for taking this power

54. It is considered appropriate to set out requirements as to representatives to be included in the consultation group in legislation, as this will ensure that the full range of persons and groups with an interest in the arrangements being detailed in the plan are consulted consistently throughout Scotland. It is also appropriate that the list be set out in secondary legislation as opposed to in the Bill itself, as this will allow the necessary level of flexibility for the membership to be adjusted in future in light of any future changes to integrated functions as well as the changing complexion of service users and providers over time.

Choice of procedure

55. This is subject to negative procedure which is considered appropriate as the regulations will deal with the detail of consultation requirements rather than broad principle. A higher level of Parliamentary scrutiny is not required for a provision of this nature.

Section 27 – Steps following establishment of consultation group

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure

56. Subsection (5) provides that groups referred to in subsection (4)(d) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed. “Prescribed” means prescribed by regulations.

Reason for taking this power

57. It is considered appropriate to set out requirements as to who is to be consulted on the draft strategic plan in legislation, as this will ensure that the full range of persons and groups with an interest in the arrangements being detailed in the plan are consulted consistently throughout Scotland. It is also appropriate that the list be set out in secondary legislation as opposed to in the Bill itself, as this will allow the necessary level of flexibility for the list of consultees to be adjusted in future in light of any future changes to integrated functions as well as the changing complexion of service users and providers over time.

Choice of procedure

58. This is subject to negative procedure which is considered appropriate as the regulations deal with the detail of arrangements for consultation rather than broad principle. A more detailed level of Parliamentary scrutiny is not required for a provision of this nature.
This document relates to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

Section 32 – Carrying out of integration functions: localities

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

59. Subsection (4) provides that the groups referred to in subsection (3) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

Reason for taking this power

60. It is considered appropriate to set out in legislation requirements as to who is to be consulted on decisions relating to service provision in localities within local authority areas. This will ensure that the full range of persons and groups with an interest in the service will be consulted at the local level, and that there is a consistent approach to ensuring involvement of local groups across Scotland. It is also appropriate that the list be set out in secondary legislation as opposed to in the Bill itself, as this will allow the necessary level of flexibility for the list of consultees to be adjusted in future in light of any future changes to integrated functions as well as the changing complexion of service users and providers over time.

Choice of procedure

61. This is subject to negative procedure which is considered appropriate as the regulations deal with the detail of arrangements for consultation rather than broad principle. A more detailed level of Parliamentary scrutiny is not required for a provision of this nature.

Section 33 – Integration authority: performance report

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

62. Subsection (3) provides that the Scottish Ministers may by regulations prescribe: (a) the form and content of performance reports; and (b) the period during which performance reports must be published. It is anticipated that performance reports will be required to include information assessing performance against the national outcomes and the strategic plan.
This document relates to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013

Reason for taking the power

63. To ensure consistency of reporting on delivery of outcomes across Scotland in order to address unnecessary variation. The power will provide flexibility for the form and content of reports to be adapted as appropriate, in response to progress and innovation over time, ensuring that all relevant matters are reported on and enabling Health Boards and local authorities to be held to account. It will also ensure consistency in timescales for reporting across Scotland.

Choice of procedure

64. This is subject to negative procedure which is considered appropriate. A more detailed level of Parliamentary scrutiny is not required for a provision of this nature about timescales for and content of reports. The provision will contain a level of administrative detail which would not normally be included in primary legislation.

Section 36 – Power to make provision in consequence of new integration plan

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure

65. Subsection (2) provides that, in consequence of the replacement of an integration plan by a new plan, the Scottish Ministers may by order provide for the winding-up of an integration joint board.

Reason for taking this power

66. This power enables the Scottish Ministers to deal with a possible consequence of moving from an old plan to a new plan, in the event that the parties opt in the new plan to adopt a different model of integration not involving an integration joint board; or in the event that the parties to the plan change and the appropriate course of action is for the previous joint board to be replaced by a new joint board. In such circumstances it would be necessary for the pre-existing integration joint board to cease its activities and it is appropriate for the practical arrangements for the cessation of activities and dissolution of the board to be provided for in secondary legislation.

Choice of procedure

67. This is subject to negative procedure which is considered appropriate as an order providing for the winding-up of an integration joint board will relate to practical and administrative matters which do not merit a higher level of Parliamentary scrutiny.
Section 39 – Default power of Scottish Ministers

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

68. Subsection (2)(b) confers power on the Scottish Ministers to establish by order an integration joint board.

Reason for taking this power

69. The power is exercisable where a local authority and a Health Board have failed to comply with the duty imposed on them by section 7 to submit an integration plan to Ministers for their approval. It is envisaged that it would be exercised only as a last resort where there is a need for Ministers to step in to avert potential failure to integrate services in the area in question. In such circumstances, where the local authority and the Health Board have failed to work together to prepare a plan in fulfilment of their statutory duties, it is appropriate that a new body should be established to take on responsibility for the integrated arrangements. An order under this section will formally establish the integration joint board for this purpose.

Choice of procedure

70. This is subject to negative procedure which is considered appropriate as the order is simply the mechanism to formally establish an integration joint board in circumstances which are themselves set out in the Bill. A more detailed level of Parliamentary scrutiny is not required for a provision of this nature.
Part 2 – Shared Services

Section 45 – Extension of schemes for meeting losses and liabilities of health service bodies

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

71. Section 45(3) amends section 85B of the National Health Service (Scotland) Act 1978 to introduce a new subsection (2C). This new subsection confers a power on the Scottish Ministers to specify functions of local authorities (in addition to integration functions) to which the scheme will apply.

Reason for taking this power

72. Section 45 restricts the application of a scheme under section 85B of the 1978 Act, as far as concerns local authorities, to “integration functions” which are defined as functions delegated to the local authority, functions to be carried out in conjunction with those delegated functions, or functions that a local authority carries out in accordance with a direction from an integration joint board or Health Board under section 22. The Scottish Ministers are given the power to specify by order other functions of local authorities that can be covered by the scheme. This would enable any or all functions of local authorities to be covered by the scheme if that is considered appropriate in the future.

Choice of procedure

73. This is subject to the negative procedure which is considered appropriate. A higher level of Parliamentary scrutiny is not required for an administrative provision of this nature which would simply extend the functions to which the statutory scheme applies.
Section 48 – Interpretation

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure

Provision

74. Subsection (1) confers a power on the Scottish Ministers to prescribe by regulations persons who are “health professionals”, “social care professionals” and what is meant by “social care” for the purposes of the Bill.

Reason for taking this power

75. These definitions are relevant to the requirement for Ministers to consult relevant groups before prescribing national outcomes for health and wellbeing under section 5. It is appropriate for these definitions to be set out in regulations rather than on the face of the Bill as we do not wish to restrict the scope of functions the must or may be delegated, and nor do we want to restrict the range of groups that should be consulted when innovative future practice may make changes desirable.

Choice of procedure

76. These are subject to negative procedure which is considered appropriate as the definitions are a matter of detail rather than of broad principle. This power is for defining purposes only to allow appropriate consultation. It is considered that a more detailed level of Parliamentary scrutiny would be inappropriate for provisions of this nature.

Section 50 – Ancillary provision

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure; affirmative procedure if making textual amendments of an Act.

Provision

77. Section 50 provides that the Scottish Ministers may by order: (a) make such supplementary, incidental or consequential provision as they consider appropriate for the purposes of, in consequence of, or for giving full effect to, any provision or the Act; and (b) make such transitional or transitory provision or savings as they consider appropriate for the purposes of, or in connection with, the coming into force of any provision of the Act.
Reason for taking this power

78. The new procedures introduced by the Bill may give rise to the need for ancillary provisions. The Scottish Ministers may need to make such provision by order to support the full implementation of the Bill. This provision empowers the Scottish Ministers to make provisions concerning incidental, supplemental, consequential, transitional, transitory provision or savings where this is thought to be necessary.

79. Without these powers to make ancillary provision, it might be necessary to return to Parliament, through subsequent primary legislation, to deal with a matter, which is clearly within the scope and policy intentions of the original Bill. It would not be an effective use of Parliament’s time, or the Scottish Government’s resources to deal with such matters through primary legislation. They are best addressed through subordinate legislation.

Choice of procedure

80. These orders are in general made subject to the negative procedure but an exception is made where the order adds to, replaces or omits any part of the text of an Act. In that case, the affirmative procedure applies. This approach on procedure is in line with the approach taken in most Bills and there are not considered to be any special factors justifying a different approach in this case.

Section 52 – Commencement

- **Power conferred on:** Scottish Ministers
- **Power exercisable by:** order made by Scottish statutory instrument
- **Parliamentary procedure:** no procedure

Provision

81. Subsection (2) provides that the provisions of the Act (other than sections 49, 50, 52 and 53) come into force on such day as the Scottish Ministers may by order appoint.

Reasons for taking this power

82. This is a standard commencement by order power. As usual with commencement orders, no provision is made for laying the order in Parliament as the power is to commence provisions, which the Parliament has already scrutinised, together with any consequential or transitory arrangements.

Choice of procedure

83. Whilst the order will not be subject to Parliamentary procedure, the Subordinate Legislation Committee will, in terms of remit, have the opportunity to consider the order.
Health and Sport Committee

11th Report, 2013 (Session 4)

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

Published by the Scottish Parliament on 18 November 2013
Health and Sport Committee

11th Report, 2013 (Session 4)

CONTENTS

Remit and membership

Report 1
Introduction 1
Background 2
Structure and main provisions of the Bill 4
Overall views on the Bill: themes from the written evidence 5
COMMITTEE’S EVIDENCE AND ANALYSIS 6
   Need for the bill: high-level issues and general comments 6
   Models of integration 9
   National outcomes 16
   Ministerial powers, scope and democratic oversight 18
   Relationship with other legislation and other local partnerships 22
   Role of the third and independent sectors 25
   Carer, patient and service user involvement 31
   Human rights and advocacy 35
   Involvement and engagement of GPs 37
   Strategic plans 42
   Locality planning 45
   Financial and budgetary issues 49
   Staffing issues 60
   Part 2 – shared services 63
   Part 3 – Health service functions 64
   Delegated Powers and Law Reform Committee scrutiny 65
   Local Government and Regeneration Committee scrutiny 67
   Consultation 67
Concluding remarks 67

Annexe A: EXTRACT FROM MINUTES OF THE HEALTH AND SPORT COMMITTEE 69
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.

Membership:

Bob Doris (Deputy Convener)
Rhoda Grant
Colin Keir
Richard Lyle
Aileen McLeod
Duncan McNeil (Convener)
Nanette Milne
Gil Paterson
Dr Richard Simpson

Committee Clerking Team:

Clerk to the Committee
Eugene Windsor

Senior Assistant Clerk
Rodger Evans

Assistant Clerk
Myer Cohen

Committee Assistant
Bryan McConachie
The Committee reports to the Parliament as follows—

INTRODUCTION

1. The Public Bodies (Joint Working) (Scotland) Bill 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”.2

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

---

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”.

3
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
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 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 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

---

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

---

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

---

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 report\(^{20}\) notes that “both the Cabinet Secretary and the Minister 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.


\(^{19}\) Scottish Parliament Health and Sport Committee. Official Report, 10 September 2013, Col 4193.

\(^{20}\) 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

---

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

\(^{24}\) 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” 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” 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”, it suggested that this would “create barriers with other important services (such as education)” and would make the budgetary problem “even more pronounced” 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.”

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”.

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” 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.”

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

---

The 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

---

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”\textsuperscript{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”\textsuperscript{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”\textsuperscript{50}. The Policy Memorandum also acknowledges that partners will play “a key role”\textsuperscript{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”\textsuperscript{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”\textsuperscript{53}, which could be argued to undermine the fundamental concept of an

\textsuperscript{48} Policy Memorandum, paragraph 69.
\textsuperscript{49} Policy Memorandum, paragraph 73.
\textsuperscript{50} Policy Memorandum, paragraph 74.
\textsuperscript{51} Policy Memorandum, paragraph 75.
\textsuperscript{52} North Ayrshire Council. Written submission.
\textsuperscript{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”\textsuperscript{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”\textsuperscript{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”\textsuperscript{56}. The Care Inspectorate welcomed “the approach to develop high level national strategic outcomes with regard to health and wellbeing”\textsuperscript{57} while NHS Education for Scotland indicated that “the core of having national outcomes for health and wellbeing which involves a range of key stakeholders in developing these outcomes and performance indicators is clearly a strength”\textsuperscript{58}.

82. There was a similar picture within the voluntary sector. Carers Scotland welcomed “commitment to prescribe national outcomes”\textsuperscript{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”\textsuperscript{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”\textsuperscript{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.\(^{64}\)

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”\(^{65}\). 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”.\(^{66}\)

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”\(^{67}\).

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”\(^{68}\).

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”\(^{69}\).

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

---


\(^{67}\) Falkirk Council. Written submission.

\(^{68}\) North Ayrshire Council. Written submission.

\(^{69}\) 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 (eg 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 (HCG)\(^73\) 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.”\(^74\)

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.”\(^75\)

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.”\(^76\)

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

\(^73\) 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.

\(^74\) 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: http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/LGR_Committee_memorandum_on_SP_Bill_27_and_SP_Bill_32.pdf [Accessed 28 October 2013]

\(^75\) 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.\(^{77}\)

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.\(^{78}\)

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—


\(^{78}\) 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—
“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
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”\textsuperscript{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”\textsuperscript{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.”\textsuperscript{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

\textsuperscript{88} Voluntary Health Scotland. Written submission.
\textsuperscript{89} British Psychological Society. Written submission.
\textsuperscript{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”91.

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”92. 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.”93

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”94. 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”95 and how they were developed.

123. Ranald Mair of Scottish Care told the Committee that it would be “a missed opportunity”96 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

---

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 to 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”\textsuperscript{109}.

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{110} 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”.\textsuperscript{111}

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.\footnote{Policy Memorandum, paragraph 96.}

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
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

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

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.”

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.”

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.”

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

---

119 Scottish Independent Advocacy Alliance. Written submission.
120 Parkinson’s UK. Written submission.
121 Healthcare Improvement Scotland. Written submission.
122 Audit Scotland. Written submission.
introduced for integrated partnerships to avoid confusion for people who use services and carers.\(^{123}\)

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”\(^{124}\).

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.”\(^{125}\)

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.”\(^{126}\)

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.\(^{127}\)

\(^{123}\) 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{126} 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”\(^{133}\).

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.”\(^{134}\)

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.

\(^{133}\) Scottish Association for Mental Health. Written submission.

\(^{134}\) Policy Memorandum, paragraph 171.
Advocacy

179. Submissions from Leonard Cheshire Disability\(^{135}\) and the Scottish Independent Advocacy Alliance\(^{136}\) 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”\(^{137}\).

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

\(^{135}\) 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”\(^{144}\).

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”\(^{145}\).

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”\(^{146}\).

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.”\(^{147}\)

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

---


\(^{147}\) 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”.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—

“This, 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.”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”.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”.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

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: http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/LGRCommittee_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\(^{156}\) 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


\(^{159}\) 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”\textsuperscript{169}.

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”\textsuperscript{170}. 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”\textsuperscript{171}.

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.”\textsuperscript{172}

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.”\textsuperscript{173}

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

\textsuperscript{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.  

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 “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”.

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” as a key strength of the Bill. The focus on locality planning was also welcomed by the Scottish Borders Partnership and by South Ayrshire Council, which described it as “an important aspect of the Bill”. Many others also supported the principle.

---

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”\(^{179}\).

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.\(^{180}\)

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”\(^{181}\).

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”\(^{182}\).

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”\(^{183}\).

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—

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 involve 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". 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.\(^{191}\)

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.”\(^{192}\)

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.”\(^{193}\)

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.\(^{194}\)

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.

_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,

\(^{191}\) 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.

\(^\text{198}\) 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”\(^\text{202}\).

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”\(^\text{203}\). A similar point was made by Carers Scotland.\(^\text{204}\) Although it recognised that it may take time for these changes to deliver savings, it said it was


\(^{203}\) British Association of Social Workers. Written submission.

\(^{204}\) 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.

---

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”.

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.”

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.”

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.

---

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: \url{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

---

221 Scottish Parliament Health and Sport Committee. Official Report, 1 October 2013, Col 4389
222 Healthcare Improvement Scotland. Written submission to Finance Committee, paragraphs 4 and 6.
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.

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”.

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
employers. The staff governance arrangements around that seem to be somewhat muddled and confused.”

299. 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.

\textsuperscript{233} Scottish Parliament Health and Sport Committee. \textit{Official Report, 1 October 2013, Col 4422.}
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.
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\textsuperscript{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.\(^\text{243}\)

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...
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.
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.

---

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.

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.
ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE TO THE HEALTH AND SPORT COMMITTEE

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

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
Public Bodies (Joint Working) (Scotland) Bill: Stage 1

10:15

The Convener: Item 2 is our first evidence-taking session on the Public Bodies (Joint Working) (Scotland) Bill. I welcome to the committee three witnesses from NHS National Services Scotland: Ian Crichton, the chief executive; Simon Belfer, the director of finance and business services; and Professor Marion Bain, the medical director. I also welcome—last but not least—Peter Reekie, the director of finance in the Scottish Futures Trust.

The first question comes from Gil Paterson.

Gil Paterson (Clydebank and Milngavie) (SNP): Goodwill towards the concept of integration comes across from people who come before the committee. Most people express a need for integration to happen. Why has the Government gone for legislation? Might that approach lead to a breakdown in the goodwill that is needed to make integration work?

Ian Crichton (NHS National Services Scotland): Do you mean legislation in relation to NSS’s area or legislation in general?

Gil Paterson: I mean legislation to make joint working function properly.

Ian Crichton: It probably shows that the Government’s patience to wait for people to get there themselves is limited. I do not think that we need legislation for us to be able to work together; during the past year, NSS has done a lot of work to improve the way in which we work with other public bodies without there being such legislation. However, over probably the past decade, the evidence is that without a bit of a push, the public sector finds it difficult to integrate.

Gil Paterson: The committee has heard from many places about the good work that has been going on in Highland. It looks as if there is a way to achieve integration without having to twist folks’ arms. Has the Government looked at the Highland experience? Has it perhaps overlooked the possibility of ensuring that the Highland model works effectively, rather than introducing legislation?

Ian Crichton: I am not an expert on the bill but, as I understand it, it provides that people will be able to choose from two different models: some kind of body corporate that is created between two existing bodies; and a model such as Highland has adopted. The Government seems keen to allow local choice in how integration actually happens. The role of NSS is a little different. We
are trying to support that effort, regardless of the choice that people make locally.

**Gil Paterson:** You mentioned local choice. If people backslide or cannot make up their minds about which model to choose, will the Government step in and say, “Enough is enough. You need to go ahead, and this is the model that you must use”? Has the Government got the balls to do that?

**Ian Crichton:** I think that that is a matter for the Government to comment on.

**Gil Paterson:** Okay. Thank you.

**Aileen McLeod (South Scotland) (SNP):** Part 2 of the bill will enable National Services Scotland to extend its services to other public bodies. In June, the Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013 came into force. For clarification, will the witnesses from NSS say whether the provisions in the bill differ from those in the order?

**Simon Belfer (NHS National Services Scotland):** The provisions are largely the same. The idea was to enable us to start having conversations with other parts of the public sector by putting in place the reform order as a stopgap, with the approach then being properly codified in the bill.

There are a couple of areas in which there are differences, which we will take up with the people who drafted the bill. The definitions of “services” and “customers” in the reform order are slightly different from those in the bill. Those are small, technical differences, which we will happily take up as the bill progresses—I can go into more detail if you want. However, the provisions in the order and the bill are largely the same.

**Aileen McLeod:** Do you have plans to extend your services?

**Ian Crichton:** It is important that we ensure that the committee understands why we wanted the reform order in the first place. We knew that the bill was coming, and we know that Scotland will integrate its health and social care during the next decade. If there is to be an integrated landscape in the future, in which the national health service will be quite different—and particularly if new bodies are to be created between existing ones—it will be important that we have the room for manoeuvre that enables us to give support more broadly. That was a key reason why we wanted the reform order.

Another reason was that we felt that we could help public bodies make use of the range of services that we provide, without generating significant incremental cost. Given current budget constraint, we thought that there were opportunities in that regard. The order provided us with a stopgap, which allows us to operate and to start to get to know people beyond the health service. The bill will build on that, to enable that to be substantively the case in the new Scotland.

**Aileen McLeod:** What capacity is there in NSS to extend services?

**Ian Crichton:** It varies, depending on the area that you look at. We provide a broad range of services—I am sure that the committee knows this, but we should ensure that there is a common view of the spectrum—from the Scottish National Blood Transfusion Service to the central legal office, national procurement and information technology services. We are responsible for health information and informatics.

Our capability in those different areas varies. Let us take the CLO—the lawyers. For us to provide services beyond the NHS, we will probably need to add one, two or three lawyers, depending on demand. We charge people on a cost-recovery basis for the work that we do and we do not need to change the systems or the way in which people are trained, so we have something that is ready to go. We can compare our capacity in that area with, for example, our health facilities capability. The nutrition guidelines that the health service uses, which Scotland has put a lot of money into, are just as applicable for care homes as they are for the health service, so we can use stuff and incur almost no more costs. How far our capacity can extend or push really depends on the service that you are considering.

**Aileen McLeod:** Thank you. That is helpful.

**Rhoda Grant (Highlands and Islands) (Lab):** What plans does NSS have to extend into areas that other public bodies cover?

**Ian Crichton:** Our planning is evolving. We have spent the past year getting to know a lot of other public bodies, because fundamentally we want to provide a helping hand. We have constrained capacity, so we have been keen to channel capacity where it makes sense to do so.

We have been working with a few local authorities on IT contracts. IT in the public sector can be challenging; it is a very technical thing to buy and often the people who are selling it understand the market better than the people who are buying it do. We have good specialisms in areas such as telecommunications and can bring significant benefits to bear in that regard, so we have been able to support local authorities on IT and contracting.

Probably the best example in that regard is the Scottish wide area network, which is the first element of the McClelland reforms—it relates to very technical, complicated procurement. We have
taken the lead on that across the whole sector. We expect to continue to play a role in supporting the McClelland reforms as they roll out across Scotland.

We are helping a couple of local authorities with data linkage. In an integrated Scotland, we will want health information to flow across bodies better than it currently does. There is a lot for us to learn about how local authorities manage information—and a lot for local authorities to learn about how we do that. We need to start working with other sectors to join things up. That is another example.

We do not currently have a plan that says, “We will go after this number of bodies and this is how we will do it.”

Rhoda Grant: I am trying to get to the bottom of why legislation is required. What was in place previously that prohibited you from doing what you are describing?

Ian Crichton: The actions of my body were restricted to the national health service. We were not allowed to operate beyond the NHS.

Rhoda Grant: Okay. Am I right in assuming that you would enter into other areas and work jointly only on invitation? Would that be part of the agreement between a local authority, for example, and NSS?

Ian Crichton: There are two elements to that. First, we need to be invited in. As far as local issues are concerned, there is no public body to which we would provide a service that did not ask for it. We can provide national expertise but make it available locally. That is not something that we impose.

The other element of control over our operations comes through Scottish ministers’ discretion around whether we can act in a certain area. A specific part of my local development plan for NSS this year lays out the areas where we will operate over the next 12 months on behalf of Scotland. An example of that is the Scottish wide area network that I mentioned. Even with the Scottish wide area network, the contract is left as a framework, so it does not force people who do not want to be involved on to it. Everybody who is in on it is a volunteer.

Rhoda Grant: You said that you operate on a cost-recovery basis. Do you speak about and negotiate that with the authorities concerned prior to carrying out the work?

Ian Crichton: One of the things that changes with the landscape is whether there is a need to tender. In health, we do not need to tender for the business that we provide because of the way that the funding flows from the Parliament. The situation will be more complicated if we start to operate beyond the health service, and our lawyers and Scottish Government lawyers are examining that.

The Convener: Richard Lyle is next.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I would like to pursue the information technology side of things—

The Convener: Richard Lyle! [Laughter.]

Dr Simpson: Sorry.

Richard Lyle (Central Scotland) (SNP): I thought that Dr Simpson had changed his name there.

Coming from a local authority background, I am aware that many councils are concerned about the bill. We all know the reasons why the bill has been introduced. Ian Crichton mentioned the Government’s frustration regarding social care. Will each area make its own decision on how much it wants to put in? Is it all or nothing? Is it a matter of identifying the problem and of saying, “Here is where we are falling down, this is how we’re going to fix it, this is how it will work, and we won’t need to debate who will pay for that, because we’ll put the money in”? Will local areas be able to make their own decisions, or is everything in social care going into the pot?

Ian Crichton: I can talk only from our perspective. We provide support where people feel that they need it. I will give an example from the health service. Last year, we put together a property framework—frameworks 2—which gives us a list of contractors that we have been able to vet and with which we have been able to agree pricing up front. We know that there will be value for money, with penalty clauses around things being delivered late and so on. That framework is then made available to any public bodies that want it so that they can draw from it for their own benefit. Previously, that would have just applied to the health service. Last year, we put together a framework that gives

The other element of control over our operations comes through Scottish ministers’ discretion around whether we can act in a certain area. A specific part of my local development plan for NSS this year lays out the areas where we will operate over the next 12 months on behalf of Scotland. An example of that is the Scottish wide area network that I mentioned. Even with the Scottish wide area network, the contract is left as a framework, so it does not force people who do not want to be involved on to it. Everybody who is in on it is a volunteer.

Rhoda Grant: You said that you operate on a cost-recovery basis. Do you speak about and negotiate that with the authorities concerned prior to carrying out the work?

Ian Crichton: One of the things that changes with the landscape is whether there is a need to tender. In health, we do not need to tender for the business that we provide because of the way that the funding flows from the Parliament. The situation will be more complicated if we start to operate beyond the health service, and our lawyers and Scottish Government lawyers are examining that.

The Convener: Richard Lyle is next.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I would like to pursue the information technology side of things—

The Convener: Richard Lyle! [Laughter.]

Dr Simpson: Sorry.

Richard Lyle (Central Scotland) (SNP): I thought that Dr Simpson had changed his name there.

Coming from a local authority background, I am aware that many councils are concerned about the bill. We all know the reasons why the bill has been introduced. Ian Crichton mentioned the Government’s frustration regarding social care. Will each area make its own decision on how much it wants to put in? Is it all or nothing? Is it a matter of identifying the problem and of saying, “Here is where we are falling down, this is how we’re going to fix it, this is how it will work, and we won’t need to debate who will pay for that, because we’ll put the money in”? Will local areas be able to make their own decisions, or is everything in social care going into the pot?

Ian Crichton: I can talk only from our perspective. We provide support where people feel that they need it. I will give an example from the health service. Last year, we put together a property framework—frameworks 2—which gives us a list of contractors that we have been able to vet and with which we have been able to agree pricing up front. We know that there will be value for money, with penalty clauses around things being delivered late and so on. That framework is then made available to any public bodies that want it so that they can draw from it for their own benefit. Previously, that would have just applied to the health service. Last year, we put together a framework that gives
Simon Belfer: There are two parts to the question. What will go into the integration pot will be for the local authority and the local health board to decide—whether they adopt the lead agency model or the body corporate model. Part 2 allows us to offer services if requested or required by a body other than the health board. It also enables a local authority to use us. Those two things are slightly different and separate. There would be a discussion where we stated the services that we offer and asked whether the body was interested. We would have a normal discussion, a negotiation and an arrangement around those services. That is quite different from saying what must go into the integration pot, which will involve the local authority and local health board. Does that help?

Richard Lyle: Yes, thank you.

10:30


Dr Simpson: It is confusing to have two Richards. I apologise to my colleague, Richard Lyle.

I want to pursue the IT side. We have not made the huge IT mistakes that have been made south of the border. However, we have a rather fragmented system, and it seems from Simon Belfer’s description that that will continue. For example, the NHS Fife Scottish care information store cannot be accessed by consultants in Tayside—and that is just the NHS element. Once we put health and social care together, there will be an even greater problem, unless there is some agreement about the form of IT. There will be 32 community healthcare and social care partnerships, so the system will be even more fragmented.

We can add to that the fact that we have just wasted £56 million on e-care. That is not your responsibility, but if you are going to get into that area you should be aware that the track record on the local authority side is not all that great, either. After six or seven years, e-care has not been a success. That could be quite useful for what is coming.

There is a third element, which is the issue of privacy and confidentiality for the patient. I have been and continue to be concerned that the terms of the judgment in the European case of I v Finland have yet to be met in Scotland, because we have only a retrospective system of identifying breaches in confidentiality. The judgment in the I v Finland case said clearly that systems of patient consent to time-limited access should be introduced, but those are not being introduced in Scotland, where we rely on a retrospective system.

If we add social care to that, as well as pharmacy, which is also looking for access, as are other prescribers such as optometrists and podiatrists, the potential access to confidential information becomes a major issue. Will the bill allow you to be any more prescriptive or directive in ensuring that the principles of confidentiality are maintained, and that systems are integrated and speak to one another so that we do not have fragmentation? Those two elements are at either end of the problem.

Ian Crichton: I shall make an initial response and then hand over to Marion Bain.

You are right to say that the issues in that area can be boiled down to three key things that Scotland needs to think about. The first is information governance, and you have mentioned responsibility for patient privacy. There is also responsibility to ensure that, if we have the information, it joins up and protects people. Those two sides of information governance are challenging.

The second element, as you also rightly pointed out, is that there has been extensive systems fragmentation over time, primarily because a lot of different bodies have responsibility for buying what they want. Sometimes they have bought the same systems from a supplier who picks each of them off, and sometimes boards have bought things that are cheap but which might not have a lot of resilience behind them. Therefore, we have had a fragmented scenario. In health, the situation has significantly improved over the past five years with convergence of patient management systems. IT for general practitioners has really been separated into two different areas, so on the whole there has been a degree of convergence in the health service. That could be quite useful for what is coming.

More important than the systems—because systems can be interfaced—are the standards. Scotland now has a big opportunity to ensure that we secure decent standards. If we can sort out those standards, it does not matter whether people have different IT systems, because they will at least all be operating to the same level and doing the same kind of things. We have made some progress, but there is more to be made. Given that we support such efforts, I would welcome more direction on standards. McClelland gives Scotland the opportunity to do some of that, but Marion Bain knows more than I will ever know about the information governance space.

Professor Marion Bain (NHS National Services Scotland): I agree with all those comments. We know that there has been a problem over many years. In answer to the question, I do not think that it is our role to be prescriptive about such things, but the bill will...
allow us to be supportive in moving the agenda forward. Actually, the issue is a really good example of why we as an organisation are so keen to be involved in this space.

Part of our current role within the health service is not just to provide the specialist IT expertise but to put that alongside the information governance, so they go hand in hand. In the part of our organisation that deals with IT, we have information governance specialists as well as IT specialists—alongside clinical input—which allows us to have systems that provide what people need in caring for patients. That is the sort of area where, having built up our support for the NHS, we could naturally support the broader health of Scotland by being able to apply the approach to the whole health and social care agenda, so that we get that safe sharing of information for the benefit of the public, with everyone having the confidence that confidentiality is being adequately considered.

In many ways, that is a good example of why we in NSS are very keen on the bill and on the work that is already being done. We feel that we will be able to take some of the things that we are already established in, which provide real benefit, and allow them to be applied more widely.

Dr Simpson: Well, I look forward to that.

Bob Doris (Glasgow) (SNP): First, as a tiny supplementary to Richard Simpson’s question, I want to ask about where NHS National Services Scotland fits in. Even prior to health and social care integration, there is still a lot of fragmentation of IT systems within the health service. The situation will not be changed by the bill, which I understand is more about how you will be able to use some of the good work that you are currently doing with local authorities and other public bodies. Should there always be the ability to have local decision making about IT systems? In a nation of 5.3 million people, should the 14 health boards still have the ability to buy 14 different IT systems? Surely to goodness, as we move forward, there should be some central co-ordination of that.

Ian Crichton: I mentioned standards, and I think that standards are more important than systems. What is required to run hospital and community resources in Orkney might be quite different from what is needed to run services in Glasgow, so there would be a danger in prescribing everything centrally. The centre needs to get better at having a clearer strategy, such as through the e-health strategy board. The strategy needs to be increasingly clear about our route map, if you like, but I think that there has been more clarity in recent years. There would be a real danger in prescribing everything from the centre.

As with most things in life, there needs to be a balance. We need to ensure that everyone is clear about the standards and then, as people go to market to procure, a body such as ours can be really useful—we have some heavy hitters who have expertise in such procurement exercises—in ensuring that procurement is done properly. We are used to supporting the health boards in that space.

Bob Doris: I will not indulge myself by asking further supplemnetaries on that, although it is an area of interest.

I want to ask about the different corporate structures that will emerge from health and social care integration, particularly for health boards. I have to admit that I was unaware of those until I started looking at the bill in more detail. I do not know all the details, but I hope that Mr Reekie will be able to help us with the provisions on the disposal of surplus assets by health boards. What are the current constraints? How will the provisions on health and social care address some of those constraints?

Peter Reekie (Scottish Futures Trust): As you will know, part 3 of the bill has a couple of provisions that are very relevant. On disposals, we are particularly keen to see health boards and local authorities being able to work a lot more closely together on their property strategies, both for building new facilities and for the disposal of facilities that are no longer needed.

Often it would be possible to get a better deal on the disposal of assets by bringing packages of things together that would be more interesting to private sector development partners. Members will be aware of this from their own localities, but 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.

Currently, a local authority can go into a limited liability partnership, which is the sort of corporate structure that the private sector often uses in such situations, with the private sector and work out mutually agreeable risk and reward sharing over a period of time to redevelop the property. Because of the structure of the current legislation, health boards are not allowed to become a member of one of those limited liability partnerships. If such an agreement is set up as a company, health boards can be in; if it is set up as a limited liability partnership, they cannot. That is an anomaly in the current legislative structure. 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.

**Bob Doris:** When I was preparing for today’s meeting, I read that health boards’ ability to provide services or enter into joint infrastructure agreements with neighbouring health boards is also quite constrained, but that that will change under the bill. Could you say a bit more about that, particularly about where the barriers might be at the moment, or could you describe a potential infrastructure venture that could not go ahead with the current arrangements but which would be able to go ahead following integration?

**Peter Reekie:** Again, this is about efficiency and giving us the ability to do things commercially as efficiently as possible. In the hub programme, for example, if a health board is buying two or three small health centres, there are a number of reasons why it might make sense to package those into a bundle. If we are developing a design, build, finance and maintain contract over a number of years, the costs of the legal and financial advice for a transaction and the costs of running that agreement are not huge, but they are significant. Therefore, if we are able to bundle together two or three small health centres into a single transaction, that will just be plain better value.

If all those three health centres are in the same health board area, buying them is really easy to do. We can have a single contract and it will all work really well. If we have a hub territory that spans a number of health board areas, as we do, and we would like to bundle together a couple of health centres that are in different health board areas, that is more tricky, because one health centre is not allowed to contract on behalf of the other for the provision of that facility.

In the north area, we have managed to get around that. NHS Grampian and NHS Highland are working together in Forres, Woodside and Tain; they have a single procurement agreement for three health centres. However, we have had to use a slightly complex structure in which one contract has two clients, and that has caused more legal thinking than would be required if one health board was able to take the lead and enter into a contract for the three health centres, allowing the other health board to occupy one of them afterwards. Allowing that to happen would just make things simpler.

**Bob Doris:** Okay. Can I just make sure that I am clear about this? I represent Glasgow region, and under the hub model, in the area of Glasgow in which I stay, Woodside centre is going to be rebuilt, as is Maryhill health centre and one in the south of the city. I assume that they will all be packaged together to get the best deal for the public purse. I know that nothing is plain sailing in this world but, would the contract for the venture that you have just described to me have been far easier to pull together if it fell within one health board area?

**Peter Reekie:** Yes, if it was all within one health board area. A single client would make the contractual structure much simpler. There would be one contract and one client. In your example it would be Greater Glasgow and Clyde NHS Board and Hub West Scotland. In the north area that I was talking about, and Forres, Woodside and Tain health centres, NHS Grampian and NHS Highland were trying to bundle projects together, and the ability for one of the health boards to act as a lead would have made that a lot easier.

**Bob Doris:** It is always dangerous to ask a question without knowing the answer to it, but if you needed to build a health centre in a location that made it geographically suitable to provide services to patients from two different health board areas, could you do that under the current structure? Will that change with the bill?

10:45

**Peter Reekie:** I think that the ability of health boards to provide services to one another is considered separately from the bill. That is not my area of expertise, but I know that it is possible for health boards to provide medical services to patients from outwith their areas.

**The Convener:** Richard Simpson and Nanette Milne have supplementaries.

**Dr Simpson:** Part of the purpose of integration is to allow different services to be co-located. For example, at the Broxburn and Fauldhouse centres, which were quite expensive, health services are integrated with social services. Such integration is extremely important but, beyond that, integration is also about allowing the benefits people to provide services from the same place. As well as providing the flexibility for health boards to co-operate as you have described, will the bill provide the flexibility for local authorities and other agencies such as the Department for Work and Pensions to contract jointly for buildings from which co-located services will be provided?

**Peter Reekie:** One of the most powerful points of the hub programme is that it allows local public bodies, particularly health boards and local authorities, to procure and occupy facilities together. There are several good examples of that on the ground. Not far from here, Hub South East Scotland has just handed over the Wester Hailes healthy living centre, which brings together NHS Lothian, City of Edinburgh Council and some third sector organisations in one facility. Primary care
and outreach consultant clinics will be provided alongside social care and children and families services. It is our belief that shared facilities and co-location can be a catalyst for integration; they do not necessarily have to follow on behind it.

To address one of the points that was made earlier, NHS Lothian is providing the IT and the City of Edinburgh Council the facilities management across that facility, although it is probably occupied 60:40 by the health board and the council. There are good examples of integration being facilitated through a hub arrangement in a shared facility.

Members might also be interested to know that on the other side of the country, in Eastwood, we have just worked with NHS Greater Glasgow and Clyde, Renfrewshire Council and Architecture and Design Scotland, through Hub West Scotland, to come up with a reference design for an integrated health centre that brings together local authority and primary care services in one place. That work has involved two of Scotland’s top architects—BDP and Gareth Hoskins Architects. The results of that reference design will be on our website so that people in other areas across Scotland will be able to piggyback on it and use it as an exemplar for designing buildings that bring services together.

Dr Simpson: That is extremely welcome. The bill will allow you to put together a contract across health boards. Will you be able to do that across local authorities as well, or can you already do that?

Peter Reekie: That can already be done between local authorities and health boards.

Dr Simpson: Can it be done between local authorities?

Peter Reekie: I believe that that is possible, but such overlap is less of an issue for us in hub contracting arrangements.

Dr Simpson: Right, but if, for example, three health centres were to be co-located with three local authority services but two different local authorities and two different health boards were involved, would the current legislation or the new bill allow you to put all that together so that one health board could contract on behalf not only of the other health board but of the two local authorities? Unless we get full integration, we will go only part of the way to addressing the issue.

Peter Reekie: I confess to not knowing the detail of whether local authorities can act on behalf of one another in the same way that the bill will allow health boards to do, but I can find out about that and provide you with some written evidence, if you would like me to.

Dr Simpson: That would be very helpful.

The Convener: We heard in the bill team briefing that the legislation puts health boards on a similar footing to local authorities. I will sneek in with a supplementary here. We have already discussed co-location and assets. Will giving health boards powers that are similar to those of local government enable them to form arm’s-length companies and other such bodies, as local authorities have done in order to deliver leisure and other services? Is that a possible consequence, or is it not envisaged?

Peter Reekie: It is not envisaged as a natural consequence of the bill. Part 3 specifically allows health boards to enter into different corporate structures, but it really refers to the possibility of a board becoming a member of a limited liability partnership as well as a company. Health boards can already co-invest or become part of companies that exist under the Companies Act 2006, and the bill extends that provision to include LLPs and other corporate structures.

Nanette Milne (North East Scotland) (Con): I have a regional interest in the issue. I think that I am right in saying that the proposed health centre at Inverurie in Aberdeenshire is to be bundled with another one in Highland. How is the lead board determined when such projects are set up?

Peter Reekie: A range of factors are involved in the decision. One factor might be which board in the bundle has progressed furthest with its project; another might be the range of skills and experience of the teams in the different health boards. The decision could be made simply on a value basis, with regard to which project carries the balance of the capital value. There are no specific arrangements in place.

Nanette Milne: Once the lead board is chosen, how much impact will carrying out that function have on its time and resource requirements?

Peter Reekie: That would be very project-specific. Project management and commercial resources will be required for all the projects. Overall, the whole is less than the sum of the parts, so all the boards acting together will need less overall resource than they would if they were acting separately. The lead board will obviously be required to lead on the project management and commercial aspects of the deal, although running those through the hub will minimise the impact in comparison with that using more traditional procurement models, because the partner will already be in place and much of the documentation and commercial agreements will already be tied down.

Nanette Milne: Finally, once the project is complete and the buildings are there, where does responsibility for maintenance thereafter lie? Does
it remain with the lead board, or is it split between the two boards?

**Peter Reekie**: This type of structure is envisaged mainly for contracts that will be let on a design, build, finance and maintain basis, so the maintenance of the facilities will become the responsibility of the delivery partner for the next 25 years or so.

**Mark McDonald (Aberdeen Donside)**: We discussed disposal of assets earlier, including some physical assets, which could include land. Many local authorities are land-rich, but I am not sure whether any health boards have large amounts of land in their portfolios.

It would be interesting to know where we are in identifying surplus assets that health boards currently hold. How many of those assets could the legislation potentially unlock?

In a situation in which capital moneys are tight, additional capital can be realised through the disposal of assets and the reinvestment of capital receipts. Has any work been done to identify surplus capital assets that are not disposable at present as a result of the blockages that you have identified?

**Peter Reekie**: A lot of work is being carried out on identifying surplus assets in individual local authorities and health boards, and those bodies now have very good sight of their potential surplus assets now and in the future. We are trying to deliver a more integrated look at those assets and are working with a number of health boards and local authorities on place-based reviews. In other words, we are looking across the whole assets of a health board or local authority in a town or part of a city to find out which areas it would be best to develop and which it would be best to dispose of. It is not that the bodies themselves do not know what they have or where it is; however, by bringing them together, we can sometimes create better value or a more integrated future plan.

I do not have figures for the total ability to increase value through what you might call the marriage value of bringing together sites across Scotland, but I can tell the committee that bringing together parcels of land and certain elements of assets often increases their value and that allowing this to happen can only be a good thing.

**Mark McDonald**: In that case, is it fair to say that this is less about allowing the disposal of assets that currently cannot be disposed of than it is about maximising the value of those assets by allowing these kinds of arrangements between local authorities, health boards and the private sector to take place? Is it more about maximisation than about unlocking the ability to dispose of assets?

**Peter Reekie**: Yes, it is about maximisation. However, in the process of maximising value or allowing bodies to jointly plan what they want to do and the order in which they do it, there will be investment as well as divestment and certain things could become possible commercially that would not have been possible before. Property developers talk about what is above and below water; that waterline moves and if by bringing certain sites together we can add value to them and take them above the waterline, we can allow things to happen that would not have been able to happen before.

**The Convener**: Do any other members have questions?

**Rhoda Grant**: Going back to Peter Reekie’s comment about procurement and pulling things together, I should say that, aside from that, part of the Health and Sport Committee’s role is to look at health inequalities. Part of health inequalities is the inability to find a job. If you bundle such contracts together over such a huge area, you will actually stop the workforce being part of the bidding process. When you think about, say, building a health centre in Glasgow, how do you calculate the entire cost to and what is best value for the public purse? How do you make work available and open to those in areas in deprivation who need it?

**Peter Reekie**: I do not think that by bundling projects together you affect which individual does the work on the ground at different sites. All of our hub companies have to advertise and compete their contracts at a lower level, and the competition for what we call tier 2 contractors will bring in the most appropriate and value-for-money contractor to each opportunity. In the past, a very high number of contracts have gone to local small to medium-sized enterprises—for example, well over 80 per cent of the contracts for the Drumbrae project in Edinburgh were delivered by local SMEs—and given the nature of the construction industry and how it delivers these things some of those packages will be subcontracted out again to very small-scale entities local to the individual project. It is important in, say, mechanical and electrical packages that there is a good amount of design integration, and that design will be carried out by a larger-level regional contractor that might well be able to cover three health centres.

**Rhoda Grant**: Are they forced to do that by whatever has been written into the contracting process?

**Peter Reekie**: Yes. Subcontract tendering is written into the contract, as are key performance indicators for community benefits and jobs and training places on every single project that is delivered through hub.
The Convener: Concerns have been highlighted about what you can do with regard to procurement and so on, but I suppose that what we have been asking about is your evaluation of a bid at a local level. I acknowledge that the construction industry is free-flowing and reaches across the whole country and that people in my constituency will benefit from a project in Edinburgh, but the fact is that more and more local construction partnerships are being set up in our constituencies and are requiring contractors to take on local apprentices or local labour at the appropriate level. Is that sort of element prominent and costed in each of your contracts?

Peter Reekie: Absolutely. It is prominent in every contract.

Bob Doris: I was only going to make a comment, convener, but I now also have a question to ask. I moved into a new house a year ago now and the builder is still on site—

Peter Reekie: It wisnae me.

Bob Doris: Everything that happens with the house is dealt with by a subcontractor, who is often locally based. Only one large construction company in the whole of Scotland has direct staff; in every other case, the work is subbed out, usually to local firms. I think that it is important to put that on the record.

Given that the hub model is about greater buying power, have you been able to put more community benefit clauses into contracts than you were able to before? Has the amount of community benefit increased because of your increased buying power? In other words, have you been able to drive down prices at one end and drive up community benefit at the other end? I would certainly be interested to find out whether that has been a feature of this approach.

Peter Reekie: The hub model gives us a long-term relationship with the development partner and the ability to say to them, "This will affect your future workload as well as this individual project, because you need to show that you are meeting all of our KPIs on employment and training in order to get the future pipeline of work that you want from hub." By linking that long chain of projects together and allowing people to see where future work is coming from and to plan for that through community partnerships and long-term relationships with local subcontractor supply chains, we deliver not only better value in cost terms but, in my view, better outcomes for communities.

Bob Doris: I know that there has been a bit of drift in our scrutiny of this issue, convener—

Mark McDonald: Just a tad.
North Lanarkshire Council welcomes the opportunity to give evidence on this important area of policy and legislation.

North Lanarkshire Council has long worked with NHS, third and independent sector partners to achieve success by extending the boundaries of collaborative working and develop integrated services where they can demonstrably deliver improved outcomes for our citizens in more efficient ways. This approach has yielded high performance levels, consistently evidenced by external inspections and evaluations, and has also led to the development of a suite of integrated services e.g. joint community assessment and rehabilitation teams, a joint equipment and adaptations service, integrated day services for older people, integrated addiction teams etc. Performance is overseen by robust joint governance arrangements, led by the North Lanarkshire Health & Care Partnership.

The efficacy of the approach gained high profile recognition as recently as July 2011 when the Nuffield Trust published “Integration in Action: Four International Case Studies” featuring North Lanarkshire Health & Care Partnership, Community Care North Carolina (USA), Greater Rochester Independent Practice Association (USA), and Regionale HuisartsenZorg Heuvelland (Netherlands).

In respect of joint commissioning, the North Lanarkshire partnership was one of the first in Scotland to have a comprehensive joint commissioning strategy. The Audit Scotland report “Commissioning Social Care” (April 2012) cites this as a best practice exemplar, together with another local example on service user and carer participation.

It is, therefore, in the above context that the council supports the overall aspiration for closer joint working between the NHS and local authorities and even more pressingly, the need for much more effective relationships across primary and acute care. This is especially relevant in North Lanarkshire where people from this authority can be admitted to, and discharged from, 7 different hospitals in 4 different health board areas. The Scottish Government’s complementary proposal to align NHS boundaries with those of local authorities is supported as an aid to community planning and commissioning, but it is a source of concern that neither the plans for integration nor the boundary changes will address many of the issues associated with the acute sector.

For this reason it is essential that the Scottish Government completes what it created a national working group to do- and ensure that the acute dimension is appropriately represented in new partnership arrangements. There are also significant factors that influence patient flow to acute settings over which local partnerships have little influence e.g. the roles of NHS24 and the Scottish Ambulance Service, that require to be taken into account to effect
transformational change. Our local experience is that the relationship between the local authority and primary care is actually the least pressing concern that requires to be addressed when viewed from a whole system perspective.

The council is also supportive of the concept of a national outcomes framework provided local government is seen as an equal partner in their development but unless the acute contribution is well defined the partnership will not be able to deliver all the intended outcomes.

North Lanarkshire Council’s views diverge from that of the Scottish Government in respect of three main areas:
• The proposed extent of ministerial powers contained within the Bill
• The proposed dilution of local elected democratic accountability
• The prescriptive nature of the Bill’s requirements

Ministerial Powers
The Bill ascribes extensive powers to Ministers that had not previously featured in consultation or discussions on the content of the legislation. That “Scottish Ministers may by regulations prescribe functions of local authorities that must, may or may not be delegated under an integration plan” creates a power, without recourse to further primary legislation, to transfer any local authority functions i.e. those that lie beyond community care such as Housing or Education. This should properly be a matter solely for local determination.

The Bill also states that
“The Scottish Ministers may by order make provision:
(a) about the membership of integration joint boards
(b) about the proceedings of integration joint boards
(c) giving integration joint boards general powers (such as powers to contract, acquire or dispose of property or rights or borrow money or incur other liabilities) in connection with the carrying out of their functions
(d) about the supply of services or facilities to integration joint boards by a local authority or Health Board
(e) about any other matter relating to the establishment or operation of integration joint boards that the Scottish Ministers think fit”

Again, these are all areas that should properly be a matter solely for local determination, for which it would be quite inappropriate to assume as a power of central government.

Finally, the integration plan should be a matter for local agreement, not Scottish Government approval, nor should it be for the Scottish Government to concern itself with the managerial arrangements partnerships put in place (the Bill states that “the responsibilities of the Chief Officer are subject to the agreement of Scottish Ministers”).
Dilution of Local Democratic Accountability

In addition to the above, there are a number of provisions contained within the Bill that dilute the council’s responsibility to exercise dutiful governance. Under the body corporate model, the Integration Board assumes autonomy for a budget that is likely to be greater than that which remains in the domain of a council, but without the need to refer back to the parent bodies. The desire to empower Integration Boards is understood but this carries significant risks that are not ameliorated by the small numbers of elected council members proposed on Integration Boards.

For social policy to succeed in the face of factors such as demographic change, it is essential that the aspirations of Reshaping Care for Older People to transfer resources from spend on institutional care (including hospitals) to community based support, are realised. At the heart of this is the level of funding of health and social care as a whole.

The nature and, in North Lanarkshire’s case, distribution of acute sector care; the high profile generated by the public experience of it; and the target-driven performance regime that accompanies it; combine to create a magnetic draw on scarce resources. It is critical that the local government contribution to integrated budgets is not used, for example, to place more people in care homes when there are problems managing patient flow in acute settings or prop up unsustainable arrangements in our hospitals.

The oversight from local government in the proposed governance arrangements is far too slight to prevent such occurrences, particularly when set alongside the level of authority invested in the Chief Officer.

Prescriptive Nature of the Bill’s Requirements

The Bill’s focus on outcomes does not sit comfortably with the lack of scope for partnerships to determine the arrangements that best suit local circumstances (whilst still remaining accountable for defined outcomes). Outcomes are much more important than structures – an extensive body of research suggests there is very little evidence of a direct relationship between the two.

It is therefore very disappointing that the Scottish Government has chosen to require partnerships to adopt one of two models, instead of simply requiring them to focus, and be accountable for, the outcomes associated with integration. This is a ‘two sizes fits all’ approach that does not recognise the progress some partnerships have made through local integration and collaboration via arrangements that are fit for local purpose.

Perhaps the biggest risk of all for this council in entering into either model is that of fragmenting high profile, high performing, well integrated responsibilities associated with public protection; children’s services; justice; addiction; homelessness and housing. This council’s Housing and Social Work Services manage all these functions under a single Executive Director. People do not live their lives in isolation from one another. There is a close relationship between addiction and child protection, for example. Many people
with addictions commit offences to fund their addiction. It would be the height of folly to create different organisational arrangements that dis-integrate some areas of activity, whilst integrating others. That is, nonetheless, a real risk.

It is recognised that the Bill does not prevent partners designating a wider suite of functions to fall within integrated arrangements. But this in turn increases the need for governance arrangements that adequately reflect the responsibilities of local government.

Other Comments
The scale of putting in place such arrangements must not be underestimated by politicians. For example, in respect of workforce planning there are issues to be addressed regarding industrial relations (as there is a different model in either sector), terms and conditions in integrated teams and potential equal pay claims (as there is a different model in either sector).

In either model a local authority would seek to be assured that the responsibilities of a Section 95 Officer can be properly executed. There is also a range of ongoing work with the Scottish Government that requires to be concluded relating to accounting treatment and VAT; financial recording and reporting; financial controls, assurance and risk, financial planning, performance and function; capital and assets etc.

North Lanarkshire Council
16 August 2013
Public Bodies (Joint Working) (Scotland) Bill

West Dunbartonshire Community Health and Care Partnership

Introduction
As an already fully integrated health and social care partnership, West Dunbartonshire Community Health & Care Partnership (CHCP) is particularly well-placed to comment on the national proposals, reflective of our actual experience of working to realise the benefits of integration in practice.

Q.1. Do you agree with the general principles of the Bill and its provisions?
West Dunbartonshire Community Health & Care Partnership welcomes the Public Bodies (Joint Working) (Scotland) Bill.

West Dunbartonshire CHCP covers all of children’s services (health and social care) as well as criminal justice social work. While it is unsurprising that the Bill has provided for local discretion in relation to the inclusion of those social work services, we did note that the Scottish Government’s response following its consultation to shape the Bill effectively accepted the logic that local health and social care partnerships should have the ambition and provide the leadership to grasp such a wider remit – not least in regards to also responding to the requirements of the new Children & Young People’s Bill.

Q.2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
The significance of delivering integrated governance and strategic management arrangements that represent a single “health and social care system” is important to acknowledge. As such, the Bill is well-placed to enable its key policy objective, i.e. to improve the quality and consistency of seamless health and social care services.

However, it is important to also recognise that no organisational model can provide a convenient “magic bullet” nor act as a panacea for the complexity and scale of health and social care challenges - particularly within the extremely challenging financial climate that is anticipated to persist for some years to come. A key finding of Audit’s Scotland’s Review of Community Health Partnerships Report was that CHPs had inconsistently delivered on a joined-up service agenda across Scotland. Our view is that was an unfair criticism to level at CHPs themselves, as this was at least a part-consequence of the original legislation attempting to achieve too many different policy objectives; and Audit Scotland viewing all of the objectives set as having equivalent weight and priority. As such, it is important that the accompanying guidance (if not necessarily the Bill itself) is appropriately calibrated to avoid sowing the seeds of unfair expectations.
Q.3. Please indicate which, if any, aspects of the Bill's policy objectives you would consider as key strengths

Two of the most compelling characteristics of the Bill’s vision for a successfully integrated system are:

- Consistency of key outcomes, so that people have a similar experience of services (and also carers have a similar experience of support) while allowing for appropriate local approaches to delivery.
- Commitment to streamlining existing bodies and structures.

Within West Dunbartonshire, the established CHCP’s status as a joint vehicle for the planning, allocation and management of WDC and NHSGGC health and social care resources (both strategically and operationally) is recognised as a clear manifestation of community planning in practice. In our view, comprehensive integrated partnerships will be better placed to focus on prevention and early intervention - working with the whole family and whole community – and act as effective Community Planning Partners in the spirit of the Christie Commission’s recommendations for public sector transformation.

This is one reason why it is critical that each Partnerships’ Chief Officer (and their senior team) are entrusted with the authority and mandate to deliver what is a hugely ambitious agenda within a highly visible arena; and that they can rely on visible support - alongside fair and robust scrutiny – from their local Integration Authority, Council, NHS Health Board and indeed the Scottish Parliament. It is important then that in parallel with enacting the Bill, the opportunity is taken to streamline reporting and scrutiny regimes rather than multiplying silo-ed activity and bureaucracy – e.g. so that Partnerships are not having to invest valuable expertise and resources reporting on the same issues through different routes; and using different formats/templates for different Boards/Committees; myriad national external scrutiny and improvement bodies; and different Scottish Government Directorates.

We are also supportive of the position that key outcomes agreed for the new Partnerships to be visible within their respective Community Planning Partnership (CPP) Single Outcomes Agreements (SOA) – but that the guidance is disciplined in not specifying too many headline outcomes/targets as national non-negotiables. Merely seeking to include a battery of national outcomes/targets for the new Partnership could be argued to undermine the fundamental concept of an SOA, i.e. that it is developed and agreed on the basis of a local determination of priorities across a range of stakeholders based on the particular needs of local communities.

Q.4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

While there is a pragmatic logic for the proposition of an initial focus on improving outcomes for older people, there is a risk that a series of arrangements could be developed that would not be efficiently scaled up or transferable to other care groups. The reality is that within the context of the Older People’s Change Fund there is already considerable focus (including
dedicated performance reporting and robust governance) on the Reshaping Care for Older People’s agenda – so in practical terms, such an initial focus as suggested would 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 may suggest a piecemeal approach, with different integration models devised for different care groups with complicated structures and unwieldy bureaucracies as a consequence).

In a similar vein, it is difficult to rationalise why any local area would not share an equivalent ambition for a successfully integrated system for children and young people’s health and social care services; and for the accountabilities for such a system not to be hardwired into the responsibilities for these new Partnerships. Child Protection case reviews repeatedly highlight inadequate and hesitant interagency communication and information sharing as contributing factors to significant incidents. While it would be naïve to argue that an integrated management and governance would somehow be a “magic bullet” to resolve such behaviour, it is reasonable to view them as enabling factors for more effective risk assessment and care management. One example of this would be a single Chief Social Work Officer for an authority area within the new Partnership consistently articulating the same message for child protection to all health and social care professionals across all services. This would appear to be consistent with the Children & Young People’s Bill. Unified delivery of these services in a single Partnership will improve quality, efficiency and effectiveness. It is important to note that we do not believe that the joint working with other Council functions – particularly Education services - in relation to children and young people would be undermined by fully comprehensive Health and Social Care Partnerships. Indeed, just as the proposals as they currently stand recognise the importance of robust working arrangements between the new Partnerships and Council Housing services in relation to the Reshaping Care for Older People agenda, we see no reason why an equivalent emphasis should not be placed in terms of Education services in relation to the Getting It Right For Every Child agenda and the duties on public bodies that are separately confirmed by the Children & Young People’s Bill. As such we would be keen for the respective guidance accompanying both Bill’s to more explicitly cross-reference each other to encourage and enable local areas to implement both in at least a joined-up and co-ordinated manner; and for national scrutiny and improvement bodies to be required to think and operate in a similarly joined-up and consistent fashion..

There is a need for further clarification of the relationship between both the Integration Authority and the Chief Officers with respect to NHS acute activity, not least to ensure that the accountability that rests with the Chief Officer is reflected in the level of authority that they and their management teams have; and also not to fracture or complicate the delivery of hospital acute service provision.

There is a need for further clarification of the financial governance and accounting arrangements that will be deployed in respect of the new Partnerships. The Bill’s Financial Memorandum expresses an expectation that
by moving more towards early intervention and preventative support that use and cost of more acute services can be achieved - however this would require a freeing-up of resources from these acute provisions to allow the investment in the early intervention services. There must also be a danger that the early intervention does nothing but simply delay the intake to acute provision for a few years and the demand actually does not diminish overall and in fact the total cost of overall provision is actually increased. Given the above vagueness regarding potential savings it is difficult to place too much reliance on them. When also taking into account the stated need for any such savings to be reinvested in Partnerships to help meet projected future demand, this gives the impression that the Scottish Government feel that there is no need to fund the future demand pressures as Partnerships will be able to self fund through efficiencies - despite the efficiencies being clearly described as being effectively crude estimates with little evidence to support them. There must also be doubts about the practical ability of the acute provision to actually provide resource release to non-acute services – and indeed. This will be particularly difficult as, based on past experience and future demand pressures, these services are more likely to place funding pressures on Partnerships rather than bring efficiency / resource release opportunities.

On a linked issue, perhaps the Bill and guidance could allow for a reduction in the number of currently silo-ed and increasingly over-lapping national audit/inspection/improvement bodies: such a reduction could be used to free-up much needed resource to be transferred to the new Partnerships to assist in meeting the costs of care given the predicted demographic changes over the next few years.

We support the development of locality planning as a transparent vehicle for engagement with local professionals in decision-making in relation to the communities we all serve. It is important to ensure that new Partnerships enjoy legitimacy as a force for positive change amongst professional groups, including NHS external contractors; and also provide a means to ensure that those same professionals constructively discharge a wider leadership role across their respective peer groups and within their respective professional communities. This would be strengthened by an accompanying consideration of how national government can encourage all GPs and other external NHS contractors to constructively participate in these arrangements so that the responsibility for the effectiveness of these arrangements are mutually shared by all; and indeed ensure that the Partnership’s decision making processes benefit from the widest evidence-based contributions of staff and not solely relying on the inputs of enthusiastic local clinicians/professionals.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

As an established CHCP, West Dunbartonshire has already achieved the more substantive efficiencies associated with integration, most notably by rationalising its senior management arrangements. We can evidence that (even within the context of having to manage two distinct ledgers) integration enables more co-ordinated and efficient use of health and social care
resources. Our CHCP can also demonstrate how joined up management and support can enable staff to work well together irrespective of their contractual employing organisation - not least as affirmed by the recent UK Healthcare People Management Association (HMPA) Excellence in Human Resource Management award that the CHCP has been recognised with.

A pooled budget would certainly aid that further – but we also recognise that it requires adjustments to the wider corporate processes of the Council and the Health Board to strike the “right” balance between consistent practice across both corporate organisations; and providing the Partnership with sufficient flexibility to innovate and streamline its approach locally. As per above though, there will continue to be a host of challenging agendas that the new Partnerships will also have to contend with in relation to the sustainable management of financial resources, e.g. GP prescribing and self-directed support.

**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

We would highlight the extremely positive findings of our recent Care Inspectorate scrutiny assessment report of WD CHCP ([www.scswis.com/index.php?option=com_docman&task=cat_view&gid=287&Itemid=378](http://www.scswis.com/index.php?option=com_docman&task=cat_view&gid=287&Itemid=378)). This provides evidence from practice of how an existing integrated health and social care partnership has further improved care provision; and should alleviate expressed (and speculative) anxieties in relation to potential dilution of social work practice provided that the leadership (senior management and lead professionals) of the Partnership possesses sufficient expertise, integrity and vision.

A timely example of how an integrated health and social care partnership can improve the overall care experience with patients and carers has been our successful integration of Ardmore Day Hospital with Local Authority Day Care provision (which has just been recognised as a finalist in Scotland’s Dementia Awards 2013).

**West Dunbartonshire Community Health and Care Partnership**

2 August 2013
1 Do you agree with the general principles of the Bill and its provisions?

a) The City of Edinburgh Council and NHS Lothian have a long history of positive partnership working and the intentions of the Bill create a useful and forward thinking framework to allow continued improvement across governance, strategy, planning, resource management and, most importantly, frontline service provision to deliver positive outcomes for the people of Edinburgh who need health and social care services. Edinburgh has had a Joint Director for health and social care services for eight years.

b) In summary, the City of Edinburgh Council:
- strongly endorses the policy ambition for integrating health and social care as outlined in the Policy Memorandum
- strongly supports the policy intentions of Scottish Ministers behind the Public Bodies (Joint Working) (Scotland) Bill
- agrees that the intentions of the Bill create a positive framework for the delivery of integrated health and social care services
- welcomes the fact that the Bill does not focus on structurally-led models of reform and focuses on building on many years of positive joint working
- agrees that it offers an opportunity to improve the transition points between current primary and secondary health care and social care, subject to clarification of the scope of services
- strongly supports the integration planning principles
- strongly supports the intention to prescribe national outcomes for which both the NHS Board and Council are jointly accountable, and the intention to consult with health boards and local authorities on these; however, this must be balanced against local responsiveness to population needs
- strongly supports partnership working with NHS and also with a range of non-statutory partners for the long-term planning and provision of health and social care services
- very much welcomes the emphasis on meaningful and two way engagement with all relevant stakeholders, and whilst this will be a significant challenge on the scale required in Edinburgh, it is strongly supported
- welcomes the intention to provide some funding to NHS boards and local authorities to support the challenges of change management and organisational development during the transition
- is of the view that the provisions alone will not deliver the whole answer to the scale of rising demand expected now and in the future.
c) However, the Council also **has some specific concerns:**

- the Bill is insufficiently clear regarding the nature of the body corporate model and the governance and accountability roles of the parent bodies with respect to the joint board, its creation and operation
- there is an apparent mismatch between the focus of the Policy Memorandum and the detail of the Bill itself in relation to the potential scope of services; the powers included in the Bill could be interpreted as extending well beyond the policy focus of adult health and social care services; and this could create opportunities for integration of other local government services, without specific legislative consultation and debate and at the potential expense of local democratic accountability
- the extent of power and control being granted by the Bill to Scottish Government Ministers, which appears to be in conflict with the policy intention of local partnership working and with local democratic accountability and engagement; and
- the remedial measures reserved to Scottish Ministers when a partnership approach fails are unlikely to deliver the expected policy intentions, and a more supportive, conciliatory approach should be adopted to build relationships; given the history of partnership working in Edinburgh and progress so far, both the City of Edinburgh Council and NHS Lothian are confident that such measures will not be needed.

d) The comments below are written from the point of view of preferring the ‘body corporate’ model of integration over the ‘delegated models’ and are caveated by the need to address the issues listed later in this paper, which if not addressed will impinge on the nature of the partnership approach and hence on the reality of achieving policy objectives, benefits and outcomes for people, as well as on local democracy into the future.

2 **To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**

a) The creation of an equal partnership approach to delivering services as outlined in the Policy Memorandum, which at the same time, maintains accountability through both parent bodies is a positive step in joining up services, resources and budgets for the benefit of people who use them. It has the potential to maintain an equal measure of both local democratic and ministerial accountability.

b) The City of Edinburgh Council considers that only by supporting the best of both NHS and council approaches can true service improvement be delivered on the ground, in terms of shifting the balance of care to the community for the benefit of the local population.

c) The scope of the functions to be 'delegated' is critical in achieving the policy objectives. There is a need to ensure that the scope includes the
provision of acute care to enable the delivery of the policy ambitions and outcomes.

d) Neither the City of Edinburgh Council nor NHS Lothian are in favour of the ‘delegated’ model as it will create significant upheaval for organisations, employees and possibly services users, and could be a major distraction for some years. A partnership approach would help to avoid this.

e) For the City of Edinburgh Council, the partnership approach would build on eight years of partnership working with NHS Lothian, through the Joint Board of Governance and a Jointly Accountable Officer.

f) Any model of integration will rely on continuing to build trust and confidence between the City of Edinburgh Council and NHS Lothian, and with other interested stakeholders across the city. Both are critical to developing a real joint vision for health and social care for Edinburgh. The policy intentions of the Bill provide a framework to do this.

3 Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

Integration plan - Section 1
a) The approach to making services, resources and budgets transparent between partner organisations via joint governance and an Integration Plan is positive and productive, and should allow a smoother, steadier response to the demand and budget pressures than could be achieved by large scale reorganisation.

Integration planning principles – Section 4
b) The major strength of the Bill is the policy intention to address disconnects in the current system, to remove barriers to current joint working and to shift the balance of care without the distraction and territorialism, which can be created by wholesale restructuring. The need to move beyond an organisation’s administrative convenience to a better focus on the needs of recipients, and the contribution of local professionals and the community is vital if society is to deal with the demand pressures forecast. A move towards person centred services through integration is a real opportunity to be grasped.

Engagement of non-statutory partners – Section 6, Section 26, Section 30
c) A further strength is the focus on involvement and engagement of a wide range of stakeholders in the co-production of service design, development and delivery. To enshrine this in legislation is a helpful step forward. The flexibility for the Integration Authority to determine additional consultees beyond a minimum is welcomed. The Shadow Edinburgh Health and Social Care Partnership has adopted an inclusive approach to – and made good progress with – the involvement of non statutory partners from the third sector, services
users, local professionals and carers who have a critical contribution to make to improving outcomes for people.

Section 1 (5)
d) It is also a strength that some functions may not to be delegated. This is to be welcomed in instances where specific accountabilities prevent a conflict of interest and protect individuals’ wellbeing, rights and liberties, e.g. the role of mental health officers.

Guidance and Regulations
e) The Council welcomes the intention of the Scottish Government to prepare specific guidance/ regulations, which will enable a responsive approach to changes in circumstances over time. However, the Council would wish for flexibility to local circumstances to be built into the guidance, where the approach taken by the parent bodies and Integration Authority meets with the policy ambition and spirit of the Bill.

4 What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

a) The main areas of expected benefits include:
- releasing untapped creativity around service design and delivery
- the acceleration of creating new, responsive, joint models of service delivery to allow the balance of care to be shifted from the acute to community setting, but with enhanced clinical/rehabilitation support
- supporting a shift in focus away from narrowly defined targets around processes towards improving outcomes for people and allowing a more holistic view of health and social care as a single system, particularly in service related to prevention, social justice and health inequality
- streamlined pathways of care, with fewer disconnects and a smoother more effective response for people
- real potential to reduce re-admission to hospital for individuals and to support ongoing independence in a homely environment; and
- joint performance in assessment and shared objectives should demonstrate real progress against joint national outcomes.

b) There may be efficiencies associated with all of the above, however, demand pressures are such that there are unlikely to be cashable savings, rather a reinvestment of staff and other resources to respond to rising and complex demand, supported by a shift of NHS resource to develop more community based health care out with the acute hospital setting.

c) There may also be small efficiencies with the joint approaches to budgets, planning and commissioning, however, these are likely to be offset by the costs of developing improved approaches to engagement with and involvement of non-statutory partners.
5 What effect do you anticipate integration plans will have on outcomes for those receiving services?

a) Having joint local outcomes governed through our joint Shadow Partnership arrangements is already having a positive impact on the operational management of Edinburgh’s health and social care services.

b) Looking forward, the impact of a transparent view of a large proportion of all health and social care resources for a local area, plus an agreed common aim (national outcomes), against which both organisations are measured equally cannot be underestimated.

c) Such a context creates a real opportunity for moving forward with the best interests of recipients at the forefront of everything we do, rather than being led by separate organisational drivers.

d) It creates an opportunity to develop real understanding of each service and each professional practitioner's important role in the whole system of health and social care.

e) It also creates the potential for financial and human resources, ICT and structural barriers to be removed or managed more effectively for staff at the frontline who often already work well together in spite of these barriers.

f) These factors can only impact positively on the quality of frontline services and the potential for positive cultural and service change for the benefit of people who need our services, allowing staff to focus on the person and not the barriers that hamper their work.

6 Concerns and Areas where the Bill could be Strengthened

a) The Council has some concerns about the detail of the Bill. Most comments relate to an apparent mismatch between the intentions of the Policy Memorandum, which the Council fully supports, compared with the details within the Bill and the extent to which Scottish Ministerial power needs to be balanced against local democratic accountability.

b) Consultation on Integration of Health and Social Care – Scope

1) The Scottish Government consulted on the specifics of integrating adult health care and social care services with local flexibility to extend this to other health and council services, e.g. some housing services and children’s services. Furthermore, the Policy Memorandum is clearly focused on adult health and social care services.

2) However, the detail of the Bill appears to have moved far beyond this focus, and can be interpreted as providing for much wider
ranging local authority services to be included within the scope of a body corporate model.

3) None of the key elements of the proposals, i.e. the preamble in the Bill, the Integration Plan, Integration Planning principles, Strategic Plan, etc., specifically mention the scope of the services for either the local authority or health board. Therefore, it seems possible for Ministers to make provision, by regulation, for other local authority services to be delegated to a body corporate or for the remit of a joint board to grow.

4) This does two things:
   - it creates the potential for other local government services to be delegated to a body corporate, whilst avoiding the need for Government consultation and legislative debate on the matter; and
   - it misses an opportunity to address specifically the two disconnects, which Scottish Government identified in the consultation in 2012, i.e. between social care and primary care, and primary care and secondary care.

5) This concern could be overcome if the Bill were to reference the minimum scope of local government and health board functions / services to be included, with appropriate definition of the term ‘functions’. It is important that the scope fully reflects the policy ambition to address the ‘disconnects’ between acute and primary care and primary care and social care.

6) One area of scope where further consideration is needed is in relation to children’s health and social care services. Children cannot be seen in isolation from their families, and where local authorities have integrated their children’s social care services with their education services, there is a need to consider the best approach to linking with children’s health services to ensure whole families can be well supported. Edinburgh would like to establish a separate partnership for children’s health and social care services and it would be helpful if the Bill could provide a steer on the practicalities of this.

c) Definition and Governance of Body Corporate – Section 1 (4):

1) The Bill is insufficiently clear on the nature and make-up of the ‘body corporate’ (joint board) model. It does not state what type of legal entity the body corporate will be; nor does it state its composition. There are no general principles proposed for the primary legislation, which would ensure that the local authority and health board will have representatives on the joint board. It is also
not clear from the Bill to whom the joint board will be accountable and how it will be held to account.

2) The term ‘body corporate’ appears to have a very particular definition in law, which is not referenced in the Bill; and definitions seem to preclude the development of a formal partnership with accountability arrangements, as required by the Policy Memorandum.

3) The Bill is strong on the powers and role of Scottish Ministers in relation to the different models of integration. To balance this, it should articulate more clearly the legal/governance accountability arrangements of the local authority and health board in relation to the joint board and the role, which each parent body will have in its creation, ongoing governance, accountability and operation in line with the Policy Memorandum.

4) Specifically, the Bill needs to demonstrate the clear role of the parent bodies in such matters as: formally agreeing the nature of the joint board; establishing the Integration Authority and the functions to be delegated; approval of the Integration Plan prior to submission to Scottish Ministers; approval of Strategic Plans, etc.; and the monitoring role through the Performance Report.

d) Delegation- Section 21 and 22

1) The Bill does not clearly articulate the capability of the joint board to carry out the delegated functions itself initially (as it has no staff), but rather has to direct the local authority and health board to carry out the functions. This brings into question whether the joint board can therefore have the same duties, rights and powers as the entity which delegated the functions?

2) It seems unusual to the Council that the effect of the delegation, as per section 21 of the Bill, is to make the person to whom the function is delegated subject to the same duties, and have the same rights and powers, as the person who delegated that function. It becomes difficult to see who is accountable to whom. It may be helpful to reflect on the current process within a local authority: where the Full Council may delegate a function to a Director, yet it is ultimately the Full Council that has the duty and is liable for any failure to discharge it. In turn, the Full Council can hold the Director to account by establishing performance measures, and ultimately through disciplinary action. We would assume that the Bill will be clarified with respect to the provisions and expectations for changes to local authority standing orders and financial regulations.

3) It is rare that all powers associated with a function would be delegated in a local authority – usually there is some form of
limitation to the delegation, for example a Director cannot discharge functions that carry a material risk or are politically controversial.

4) These points lead the Council to seek clarification on the term “delegation” of the function, as described in the Bill. It could be interpreted as being either a “duplication” of the function (if the local authority retains the duty to discharge the function) or a “transfer” of the function (if the local authority does not retain the duty to discharge the function as per the proposal in paragraph 97 of the Policy Memorandum).

e) Local Government (Scotland) Act 1973 s 57

1) Local authorities cannot delegate any functions to another body /committee unless it has a two thirds voting majority of councillors. It would be helpful if the definition of the body corporate model approach could be clarified around whether it can be a committee of the local authority and of the health board, and whether the 1973 legislation is now superseded or is repealed.

2) This Council’s preference would be that the joint board is a joint and equal committee of both the local authority and the health board, and if this is not possible, that the local authority be granted powers to establish the joint board. If this is not to be the case, it is hard to see how the local authority can delegate, and it then becomes ‘duplication’ or a ‘transfer’ of functions as described above.

f) Chief Officer of an Integration Authority – Section 10:

1) The joint board will appoint the Chief Officer and must only consult the local authority and health board. If the Chief Officer is not appointed by the local authority and health board, it is unclear how the local authority and health board can seek to hold the Chief Officer to account if he/she does not deliver the required outcomes.

2) More clarity on the points below would be welcome:
   - as a minimum, high level principles regarding the role of local authority and health board in the appointment of the Chief Officer
   - guidance on the appointment of a Chief Officer, specifically in cases where a Jointly Accountable Officer exists, and is already managing joint health and social care services across existing partnerships; and
   - the accountability relationships of the Chief Officer to the respective health board and local authority Chief Executives.
g) Rights and liabilities – Section 21

1) Additional information on the question of legal liabilities of the body corporate arrangements would also be welcome, in particular where and with whom ultimate responsibility lies. The mismatch between the policy intention and the details in the Bill on the body corporate currently make this difficult to determine. This is linked to the points about accountability and delegation above.

2) Specifically, does the Chief Officer, the parent body, the Chief Executives, or the joint board have ultimate responsibility? If the latter, how does referring to an individual person fit with a joint board of equal voting members?

h) Strategic Plan – Section 23

1) There is no requirement for a joint board to seek agreement from the local authority or health board to the Strategic Plan. This means that the local authority will not have the final say on the delivery of ‘delegated’ services for which they are allocated resources and for which they have ultimate responsibility (paragraph 97 of the Policy Memorandum).

i) Consultation Group – Section 26 and 27

1) In preparing the Strategic Plan, Integration Authorities are to establish consultation groups. Where the Integration Authority is a joint board, this group is to constitute one person nominated by each of the local authority and health board who prepared the integration plan. This suggests that the intention of the Bill is for the joint board to be a distinct body, rather than a “partnership” between the local authority and health board.

2) It is unclear why there is a requirement for the joint board to form a consultation group with a representative from the local authority and health board if the joint board itself is made up of representatives from the local authority and health board.

j) Performance Reporting – Section 33

1) The reporting arrangements for the Performance Report to the council and health board should be strengthened to create formal accountability and meet with the requirements in sections 91-97 of the Policy Memorandum.

k) Scottish Ministerial Powers - Sections 11, 12 and 39

1) The Bill creates some very specific powers for Ministers to instruct health boards and local authorities in a very particular course of action. The main ones of concern are listed below:
Scottish Ministers may appoint staff other than the Chief Officer to an integration joint board and to specify the terms and condition of such staff (Section 11).

2) The rationale for this power is unclear when the Policy Memorandum specifies that a partnership approach is required and that local flexibility is important. It seems unnecessary when the requirements to prepare an integration plan are clearly stated, and when section 39 provides for action in the case of a failure. It also seems to contradict the Policy Memorandum, which is clear on the negative impact of creating a new organisation.

3) This apparent contradiction should be clarified, and this Council is of the view that this power is unnecessary to deliver the policy intentions outlined in the Policy Memorandum. As a minimum, the Council would wish to have assurance that this could only be done with the express permission of the parent bodies.

4) When this power is combined with the lack of clarity about scope, it is possible to interpret that Scottish Ministers could instruct local government to create a separate body corporate to deliver any local government service via a joint board. This would be an unwelcome consequence of the intended spirit of the legislation and would seriously impact on local democratic accountability.

Scottish Ministers may make provision about membership of joint boards; proceedings of joint board; giving general powers to contract, acquire/dispose of property, borrow money or incur other liabilities; the supply of services or facilities etc (Section 12).

5) The use of such powers with respect to services delegated to the joint board does not reflect the need for local flexibility and partnership working. It is in conflict with the policy intention and could also have a negative impact on local democratic accountability.

6) It could be interpreted as a centralisation of local government responsibilities and accountabilities, which are currently in the hands of local elected members. The absence of clarity about the role of the parent bodies in these matters compounds this impression.

7) As a minimum, it would be helpful if the Bill would indicate the circumstances that would need to arise for these powers to be invoked, and how this would be balanced against the need for local democratic accountability. The power should be removed altogether and replaced with a power to prepare guidance and for local arrangements to take cognisance of this guidance.
Scottish Ministers may establish an Integration Authority of the body corporate model, and to specify the make-up and workings of this body (Section 39).

8) It is understood that Section 39 would be implemented only in cases where there was a failure to deliver on any model of Integration Authority. However, forcing a specific model of integration when partnership working has failed cannot be expected to deliver a positive outcome for service users.

9) It will also overrule local democratic accountability, where a local authority considers integration with the local health board may not be in the best interests of their service users or wider population at that time.

10) It may be more helpful to consider making provision for formal support arrangements, which could be put in place to develop and improve the potential for a partnership relationship and an agreed way forward to rise to the challenge of meeting national and local outcomes for people.

11) This section also requires the local authority to delegate specific functions and to make payments to the joint board. Such instruction could impact negatively on local democratic accountability. The power effectively allows Scottish Ministers to direct local authority spend, around 25% of which has been raised through local council tax. This can be interpreted as local money to be spent by democratically elected members and not directed by Scottish Ministers. This may be a particular issue when the political make-up of a local council differs from national government, and could be interpreted as a reduction of local government autonomy.

l) Information Sharing - Section 37

1) The supplementary section on the disclosure of information between partners in relation to the purpose of preparing the Integration Plan is welcomed. It may be helpful if subsection (5) could be expanded to include:
   - the functions that are delegated and their operation; and
   - the preparation and delivery of the strategic plan.

2) Or some other such wording, which would ensure the sharing of information not just for the preparation of the relevant plans, but for ongoing operation and delivery of services to meet the requirements of the plans. It would be helpful to have guidance from the Information Commissioner on what would need to be undertaken to ensure compliance with Data Protection and Freedom of Information, with respect to a the integration models.

m) Community Planning
1) More information and clarity would be useful on the expected relationship with Community Planning legislation, partnerships and structures, particularly the relationships between the body corporate and formal community planning structures, the national outcomes and the Single Outcome Agreement, locality planning arrangements and local community planning approaches.

7 Finance

a) The City of Edinburgh Council:
   - welcomes the provision of financial support for the transition
   - notes that the majority of cost and efficiency savings are to be achieved in the acute health sector; and
   - welcomes the acknowledgement of costs for third sector support, however, notes that there are likely to be recurring costs for such support.

b) General Concerns

1) This Council considers the assumption that all additional local authority costs can be met from within existing resources to be flawed and that the local authority costs should be examined in more detail.

2) If the majority of efficiency savings are to accrue in the acute health sector, it is critical that the scope of the services for integration are clearly articulated in the Bill, to ensure that there is the opportunity to shift resources appropriately from acute to community-based primary and social care settings.

c) Non-Recurring Costs

1) Provision is to be made for funding Community Health Partnership leadership post holders who are displaced as a result of the development of partnerships. Similar resources need to be available to local authorities.

2) It would be very helpful if there were to be increased funding for ICT development and recurring costs, given that this is a key strategic enabler to joint working.

d) Recurring Costs

1) It would be helpful if greater value could be given to the role of external audit. This will be particularly important, given the issues regarding governance and accountabilities in the sections above.

2) The additional costs for encouraging clinicians in locality planning should be extended to include other stakeholders who will have a
legitimate involvement.

3) There are likely to be additional costs for stakeholder engagement in both strategic planning and locality planning.

4) Given the nature of the joint board model, it is likely that recurring costs cannot be simply absorbed through the savings from existing administrative costs, specifically remuneration for board members and stakeholder engagement on the board.

5) VAT differences between health boards and councils continue to be a financial risk, unless and until clarification is received from HMRC.

6) It is likely that additional staff cost pressures will emerge over time as a result of integration, e.g. harmonisation of staff terms and conditions. It would be helpful to make an allowance for this in future.

8 Closing Remarks

a) The City of Edinburgh Council would like to reiterate its full support for the policy intentions of the Bill. The concerns raised relate to: the mismatch between the policy intentions and the exact proposals; the lack of clarity in the proposed law; and the very significant powers, which are to be granted to Scottish Ministers. These matters will impact on a large portion of local authority autonomy and spend, currently governed through locally elected councils.

b) There are many risks associated with a programme of change of this scale. The Policy Memorandum specifically refers to a number of financial and other risks and envisages that these risks will be mitigated through: the joint nature of the governance of the Integration Authority; the provisions of the Integration Plan and Strategic Plan; and through the direct accountabilities and responsibilities of the Chief Officer.

c) These mitigating factors could be jeopardised due to the mismatches identified between the Policy Memorandum and the Bill, and specifically the lack of clarity about the governance role of parent bodies.

d) The scale and impact of these risks on both health boards and local authorities increase significantly if their governance role is unclear and could impede progress with the agenda. This would be a retrograde step, and extremely unhelpful when both the City of Edinburgh Council and NHS Lothian consider that the policy ambition is well founded, well thought out and otherwise possible to achieve.

City of Edinburgh Council
15 August 2013
Key Messages

In developing our response to the Health and Sport Committee on the matter of the Public Bodies (Joint Working) (Scotland) Bill, we would draw attention to the following key messages:

- It is our general view that the integration of health and social care should form a corner-stone of the public service reform agenda and link to wider reforms associated with community planning;

- The Scottish Government’s policy proposals have a number of commendable features. In particular, they support outcomes-based service planning; recognise joint strategic commissioning as the bedrock of integrated service planning; and afford appropriate prominence to locality planning as a means of working with communities;

- However, COSLA believes that the Public Bodies Bill is in parts too prescriptive and too detailed, and as a general rule there should be more flexibility at a local level to determine the shape and governance of the proposed partnership arrangements;

- In respect of the Ministerial powers expressed in the bill, COSLA does not agree to any Minister having powers of autonomy to make decisions which affect Local Authorities without consultation and agreement. We believe that the range of local authority services under the direction of Scottish Ministers is far too great and that the Scottish Government should introduce an amendment to ensure that the bill is consistent with the policy intention and consultation exercise;

- We would maintain that health and social care partnership arrangements should be subject to stronger-than-proposed local democratic oversight. The bill falls short in describing effective arrangements in support of these principles.

- From the perspective of whole-system commissioning, it is absolutely vital that acute budgets form part of the integrated resource. While we recognise the technical challenges associated with this proposition, to leave acute resources outside of the integrated budget would render the health and social care partnership relatively impotent. The Scottish Government should define the minimum contribution of the acute sector to the integrated budget.

- We are calling on the Scottish Government and Parliament to resolve the longer-term funding challenges associated with the cost of health
and social care to the public purse in Scotland. We are confident that the pressures building on the health and care system over the next twenty years cannot be met by better integrated services alone: the integration of health and social care is necessary but ultimately insufficient as a means of eliminating the funding gap that is likely to emerge.

Introduction

1. The Health and Sport Committee has asked for evidence in respect of the Public Bodies (Joint Working) (Scotland) Bill. COSLA’s position on health and social care integration has been developed over a number of years and has been subject to considerable scrutiny by council leaders and our professional associations. We have also worked in detail with our partners in the Scottish Government and the NHS to ensure that the proposed arrangements are robust and practicable – but we continue to feel that the bill has a number of short-comings, which we would hope to resolve by working with the Scottish Government and Parliament.

2. There is a general consensus, within the context of public sector reform, that closer and better working practices between NHS Boards and local authorities are both necessary and desirable. However, a variety of views have been expressed within the local government family about how best to achieve this. Some believe that the proposed models of integration are appropriate and practicable; others feel that the Scottish Government’s proposals are too prescriptive and focus on structural change at the expense of outcomes; and others again believe that whatever the merits of the delivery arrangements, the proposals pay insufficient regard to important issues like the democratic accountability of the council. These matters – and others – are rehearsed in more detail below.

3. We also feel that it is important to make a distinction between the policy intention and the content of the bill. Whereas the policy intention is familiar in terms of the two primary models of integration (the body corporate model and the lead agency model), there are a number of new issues to consider in respect of the bill itself – some of which were not alluded to in the Scottish Government’s consultation process.

4. We have split our submission into three sections: an analysis of the bill and its implications for local government; commentary on the policy intention and the models of integration proposed; and an assessment of the financial and workforce implications.

Analysis of the Bill

5. Public services in Scotland face an unprecedented challenge: to improve outcomes for the people of Scotland and reduce inequalities at a time of increased demand, by ensuring the best use of increasingly limited resources.
6. Local government has invested significantly in arguing that effective and sustainable reform requires public agencies to be empowered to work together to improve lives across Scotland’s communities. We have also argued that Community Planning and Single Outcome Agreements are at the heart of this agenda. These views have gained considerable traction, and both the Christie Commission, and the Government’s response to it, have recognised the need to build on and strengthen those processes.

7. In considering the public service reform agenda more broadly, COSLA has expressed general support for an agenda that develops outcomes-based approaches; uses resources flexibly; promotes co-production, early intervention and prevention; facilitates service integration; and enhances local democratic scrutiny. These themes are all explored in detail in our recently published vision for local government.¹

8. The overall thrust of the Scottish Government proposals on health and social care integration would align with many of these general principles. COSLA would argue, however, that the proposals are at times too prescriptive and too detailed, and as a general rule there should be more flexibility at a local level to determine the shape and governance of the proposed partnership arrangements. We would also maintain that health and social care partnership arrangements should be subject to stronger-than-proposed local democratic oversight. The bill falls short in describing effective arrangements in support of these principles. In particular, we would highlight potential issues in relation to:

   - The ubiquity of Ministerial powers
   - The extent of Scottish Government oversight; and
   - Democratic accountability

Ubiquity of Ministerial Powers

9. COSLA does not agree to any Minister having powers of autonomy to make decisions which affect Local Authorities without consultation and agreement. We want to halt the erosion of local choice and discretion caused by the imposition of new duties from the centre, and assert a presumption against Ministers using or developing powers to act with regard to local government services.

10. To that end, we explicitly reject the provision within the Public Bodies (Joint Working) (Scotland) Bill where:

   Scottish Ministers may by regulations prescribe functions of local authorities that must, may or may not be delegated under an integration plan²

¹ www.cosla.gov.uk
² Part 1, Section 1, Subsection 6 (a)
11. This gives Scottish Ministers unshackled power to play around with local government services: it does not limit the scope of integration to adult social care (as is the policy intention – and as was the focus of the Scottish Government’s own consultation). The scope of the legislation means that the powers to make regulations extend to all local authority functions. It therefore establishes, without recourse to further primary legislation, Ministerial powers to require that any local authority function must be transferred to delegated arrangements (be those lead agency or joint board arrangements). While we would hope that the Parliament would remain true to the spirit of the bill in enacting any regulations in this area, the bill nonetheless opens up future risk in respect of other mainstream local authority services – like education or housing – being passed into delegated arrangements through regulations written by Scottish Ministers.

12. We have explored this matter in detail with Scottish Government officials, expressing a wish to see an amendment introduced at Stage 2 in the parliamentary process which would define the local government functions as adult social work or social care services alone. This would be consistent with the policy intention and consultation.

13. In addition to the scope of the bill being too broad, the use of Ministerial powers is further evidenced later in the bill, where

*The Scottish Ministers may by order make provision —*

(a) about the membership of integration joint boards,
(b) about the proceedings of integration joint boards,
(c) giving integration joint boards general powers (such as powers to contract, acquire or dispose of property or rights or borrow money or incur other liabilities) in connection with the carrying out of their functions,
(d) about the supply of services or facilities to integration joint boards by a local authority or Health Board,
(e) about any other matter relating to the establishment or operation of integration joint boards that the Scottish Ministers think fit

14. This invests too much authority in Scottish Ministers, at the expense of local partnerships. On the membership and proceedings of the integration joint boards, we would maintain that this is primarily a local matter – at the very most, these principles should be expressed in national guidance agreed with COSLA. We hold a strong belief that the parent bodies alone should identify who represents them on the integration board.

15. On the measures that allow Ministers to empower partnerships to establish fully incorporated integration authorities (with employment, contracting and borrowing powers etc.), we recognise the potential flexibility this could provide partnerships into the future. We are satisfied that the full incorporation of integration authorities (e.g. employment capabilities,

---

3 Part 1, Section 12, Subsection 1
borrowing powers etc.) is an option (should Ministers be agreeable to making provision), not a requirement, under the proposed legislation. However, the bill needs additional safeguards written into it: we want to ensure that a move to fully incorporate a partnership is only possible with the consent of the council and the Health Board.

16. The final clause (e) simply invests too great a degree of power in Scottish Ministers. We hold to a vision of democracy that is more decentralised – and which contains more checks on central government power.

17. Our final substantive point on the ubiquity of ministerial power relates to the shift towards outcomes based planning and service delivery. This represents one of the strengths of the integration agenda. The improvement of outcomes needs to be the methodological driver of change and the touchstone for assessing success. For this to work, the development of an outcomes based approach needs to be taken forward in partnership – both locally and nationally. However, we do not believe that the bill is faithful to this principle in that it gives Ministers the power to ‘prescribe’¹ these outcomes and defines local authorities as a mere consultee in the process of determining these. We think the bill should recognise local government as a democratic institution and reflect – as with Single Outcome Agreements – that the identification of outcomes should be agreed between the Scottish Government and Scottish local government.

The Extent of Scottish Government Oversight

18. As a democratic institution, COSLA believes that Scottish local government should be an equal partner to the Scottish Government – not a subsidiary. While we recognise the remit of government in developing national policy, we consider the accountability of councils to be first and foremost to the local electorate. Within this context, we feel that the Public Bodies (Joint Working) (Scotland) Bill is unnecessarily centralising in its content.

19. We are clear that the bill was intended as enabling legislation, which would empower local partnerships to overcome legislative barriers to establish fully integrated partnerships capable of managing the whole journey of care (from the community through primary healthcare to secondary healthcare). However, while the bill establishes the mechanisms that will allow partnerships to integrate services covering the whole journey of care, parts are written in a way that binds rather than enables.

20. For example, the bill states that the Local Authority and Health Board ‘must submit the integration plan to Scottish Ministers for approval’.⁵ Again, the bill invests authority in Scottish Ministers without fully explaining the criteria against which an integration plan will be judged. While we would acknowledge that the bill does not provide discretionary powers for

⁴ Part 1, Section 5, Subsection 1
⁵ Part 1, Section 7, Subsection 1
a Minister to instruct, for example, a partnership to include children’s services within its integration plan, we would hold that the relationship thus defined makes local government subservient to Scottish Ministers. The integration plan should ultimately be agreed by the two democratic institutions which are accountable to the electorate for performance against outcomes, namely, the Scottish Government (on behalf of the Health Board) and the Local Authority.

21. In addition, there are some instances of central government oversight being exerted in a way which is not sufficiently sensitive to partners’ roles and responsibilities, and goes beyond the scope that would normally be expected. For example, the Scottish Government has consistently indicated that the Jointly Accountable Officer (referred to as the ‘Chief Officer’ in the legislation) should report to the Chief Executive of the Health Board and Local Authority. While we do not object to this reporting relationship, it is slightly odd that primary legislation should involve itself in defining managerial relationships within organisations. What is more, the principle is expressed in legislation as: ‘the responsibilities of the Chief Officer are subject to the agreement of Scottish Ministers’. In our view, the term ‘responsibilities’ goes beyond the matter of the seniority of the JAO post. We believe that the responsibilities of the Chief Officer is rightly a matter for partnerships to determine.

22. There are further examples of the bill reaching too far in prescribing an approach to key processes which should designed by partnerships to suit local circumstances. A good example is around level of the direction on whom to consult over the integration plan and strategic plan respectively. In respect of the latter, the legislation goes beyond the principles of engagement for the strategic joint commissioning plan and outlines how the consultation and engagement process should be operated, and who should be involved. As such, we would like to see more limited expression of the principles on the face of the primary legislation, with more of the detail committed to secondary legislation and guidance. We think that this would give us more time to work on the content and would make the legislation less vulnerable to becoming outdated by changes in practice.

Democratic Accountability

23. The principle of delegation is at the heart of the Scottish Government’s plans to integrate adult health and social care services – whether to the body corporate or lead agency – and from there to the localities. This correctly requires us to invest a level of autonomy in the partnership board under the body corporate model.

24. However, as currently constructed, the bill establishes a situation whereby once the partnership is created through the integration plan (and the functions to be delegated are signed-off by the Local Authority, Health Board, and Scottish Government, along with the relevant budgets), the

6 Part 1, Section 10, Subsection 7
joint board then has the autonomy to make decisions on what its total budget is spent on without referring back to the parent bodies.

25. The key advantage to this arrangement is that it maximises unitary control over the integrated budget and the capacity to redesign services. It provides a commissioning capacity that extends to acute provision, primary care and social care and so optimises the ‘total resource’ that can be deployed and redeployed to improve outcomes. This is important because if we should integrate health and social care services only to find that we invest resources in line with historical spending patterns, then the exercise will have been a failure and a needless distraction. So the commissioning authority of the partnership board is important – but could be improved by stronger democratic oversight on the social care side.

26. The board will be autonomous from the council; it will not simply form part of the council’s committee structure. Similar to the issues that arose under the old police board structures, the elected members on the board will not be accountable to the council as such, only to the fulfilment of the board’s duties under the ‘integration plan’. While respecting the need to give the integration board some autonomy, we believe that the council committee structure has an important role to play in scrutinising the work of the integration authority and that the bill should make clear that there is an opportunity to connect the activity of the board to the broader council and indeed to the Community Planning Partnership.

27. While this would strengthen democratic oversight, additional measures should also be considered. For example, in respect of the major redesign of health services, the Cabinet Secretary reserves the right to ‘call-in’ decisions taken by Health Boards – and potentially overturn these. On the assumption that the Cabinet Secretary will not want to forego this power, we would maintain that there is a similar need for democratic oversight in respect of the redesign of social care services – and that the full council should have ‘call-in’ powers under these circumstances. For example, if the integration authority decided within its strategic plan to outsource care home provision, the decommissioning of in-house services and properties could represent a significant risk to the council. It seems appropriate that decisions of this magnitude should require the full democratic oversight of the council.

28. Finally, insofar as the primary democratic accountability of the council is to the electorate, local government is not performance managed by the Scottish Government – unlike the NHS. While we accept that the new partnership arrangements will require suitable performance management arrangements to be put in place that satisfy a number of parties, we are concerned about the ability of Scottish Ministers to prescribe in regulations the form and content of performance reports. If Ministers can identify content, they can identify priorities – and the priorities of the Scottish Government might not be shared by Scottish Local Authorities.

---

7 Part 1, Section 33, Subsection 3 (a)
For example, the HEAT system which is used to manage the NHS has traditionally focused on acute care, with a predominant focus on access and treatment times. Our worry is that this drives activity and resources towards the acute sector, which is the exact opposite of what we need to do in public policy terms.

**Analysis of the Policy Objectives**

29. The Scottish Government’s Policy Memorandum sets out the problems it seeks to resolve through the Public Bodies bill:

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

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

30. We would accept that the Scottish Government’s analysis of the challenges facing the health and social care system – particularly around the needs of older people - is broadly accurate. However, the size and nature of these challenges varies across Scotland.

31. What is more, while public services need to be able to respond to the growing number of older people inappropriately admitted to hospital, that is not all they will need to do. As such, we should be careful about defining a public policy problem too tightly, lest we beget a political or structural response that lacks the flexibility to engage with other complex challenges.

32. To cite a case in point: the report of the Commission on Public Service Reform was supportive of an agenda founded on the principles of coproduction, assets-based approaches to health improvement and early intervention. It is important that any new partnership arrangements not only allow for these principles to be built in, but are actually founded on them. In doing so, we should position partnerships to look not just at seamless service delivery for adults with health and social care needs - but to make inroads into appalling levels of health inequalities and integrate the public health function into partnership activity. Our starting point should be to engender the preconditions of good health.

33. We also need to be careful not to assume the same set of problems exist for all population groups. The proposals will require that services for adults as well as older people should be integrated. However, we need to be mindful that the interface issues can be slightly different for the adult
populations. For instance, for people experiencing mental ill-health or who have a learning disability, the interface with employment service and welfare advice is crucial. Or for people with drug or alcohol addictions, oftentimes a complex relationship exists within the family unit, and interface issues here are as focused as much on the criminal justice system, or the housing system, as any relationship between community care and acute hospital provision. Or again, in respect of children’s services, the connection to the education system is particularly important. We make these points to illustrate that it is not just the interface between health and social care which is at stake in these reforms. One of the reasons that public service reform is challenging is that whatever organisational boundaries exist, interface issues will continue to require management.

34. Finally, and contrary to much of the rhetoric expressed on the relationship between Scottish Local Government and NHS Scotland, COSLA would hold that the last ten years has witnessed the steady improvement of partnership working at both local and national levels. Beginning with large scale hospital closure programmes for people with disabilities, through to the position today, we would maintain that it is possible to trace steady improvement in the quality of partnership working and – importantly – the quality and cohesion of service delivery. That is not to say that we have achieved as much as we can; and it is clear that some partners have experienced significant strain on their relationship across this timespan – but we are building from a position of strength and that should be acknowledged.

Strengths of the Policy Framework

35. While there are a number of elements to the Government’s proposals with which we disagree, it does not alter our general view that the integration of health and social care should form a corner-stone of the public service reform agenda.

36. The Scottish Government’s policy proposals have a number of commendable features. In the first instance, they support outcomes-based service planning. One of the key factors that has shaped progress towards a shared set of over-arching outcomes has been an emerging consensus on public policy. This has been most recently expressed in the high level outcomes crafted in support of the integration agenda: we want people with disabilities, long term conditions or who become frail in their old age to live as safely and independently as possible in the community, and have control over their care and support. However, the simplicity of this idea sometimes gets lost amidst the difficult task of managing large bureaucracies like NHS Boards or councils, and under the pressure of significant financial constraints and different performance arrangements, too often organisational behaviours have driven activity in different directions.
37. COSLA acknowledges therefore, that a single set of agreed national outcomes to drive activity and performance has the potential to further improve the partnership agenda. We will want to make sure that outcomes reflect the priorities of local government, the NHS, Scottish Government, and our partners in the third and independent sectors, and achieve a strong strategic fit with SOAs. The outcomes should be agreed politically between the Scottish Government and COSLA.

38. However, even with nationally agreed outcomes driving performance, there remains the potential for performance management systems to drive activity in different directions. The NHS in Scotland is performance managed by the Scottish Government, with a high degree of prescription on target setting and performance monitoring – often on access and treatment times - coupled with centre-facing reporting arrangements. Councils, however, are performance managed through democratic scrutiny by local elected members, with locally-agreed targets and performance monitoring systems, coupled with community-facing reporting through duties on public performance reporting. We think that further alignment work needs to be undertaken in this area to ensure that the system becomes truly cohesive – and that targets and ambitions are measured against the outcomes experienced by citizens.

39. The second main strength of the Government’s proposal is in the prominence given to whole-system commissioning. The proposed arrangements recognise the commissioning agenda of the integrated partnership – based on the ‘total resource’ of the partnership - as the bedrock of integration and service redesign:

   *The ability to look at overall expenditure for defined populations and user groups, and to use budgets flexibly, is a hallmark of integrated care. This is important, both to enable efficient allocation of resources and also to ensure that needs are met in the most appropriate and cost-effective way.*

40. We agree with the Scottish Government’s proposal that partnerships should be required to develop a strategic joint commissioning plan for all adult health and social care services. The commissioning process will normally involve: assessing and forecasting population need; planning the range, type and quality of services and support mechanisms that need to be put in place to meet to those population needs; putting in place arrangements to deliver or procure these services and support mechanisms; and reviewing the process by establishing whether objectives have been met.

41. The reason that commissioning is important is that it links service delivery to population need. It also facilitates change and service redesign and the twin challenges of demographic change and diminishing public finance suggest that radical change is required. Good commissioning challenges conservative practice and acceptance of historical spending patterns. It

---

8 Policy Memorandum, paragraph 102
requires flexibility of resource to make different investment decisions. Simply put, it is the means by which partnerships can focus on delivering more upstream investment in community-based services and disinvest in institutional care.

42. For this reason, **it is absolutely vital that acute budgets form part of the integrated resource.** While we recognise the technical challenges associated with this proposition, to leave acute resources outside of the commissioning budget would render the integration agenda relatively impotent. **The Scottish Government should define the minimum contribution of the acute sector to the integrated budget.** While this requires further thought and discussion, if we are seriously committed to ‘making the resource follow the person’ then we should focus our energies on redesigning the emergency care pathway, which in turn would commit a range of acute and other inpatient resources including: front door (accident and emergency), general medicine and receiving services, and those specialisms which are mainly emergency-driven.

43. Whatever slice of acute resource is eventually committed to the integrated budget, it needs to be substantial. This is supported by the following statistics:

- Total spend on health and social care for people aged 75+ on 2010/11 was £3.1bn, of which 64% was spent on institutional care - hospitals and care homes;
- 44% of total occupied bed days (for people of all ages) was accounted for by people aged 75+
- 90% of occupied bed days for people aged 75+ were the result of unplanned admission to hospital
- 70% of all hospital expenditure on people aged 75+ is unplanned

44. Given this pattern of acute care consumption, a strong and effective commissioning plan based on an ambitious description of the ‘total resource’ will be necessary to combat the twin pressures of demographic change and diminishing public finance. Commissioning plans should establish how the balance of care will shift over time, as partners seek to move away from reliance on institutional care facilities such as hospitals or care homes.

45. The final main strength that we would like to acknowledge is around locality planning. Research from the Improvement Service has demonstrated that there can be considerable variation within local authority boundaries in terms of the distribution of outcomes – sometimes down to neighbourhood level. That would suggest that work undertaken with communities to improve health and well-being outcomes needs to be highly tailored to the circumstances of those localities – and that the professionals working in localities need to be empowered to work with communities to develop new mechanisms of support and service options. It will be important that localities – however defined – are
natural communities and that engagement structures are put in place within a community planning context.

Weaknesses of the Policy Framework

46. One of the central challenges associated with the proposals is in respect of bringing together the governance arrangements of two organisations – Councils and Health Boards - which have completely distinct DNA. We recognise the difficulty of the task presented to Government in this regard.

47. We have already touched – at paragraphs 26 and 27 – on how local democratic oversight could be improved. However, we also want to ensure that elected member input is maximised within the context of the Partnership Board.

48. The Scottish Government’s original proposal was to impose a limit of three elected members for each Partnership Board – partly because of the relative scarcity of NHS Non-executive Directors to form an equal number of NHS representatives. However, that proposal would undoubtedly have created a democratic deficit for some of our larger councils. Under these proposals, we could have seen as little as 4% of the elected membership overseeing 30% of the council budget. COSLA maintains that the public would want stronger local accountability than that and we are pleased that the Scottish Government has continued to work with us on this and related matters.

49. We think therefore that the Scottish Government would need to give very careful thought to applying a nationally prescribed maximum number of elected members. While we recognise that the Board needs to be able to operate effectively and come to decisions, this needs to be balanced against the need for a sufficient number of citizens’ elected representatives to be accountable for the decisions of the Board. We therefore invite the Health and Sport Committee to reflect on the important role that elected members should play on the proposed Partnership Boards.

50. On a related matter, we agree with the position of the Cabinet Secretary when he indicated to the Parliament on the 7th March that “it would not be right to have the executives of the health board as members of the board of the partnership’ and that Health Boards need to ensure ‘that the places on the committee are taken not just by non-executive directors but by patient representatives”. We fully endorse the Cabinet Secretary’s view on this matter; having officials fulfil a governance role in our view blurs the line of accountability.

51. The second main issue that some of our members were dissatisfied about was in respect of the limited number of delivery models which could be used to integrate service delivery (the lead agency model and the body

b_71090
corporate model). There has been limited interest in the lead agency model from within our membership, despite the profile of the work undertaken by the Highland Partnership; and a number of our member councils were unconvinced by the merits of the body corporate model, with the role of the Jointly Accountable Officer in particular being singled-out as problematic. It is worth going into more detail about the two models in question:

**Body Corporate Model**

52. The merits and demerits of this model were debated extensively within the local government family, without reaching a consensus. Some councils already successfully operate a similar structure, where jointly-appointed Directors oversee the activity of the Health and Social Care Partnership. We would highlight in this regard the experiences of West Lothian, East Renfrewshire and others, who can evidence tightly configured integrated arrangements that are capable of producing good population outcomes.

53. Against that, there were many who were concerned about the body corporate model in general and the role of the Jointly Accountable Officer in particular. There is a perceived challenge around the power, budget and authority invested in the JAO role, particularly for large councils – indeed, the body corporate could hold a budget greater than either parent organisation. Some argued, therefore, that given the scale and nature of the budgetary authority, the lines of accountability are not sufficiently strong: the Partnership Board doesn’t carry the same authority or capacity to scrutinise that the parent bodies do.

54. A second perceived challenge was that the body corporate model threatens integrated social work services – inasmuch as it has the potential to separate adult care from children’s services. This was deemed to be of particular importance for those councils with significant levels of deprivation, large numbers of looked after children; and a high prevalence of drug and alcohol misuse; violence and crime; and health inequalities. While it is, of course, open to councils to bring all social work services into the integrated partnership, it was felt that this would create barriers with other important services (such as education); and it would make the budgetary problem even more pronounced by giving the JAO an even larger operational resource to manage.

**Lead Agency Model**

55. COSLA believes that the Lead Agency model described in the consultation document, and in particular the specific arrangements being implemented by the Highland Partnership, represent a key step in the formation of more outcome focused and integrated service delivery models. We are keen to ensure that any gains made by the Highland Partnership are appropriately profiled across both children’s service and adult care, and would support any of our member councils who chose to adopt similar approaches.
56. At the same time, in survey work carried out by COSLA, very few of our member councils indicated that the Lead Agency model was being considered locally. Some councils may wish to explore the use of this model for key services (e.g. mental health) but few indicated that they would take on the population-based approach adopted by the Highland Partnership.

57. We also believe that the lead agency model has untapped potential. First, we think it would be interesting for partnerships to consider the delegation of appropriate public health services from the NHS Board to the Council. There are already examples of NHS Boards and councils adopting an integrated approach to public health and we therefore believe that the mechanisms laid down in legislation should open up the possibility of lead agency arrangements being devised for public health. This may allow for a more focussed approach to tackling health inequalities – and link-in with related council-run service like environmental health and the ‘place-making’ function of councils.

58. Secondly, in coming to an overall view about the means by which health and social care services can be integrated, we looked into the models of health and care delivery that exist in northern European countries like Denmark and Norway. In Denmark, for example, the 98 local municipalities are responsible for all domiciliary personal and domestic help, home nursing, supported housing, nursing homes, and public health care. In other words, local government delivers both the community healthcare function and public health function (which in Scotland currently resides with the NHS). Given that quality of life and healthy life expectancy in Denmark are high, we explored whether such arrangements could be put in place in Scotland (recognising that superior outcomes cannot be attributed to the basic Danish delivery structure on its own - other variables such as public sector investment also play in). We came to the conclusion that the most practical way to secure these arrangements in Scotland would be through the Lead Agency model.

59. We have outlined this possibility not because we think it should be commended to partnerships above other delivery arrangements – only to demonstrate that based on international evidence there are a number of models that are capable of improving population outcomes.

Analysis of the Financial Implications

60. In giving thought to the financial implications of the bill, three broad areas need to be considered: the potential of integrated arrangements to deliver efficiency savings; the mechanics of operating integrated budgets in pursuit of those objectives; and the additional cost to public authorities as a result of the bill.

Potential Efficiency Savings

61. A common definition of an efficiency saving is doing more for the same resource or doing the same with less resource. The financial memorandum
makes clear that in respect of health and social care integration, the objective is to do more with the same:

potential efficiencies should be considered in the context of the scale of the projected increase in expenditure attributable to demographic change… and will need to be reinvested within the partnerships in order to help meet demand.\textsuperscript{10}

62. This is because our ageing population is predicted to increase demand for health and social care services by between 18.4% and 28.7% between 2010 and 2030.\textsuperscript{11} This equates to a potential funding gap in the order of £2.5billion against current levels of investment. So the context for developing integrated services is not about being able to reduce public expenditure on health and social care – no serious commentator thinks that is advisable; rather, it is about doing more (i.e. dealing with increasing demand) within existing resources to improve outcomes.

63. Even then, the financial memorandum presents something of a conundrum. The main areas it identifies which are capable of using resources more efficiently are in respect of delayed discharge; anticipatory care; and reducing per capita cost variation. However, all of these efficiencies are contingent on being able to reallocate resources currently tied up in institutional settings. Delayed discharge efficiencies can be achieved by ‘reallocating expenditure from hospital to community based health and social care’;\textsuperscript{12} anticipatory care plans could result in lowering emergency admissions ‘if alternative care options were available to local care professionals, patients and carers’; and reducing per capita variation – which depends on reducing consumption of health and care resources to the average cost per head for the partnerships – will likewise depend on alternative care pathways being available.

64. COSLA wholeheartedly agrees with the need to shift the balance of care. However, some would argue that the impact of increasing demand has not been fully factored into the Scottish Government’s analysis. Our colleagues in NHS Scotland continue to believe that a more efficient health and care system will be able to stifle demand for secondary care – but not reduce it below current levels. If that supposition is accurate, then we will be unable to make the cash-releasing savings from the acute sector in order to invest upstream in community based alternatives; and if we cannot invest in community based alternatives, we will not be able to stifle demand for acute care. In other words, there is a very real risk of a vicious cycle emerging over the next few years in circumstances of flat or limited growth in public expenditure.

65. However, if we are simply using the NHS acute sector inefficiently, and there is a capacity to disinvest, then a different set of challenges emerge, which are more political in nature: we are going to have to close services.

\textsuperscript{10} Financial Memorandum, paragraph 34
\textsuperscript{11} Financial Memorandum, paragraph 18
\textsuperscript{12} Financial Memorandum, paragraph 27
Now this may be the right thing to do – it may improve outcomes and deliver higher quality care – but we can anticipate these being highly unpopular decisions. We need to be able to inhabit this new landscape – and bring the public with us.

66. Even then, however, we are calling on the Scottish Government and Parliament to resolve the longer-term funding challenges associated with the cost of health and social care to the public purse in Scotland. We are confident that the pressures building on the health and care system over the next twenty years cannot be met by better integrated services alone: the integration of health and social care is necessary but ultimately insufficient as a means of eliminating the £2.5billion funding gap that is likely to emerge.

The Mechanics of Integrated Budgets

67. COSLA agrees that a fully integrated budget – and the use of the ‘total resource’ - is necessary to give effect to integrated service planning and commissioning in pursuit of a common set of outcomes. However, there are a number of operational challenges which flow from the delegation of resources.

68. The policy memorandum sets out three main risks to Local Authorities and Health Boards as a result of operating an integrated budget:

- Budget setting;
- In-year financial performance management; and
- Management of acute sector provision.

69. Taking these matters in turn, there are a range of practical considerations that require some thought. For example, in delegating a budget to another party (whether the Health Board or a body corporate), the local authority would need to be assured that the duties of the Section 95 Officer can still be adequately performed.

70. In addition, the actual budget-setting process will need to be further considered. It will be important that the management of efficiencies/uplifts is agreed by both parent bodies and takes into account of the broader Scottish Government settlement and inflationary/demand pressures before coming to an agreement. It will be also be necessary to synchronise the formal budget setting timelines between councils and Health Boards.

71. For Health Boards with more than one local authority in their area, budgets will need to be discerned for each partnership area, and tensions may emerge as we move from historical spending patterns to weighted capitation. It is vital that the delegated budget from both parent organisations is completely transparent.

72. In terms of in-year financial management, the potential for cross-subsidising activity would be heavily proscribed for both councils and NHS
Boards (both councils and NHS Boards currently use cross-subsidisation as a tool to manage pressures) and this would require greater levels of discipline in spending – and, importantly, solutions to be developed for the management of over-spend. While this is clearly a job for partnerships locally, it is arguably too simplistic to suggest that overspend in social care budget lines becomes a council problem or overspend on prescribing an NHS problem.

73. Finally, on the stability of the acute sector, our NHS colleagues are concerned about their ability to manage District General Hospitals which serve a regional population base (across several local authority areas). The route of this concern would seem to be in the requirement to distribute a significant part of the acute hospital resource to the body corporate, which will then ‘commission’ the level of acute care that reflects population need. Were some of those partnerships to identify a different usage pattern in respect of the consumption of acute resource, it is argued that this could leave these institutions having to build a budget from several different sources without an over-arching strategic plan for usage. What is more, there is concern about what happens in the event that the commissioning partnership uses more acute resource than it had intended to under the joint commissioning plan.

74. We recognise that the scenario of a single Health Board with an irregular spread of District General Hospitals spread across a number of Local Authorities (the most common position in Scotland) is a particular challenging environment in which to progress the integration agenda and does not come without operational risk to the acute sector. However, it would be wrong to insulate the NHS acute budget from partnerships’ commissioning objectives and therefore we need to develop solutions that are capable of managing that risk. For example, there will need to be a supra-partnership agenda around the strategic development of the acute sector within and between Health Boards. We would suggest that this supra-partnership agenda is linked to individual Partnership Agreements. We also need to develop analytical capacities to map cost and activity data across health and social care partnerships. The Integrated Resource Framework pilots are instructive in this regard but now need to be rolled out to ensure that all partnerships have the requisite ability to examine cost and activity within the system.

75. In light of all of the technical challenges set out above, COSLA believes that National Guidance will be required to assist in the delegation of budgets to partnership level.

76. In addition to the issues set out in the policy and financial memorandum, COSLA has worked with local authority Directors of Finance and we would want to draw the Committee’s attention to a number of additional technical issues which are subject to on-going work with the Scottish Government:

- Accounting treatment and VAT
- Financial recording and reporting
Financial controls, assurance and risk
Financial planning, financial performance management and finance function
Capital and assets

77. 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.

Costs of the Bill

78. In general terms, we welcome the Scottish Government’s commitment to funding one-off implementation costs of around £16.3 million, but we are disappointed that there is no funding commitment to the recurring costs for health boards and local authorities arising from the Bill.

79. Having consulted with Local Authority Directors of Finance, we would offer the following observations on the costs of implementing the bill:

- We anticipate that there will be an increased audit burden on statutory partners and therefore the stated additional cost of £150k across Scotland seems too low. The financial recording and reporting costs are likely to increase, irrespective of the integration model adopted;
- We are unsure that funding for the Chief Officer can be met from the current CHP General Managers’ salary.
- We are also disappointed to note that financial provision is being made to the NHS for CHP leadership post-holders who are displaced as a result of the development of partnerships, yet no similar resources, either recurring or non-recurring, are being made available to local authorities.
- We think that other management costs could emerge 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 has been identified for the health sector only;
- It is unclear whether any assumptions have been made around remuneration for Board Members;
- The assumption that support services for the joint boards can be funded from existing CHP support services is unrealistic; not all CHPs currently have the full range of support services that will be required in the new Partnerships.
- Section 45 talks about extension of schemes for meeting losses and liabilities for health service bodies. We have a concern that this will allow NHS to carry reserves from one year to another.
- The Financial Memorandum correctly identifies the risks to VAT recovery and staff pay and conditions harmonisation, and estimates their potential annual costs at up to £32m and up to £27m respectively. We are concerned that the Financial Memorandum does not commit the Scottish Government to fund these pressures should they occur in future.
- Should staff transfer be required, we believe that the TUPE implications are significant and potential financial solutions may not meet TUPE regulations.

**Analysis of the Workforce Implications**

80. A good understanding of the importance of an integrated workforce has been built up over the past decade, particularly - but not exclusively - from the experience of CHCPs. The development of a properly integrated and skilled workforce will continue to be a key factor in ensuring high quality outcomes for service users and carers.

81. Successfully integrated partnerships will need to span different organisational cultures to embed effectively-coordinated teams of professionals working within health and social care settings. Many partnerships have a pre-existing or developing culture of multi-disciplinary working which is based on effective communication, trusted referral processes and a shared professional ethos. However, more work needs to be done to ensure that we fully harness the potential of integrated teams, and to identify and overcome any technical obstacles. For example, despite the successes of the last decade, single assessment processes and the advantages of co-location have not yet been fully realised. Investment in leadership capacity will be needed in order to drive forward cultural change.

82. Recognising and managing the distinctive models of Employee Relations (ER) across local government and NHS Scotland will also be an important factor in developing harmonious delivery models. Following the introduction of Agenda For Change, organisational development in the NHS Boards is progressed through local partnership agreements with the trade unions, while the broader ER framework remains heavily centralised, as expressed through the national partnership model for the NHS in Scotland and UK-wide negotiations on terms and conditions. By contrast, within local government, each council is an individual employer and the bulk of terms and conditions of employment and staff policies are developed locally in conjunction with relevant trade unions – albeit that pay tends to be negotiated nationally between COSLA and the trade unions. Collaborative work will therefore need to be undertaken to assess how the ER frameworks should adapt to the new integrated partnership arrangements. There will also be implications for the way in which trade unions work between themselves and across sectors.
83. Given the potential variance in pay and conditions for comparable posts across local authorities and the NHS, we are currently exploring with our professional associations whether this is likely to represent an equal pay risk. Given the challenges associated with equal pay, we would hope that the Scottish Government could commit to underwrite the costs of any successful equal pay claims which flow directly from the integration of health and social care.

84. Other technical challenges present themselves in respect the secondment arrangements to the integrated partnership and in the flexibility for staff to transfer between the two parent bodies.

85. Different terms and conditions also have the potential to lead to tensions in how health and social care partnerships manage and deploy their resources, particularly in relation to how councils and health boards work to prioritise front-line delivery. We would suggest that while councils may have greater local flexibility to re-shape or re-size their workforce, both organisations must develop and commit to an organisational development strategy for Health and Social Care Partnerships. This is hugely important, because if we are to shift the balance of care, it follows that local partnerships will need the tools to flex and redeploy the staffing resource over time.

86. We have profiled these workforce challenges not because we think they are impediments to change — but we do think that they will need to be addressed if we are to move to optimal integrated arrangements.

COSLA
Public Bodies (Joint Working) (Scotland) Bill

Aberdeenshire Council

Background

Aberdeenshire Council is pleased to submit written evidence on the above Bill to the committee.

Our response to the 6 prescribed questions are detailed below.

Do you agree with the general principles of the Bill and its provisions?

We recognise and support the general principles of the Bill and its provisions, however we have concerns over a number of important detailed elements of the Bill.

These are:

- The nature of the Bill is more prescriptive than we anticipated and is very mechanistic about the steps expected to be taken by Local Authorities and NHS Boards to achieve integrated services. We must ensure that we do not lose sight of the outcomes which will guide the work we need to do to improve frontline functions and activities for people who need them.
- The scope of integration and the fact that Scottish Ministers, without consultation or agreement with local authorities, will have powers, without recourse to primary legislation to extend integration to any function within the local authority.
- The power to further empower integration boards, again without recourse to primary legislation, which would give Ministers the power to establish new public bodies capable of holding a budget, employing staff, borrowing money and acquiring property.
- The balance of power, which seems to have moved from an equal partnership between Scottish Ministers and Local Authorities, to a sense that Scottish Ministers having the ultimate authority over the partnerships.
- Partnership autonomy seems to have increased in respect of the Strategic Plans not being subject to the agreement of the parent bodies, and thus the respective power of Councils and Health Boards are diminished, with an additional omission of the importance of community planning in these arrangements.
- Being too prescriptive of local approaches in respect of engagement.
- A sense that the Bill conveys a general sense of inequality between Scottish Ministers and the democratic sovereignty of elected members.
- Given the diversity of arrangements across health board and local authorities it is recognised that assessing the financial implication of the Bill is likely to have been challenging. The provision of information on the underlying assumptions, while certain aspects are challenged below, is helpful in understanding the initial assessment of additional
costs. The diversity of current arrangements will make distribution of any additional funds across Partnerships complex.

- focus of the financial memorandum is on the additional recurring and non-recurring costs likely to be incurred by health, with an incorrect underlying assumption that all additional local authority costs can be met from within existing resources.
- it is clear that there will be challenges in shifting resources from acute to prevention with the significance of any savings from the development of the Health and Social Care Partnership likely to be lost in the wider demographic challenge.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

Whilst Aberdeenshire Council is committed to further integration of health and care services it has never believed that legislation and inevitable structural change was necessarily the way to achieve it. There is some concern in these challenging times that attention will be diverted away from integrating frontline functions and activities to setting up new legal entities and the undoubted associated work load.

However, Aberdeenshire Council with its partners wishes to use the legislative intent to progress integration to deliver improved outcomes for its citizens and believes it can use the legislation constructively for that purpose.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

The following we would consider to be the key strengths:

- focussing on improved health and wellbeing outcomes for all adult citizens as a minimum.
- utilising all parties in improving outcomes, that is partnership working beyond the statutory agencies including natural communities and citizens
- professionally led locality planning especially addressing inequalities with some delegation of commissioning powers to localities
- ensuring best use of available facilities, people and resources

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

- we believe that giving these new partnerships the authority to commission acute services would drive forward improved outcomes through further shifting the balance of care, including a minimum budget contribution by the acute sector to the new partnership.
- the full Council should have call-in powers as well as Scottish Ministers.
At this time we believe most key areas have been addressed, and appreciate that much will be in the guidance and regulations.

**What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

At this early stage we are not certain, as there is no evidence of integration delivering recordable efficiencies.

However, against the three pressures of rising need, reducing budgets and demographic changes it is hoped that some of the benefits will build on current improvement activity and our desire to achieve our aspirations. Even though some of the financial impact of these pressures will be defrayed by imaginative approaches to supporting people, there remains a major funding gap that will require to be met.

Essential is intensive leadership development and this has already started in Aberdeenshire with Councillors and Health Board members and through tiers of officers.

In particular we are expecting to improve care pathways, improving the recipients experience being a central tenet; focus on strengthening staff relationships to achieve better joint working with reduced numbers of assessments and care plans; utilise integrated budgets more flexibly, making better use of all aspects of infrastructure, especially shared facilities and IT systems and consider integration of support functions.

We also intend to strengthen the role of localities particularly in terms of empowered professional staff engaging with communities to progress the preventative and early intervention agendas and increase targeted resources to address inequalities.

**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

Aberdeenshire Council always strives to deliver the best outcomes for its citizens, so it intends to use its integration plans to ensure that the new arrangements are designed to meet these aspirations.

*Aberdeenshire Council*

*15 August 2013*
Public Bodies (Joint Working) (Scotland) Bill: Stage 1

09:48

The Convener: Agenda item 3 is on the Public Bodies (Joint Working) (Scotland) Bill. We continue our evidence taking at stage 1. Our first panel today consists of academic experts. I welcome Andrew Eccles from the Glasgow school of social work and Professor Alison Petch, who is director of the Institute for Research and Innovation in Social Services. Do you wish to make any introductory remarks or comments?

Andrew Eccles (Glasgow School of Social Work): No.

Alison Petch (Institute for Research and Innovation in Social Services): I am happy to move to questions.

The Convener: Fine—that is good. Nanette Milne has the committee’s first question.

Nanette Milne (North East Scotland) (Con): My question is initially for Mr Eccles, but if Professor Petch wants to say anything later, that is fine. You have had an interest in the role of interprofessional working in health and social care. I wonder if you would wish to make any comment on how important you view that to be with regard to securing the proposed legislation.

Andrew Eccles: First, it is very important to have interprofessional working. A lot of it goes on already, in a variety of forms. I have a concern about using a sledgehammer to crack a nut as regards organisational and major structural reform, and we should recognise that interprofessional working takes place in a variety of ways in different localities. It is absolutely crucial, and I do not think that anyone in the room would think otherwise. It is a question of how best to do things and how to learn from the experience of what has been attempted over the past decade or so.

Nanette Milne: I, too, am interested. I have a health background myself, and I am well aware that there can be issues between health professionals and social work professionals. For integration to work properly as far as the culture is concerned, they have to amalgamate.

Andrew Eccles: I agree with you. It is worth bearing in mind that there are also historical tensions between different health professionals: between acute and primary, and between allied health professionals and other practitioners. My experience, having done quite a bit of research on the front line with practitioners, indicates that the process is complex and uneven. I have worked with teams where the relationship between health and social work was, frankly, excellent but there were real tensions between different aspects of health on the same team. We could try to reduce the issue to divisions across different professions, but it can sometimes be a good deal more complex.

Nanette Milne: Has your research revealed any particular reasons for that? Is it down to personalities and local circumstances?

Andrew Eccles: It can be down to personalities. Some reasons that emerge involve other agendas that exist at the same time. When I was doing research some years ago, there was the whole agenda for change within the healthcare system, which preoccupied a lot of people. There was a sense in which people were being pulled in different directions at the same time with regard to where they might put their energies. That would be a long-standing issue with any form of organisational, structural or whatever change in interprofessional working. The context and the other agendas that might be around are pretty important for getting proposals to work.

There is a classic issue around value bases between social work and health. The British Medical Association’s submission to your committee last year raised a point about value bases, medical models and social models. Those are old arguments and it is not an insurmountable issue. One of the key issues is people being able to belong to organisations that are genuinely learning organisations, as opposed to training organisations.

When I look at the proposed legislation and consider organisational issues or issues of procedure, I think that the key issue, again, will be one of working cultures. It will be about spending time and effort getting people to understand where another is coming from and developing trust, which is key. That will be more important than organisational or procedural shifts.

Nanette Milne: Are you saying that that cannot be legislated for, or do you think that the bill will be effective in bringing it about?

Andrew Eccles: A recognition of the fact that the process is not easy is required—it requires time and space. If I mention resources, I mean not necessarily just money. For example, quite a bit of the teaching that I do is with social work managers and health managers. One of the things that becomes very apparent with their organisations is the lack of space. With the best will in the world, front-line practice takes up most of people’s time. The space to be a learning organisation is often at something of a premium.

Nanette Milne: Even with new legislation, presumably you foresee the process as being an evolutionary one.
Andrew Eccles: Yes. I do not think that the bill will guarantee; it would be folly to imagine that. More subtle and complex engagement with some of the issues is required, as is well rehearsed in the literature.

Alison Petch: I endorse a lot of what Andrew Eccles has said. There are some very good examples of the traditional barriers melting away when teams work together at the front line. However, we should not underestimate the large amount of ignorance among different professional groups about what their future partners do.

Increasing people’s knowledge and understanding will address some of that, but we also have a challenge because, in times of uncertainty and change, people tend to scuttle back to their tribes, as it were. We 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.

The Convener: We have focused on the transition a lot, as do the submissions. If the new workforce is to develop and if more and more care is to be delivered in the community, what do we need to do in the long term to ensure that the new workforce grows, works and learns in the community rather than in acute or other traditional settings? A big shift is being made. What do we need to do now to make that permanent and to go beyond the transition?

Alison Petch: It is important to separate out each group’s unique skills and to determine where much more flexible overlap can occur at the boundaries. We have tended to have distinct professions.

We have talked for years about avoiding having four, five or six different professionals moving into someone’s home. To focus on the individual and the support that they need, we need to be clear about when more overlapping and more development of generic working can occur and when a distinct professional identity is needed, as for some distinct procedures.

We need to reshape the workforce and to ensure commonality in the workforce in focusing on the individual. We tend to have all sorts of disjunctures between the hospital, the community and professional groups in the community. That often gets in the way of the delivery that is needed.

Nanette Milne: Does the bill do enough to bring together all the relevant groups, particularly locally? How do you see the leadership that will be needed to make the bill work?

Alison Petch: You have put your finger on it. The bill per se will not make any of what is proposed happen. I hope that the fact that the bill is here will raise the profile and that the requirements will ensure a focus on trying to get the approach right, but it is not the bill that will deliver—that will come from leadership and having a vision of why on earth we are doing this. We are not moving chess pieces round the board; we are trying to facilitate the best delivery mechanisms.

I am absolutely certain that we must not get bogged down in the architecture and mechanisms. Although it is challenging, we must try to infect everyone with the enthusiasm for and vision of what the approach can do to give people a decent quality of life. We must identify the shared, communal leadership that I hope will move that forward.

Andrew Eccles: I agree entirely with Alison Petch about leadership, which has been inconsistent in the past decade. It is clear from doing research that some people have bought into the approach much more than others; some people regarded it as a process that they had to follow, whereas others were much more enthusiastic. The evidence of that is clear in different areas.

I agree with Alison Petch about generic working, but there are substantial areas in which social workers and people in the health service, for example, do fundamentally different things. People need to feel that their professional skills will not be impinged on. It was interesting that some people regarded even quite small shifts in their working patterns in respect of assessment, for example, as deskilling, whereas other people saw that as reskilling. There was no common denominator; it was a pretty sensitive issue.

It is probably more a question of not having people thinking that they are going to end up as generic workers. However, there is a gap or space in which we can do things in a more generic way while holding together what I think are quite important value bases that exist in health and social care.

10:00

Rhoda Grant: Both of you seem to be telling us that, although the bill will not hamper the process, it will not make it happen.

Andrew Eccles: I do not think that, axiomatically, the bill will make it happen. Some of that view is based on what I see as the merits of the bill, which suggests that there be—to use an overused phrase—some local ownership. Such an approach is useful and welcome, because people do things in different ways and there might be particular circumstances in different areas of Scotland where people want to do things differently.
However, although that is perfectly commendable and although the bill puts down a marker, the proposals with regard to structures, organisations, procedures and the ultimate outcomes will not in themselves shift the situation. Instead, leadership must buy into the process to a much larger extent.

Rhoda Grant: Will anything in the bill as drafted prevent the process from happening? For example, I believe that you said that things were a bit too top-down.

Andrew Eccles: I would advise caution about outcome measures. A wealth of literature and some very fine work on this matter—Toby Lowe from the University of Newcastle is particularly good on it—suggest that the use of such measures can be counterproductive, because people will seek to meet the outcomes and, if you like, measure the measurable, with the possibility that some interesting experimental work or different ways of working at a local level might start to get stifled. That has the potential to be problematic unless there is greater clarity about or better specification of the outcomes.

Alison Petch: The word “outcomes” has very much become the buzzword of the moment, but we need to be clear about what we mean by it and whether we are talking about outcomes for the individual or for communities, or of a particular policy. As far as integration is concerned, we must remember that, as well as the proposed national health and social care integration outcomes, which I think are pretty much going in the right direction with their emphasis on the individual, we have 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.

Over the past five or 10 years, there have been real developments in attempts to focus on outcome-based assessment and delivery with the introduction of self-directed support. Indeed, going back to the previous question about the workforce, we need to remember that that major initiative will overlay all of this.

As a result, when we talk about outcomes, we have to be clear about what we mean. If we are not, the danger is that we start to live in a land where everyone speaks the words without necessarily meaning the same thing.

Rhoda Grant: The challenge is that we know that there is an issue, because constituents and front-line workers, who are more often told what they cannot do rather than what they can do, have said so. If the outcome—or, if you like, the desired effect—is that people can live at home, healthier and more supported, and do not come to complain to us, how do we deliver what will amount to a cultural change? After all, we have been talking about the issue for years, but it seems that little has changed. How do we as politicians effect that change and make it happen?

Alison Petch: Perhaps I am just an eternal optimist, but I think that there has been quite a lot of movement on that over the past five or 10 years as a result of the joint improvement team’s work around personal outcomes and the talking points approach. I have to declare an interest, as some of my colleagues were involved in that work. At IRISS, we do quite a lot of work with local partnerships on the delivery of outcomes. The change will not happen overnight—none of these things will happen overnight—but there has been a shift from 20 years ago, when outcomes were never the focus. It is just about the pace of change.

To go back to your initial question about what the bill can do, for me, the most important aspect of the bill is that it states the integration principles, because those are good principles. The danger is that they get lost in all the discussion about different arrangements, the production of plans and who will be the chief officer. I do not know whether there is an opportunity to strengthen those principles, because I know that what can be done in legislation is limited. However, it is important to get across to people that it is not only about the mechanics but about trying to deliver on the key principles that are outlined in the bill.

Andrew Eccles: It strikes me that in this area language is pretty important. It might be interesting to think about what we understand by integration, because there are different models of integration and there is the move from collaboration to integration. I remember that, 10 years ago, when I did some work on collaborative working, I was slightly chided by someone who said, “We are now integrated.” However, that was clearly not the case on the ground, because they were not integrated. It would be useful, when we use such phrases, to explain to front-line workers what their application in practice might mean for their jobs and what they might be expected to do. Integration is quite a heavy phase of people working together or of joint working or collaboration—it is often regarded as one end of a scale or continuum.

Alison Petch says that she is perhaps an optimist. I am not a pessimist, but I am certainly a realist when it comes to the overambition or overoptimism in the past. The overoptimism has probably been about the ability of structural and organisational change to deliver results. One problem is that there has been some linear thinking that, if we do X, Y will follow. In fact, the interface between health and social care is often a complex area, so we cannot have linear thinking
whereby we take the approach that, if we do something organisationally or procedurally, something else will follow from it. The issues are too complex for that. Alison Petch and I have talked previously about the idea of wicked issues. Such issues are not always easily solvable, there are no standardised patterns for dealing with them and outcomes will often be variable. We have to allow space for such complexity.

We must be realistic about what is achievable. We should certainly have a greater degree of working between health and social care, where that is possible. The lesson that we can learn from the past is that there were big ideas that were highly optimistic and in relation to which a good deal more spade work probably had to be done to research what was likely to happen in practice. It is important to keep people on side so that they buy into the approach.

Alison Petch and I are both aware of good research that shows what it takes to get front-line workers to buy in to such changes. There is not much point in simply saying, “You will do this,” because the changes might not make sense to them and they have to see why they should buy into the new approach. Workers have to see that there will be a better outcome as a result of the change and not view them as just another set of procedural changes whereby they are told, “This is how we will now do things.” That cultural shift is important.

Rhoda Grant: I almost disagree with you, because the people who are coming to me saying that we need change and better integration are the front-line workers who go into somebody’s home and cannot, for example, give them a bath, because that is somebody else’s job, despite the fact that that is what they should be doing for the good of the person concerned.

That happens all the time to front-line workers, who must follow rules and regulations that tell them what they cannot do. They see where the need lies at first hand, but they do not have the scope to do anything about it. The bill aims to achieve a change in approach through integration, but how do we get that to happen at management level? To an extent, the issue might be that people are empire building and keeping their own responsibilities close to them. How do we free up people on the front line who want to work in such a way so that they can do so?

Andrew Eccles: Thinking back to the previous attempts, one of the problems for me was the outcome measures that were used. The JP1AF— or joint performance information and assessment framework—outcome measures were essentially around processes. That is the problem. Moreover, organisations might start to meet the organisational targets or objectives first, certainly in times of fiscal pressure. We have to get beyond that particular problem.

The early work that was done by Wilkinson and others back at the turn of the century on work in England involved interviewing chief executives in primary care trusts, who said that their primary concern was to meet the immediate targets of the organisation effectively and that, after that, they might start to look at other areas in which they could work. That is problematic in a target culture in which organisations might be inclined to meet their immediate targets rather than something that might be slightly more ambitious and involve thinking outside the box.

Alison Petch: That is critically dependent on having individuals who see a vision. I am sure that members have heard about the getting it right for Mrs Smith mantra, which led one of the developments south of the border. It permeated throughout the professional groups in the area. I lived down there at the time, and it was on signposts all over the place. It became a collective vision that we were all in this together to make a decent life for Mrs Smith. We could all be the Mrs Smiths of the future. We must have that transformation from delivering on particular targets and having boundaries around who can do what. There has to be a belief that things can be different and can be driven, and we must have leaders who can drive them. I sometimes wonder whether those leaders can be made or whether they are just born and are innate leaders. People must have belief and commitment. It is not just about working through processes.

Andrew Eccles: I agree. To go back to one issue, there will be some work to do to establish that sense of good will among front-line practitioners to make things work, given some of the experiences. I am thinking of the community healthcare partnership in Glasgow, which lasted for four and a half years, in effect. I did work with some of the CHPs in the early stages of setting them up. Enthusiasm certainly existed, but the tensions were clear. We need not rehearse them all here, but they were pretty apparent at the time. That has left front-line practitioners who are probably sceptical and who are likely to say, “Here we go again with another round. We’re going to start to have those structures and procedures.” There is good will, but it has been dented over the past decade. The way that we attempted things perhaps 10 years ago was probably too driven by organisational change and procedures.

Malcolm Chisholm: I read about getting it right for Mrs Smith, which Professor Petch talked about, and was impressed with it. It is not the only example of good practice, but what can we learn from the evidence of where there have been big improvements? I think that there was evidence on
fewer emergency admissions and delayed discharges, for example. We have got the message that it is not about structural change in itself. Leadership was mentioned; perhaps you can mention some other things.

I have a related question. Although structural change will not cause what is required, is it a necessary precondition? For example, with getting it right for Mrs Smith, there was a big organisational change to a care trust. That is not available in Scotland, but is organisational change part of what is required or is it totally irrelevant? If it is totally irrelevant, I suppose that we might ask whether we need the bill at all.

**Alison Petch:** My personal opinion is that the jury is still out on whether elements of structural change are needed. Knowsley is an example of where good outcomes for people were achieved without major structural change. In a sense, we have to look beyond structural change, given that it looks as though elements of it will happen, to focus on the things that are necessary.

It is also important to know that the process is not instant. The getting it right for Mrs Smith approach evolved over 10 years. I fear that the thinking is almost, “Right—the problem’s been around for so long that, this time, we’ll get it right and have it sorted 12 months down the road.” We must appreciate that it will take time.

**10:15**

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.

Experience provides key elements that can make the approach work. Boundary spanners—that is a dreadful expression—are leaders who facilitate working across organisations’ boundaries. A lot of attention must be paid to the local context. It is good that the bill refers to localities, but it is essential that people understand communities’ strengths as well as their needs.

What works in Orkney or the Highlands will not necessarily work in the middle of Glasgow. That makes the situation more difficult, because it puts the onus on local leaders to understand the position, engage with their communities and build on local good will, facilities and opportunities in order to deliver. That is more complex than saying simply that we will sort out the situation by re jigging boundaries and ordaining this, that and the other.

There is a pretty strong evidence base from 10 to 20 years’ experience of what can facilitate such working, almost regardless of the structures. That is why the energy should not go into the structures.

**Andrew Eccles:** When we hit problems, we tend to reorganise—that is an old phrase, which I think is wrongly attributed to Petronius. We take that approach because we are quite good at reorganising and we tend to play to our strengths.

Some of the skills that have developed in health and local authority management in the past 10 or 15 years relate to organisation, structures and meeting targets. People might fall back on that skill set when we ask them to integrate health and social care more. They will start to think about how to organise that and the procedures that they could use. We need fundamentally different thinking, which will be difficult, because the way in which we have organised public policy in the past couple of decades has not hugely encouraged thinking out of the box.

Alison Petch was absolutely right about leadership. The last time that such an approach was taken, many people viewed it instrumentally and as something that had to be done, but we are talking much more about purposely working back from a vision of what could be achieved. Doing that will take time.

**Malcolm Chisholm:** To be fair to Scotland, far less organisational change has been imposed here than in England. A lot of the changes that have taken place have involved local authorities and health boards working out their own arrangements. Another view might be that the bill will not make much difference, because it respects and builds on what has developed.

I hear everything that the witnesses are saying about not relying on structural change. I suppose that there are two questions to ask about the bill. First, is anything in it harmful? Let us do no harm. Secondly, can we introduce in legislation some of the more fundamental points that you made about leadership, culture and so on, or is all that not really the stuff of legislation?

**Andrew Eccles:** As I read the bill, I see that a large proportion of space is given to the options for structures and what structures might look like, compared with the proportion that is given to issues to do with training. Actually, the issue is not just about training, as I have been involved in training sessions that did not seem encouraging in the context of the need to think outside the box. I would like there to be more emphasis on the idea that people in organisations need the space to be able to engage in the integration agenda.
There are lots of interesting ways of doing that. Health workers, social care workers and people from other health professions could look at vignettes of patients, in an attempt to understand what a particular patient might need—that can be quite a long process. The approach might enable people to understand why others think differently. It might be that we need a little strengthening somewhere, so that rather than just say that there will be training we say what the training might look like and why it might not simply be done in the way that it was done in the past—it might be a good deal more innovative. There needs to be space for that to happen. That is crucial.

**Alison Petch:** I take Malcolm Chisholm’s point. We have been fairly modest about structural change in Scotland. When the proposals came out, I was pleased that earlier talk about wholesale structural change had been put aside. However, after a few months of optimism I became a little more despondent because, as far as I could see, people were getting bogged down in discussions about who would be the chief officer and how we would do this or that. Some of my initial enthusiasm faded away.

I would like us to recapture some of the vision of the original proposals. 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 that we might start to do this or that. Some of my initial enthusiasm faded away.

Unless we are dedicated to cracking the issues of shifting the balance of care and pooling the support that is needed to prevent unnecessary admissions to hospital, much of what we do will just be frills around the edges. If anything can be done to overcome some of the rather permissive and vague elements of the bill, particularly in relation to what comes from the acute health budget, that would strengthen the bill.

I would also like specific reference to be made to the housing function. I was always taught that delivery depended on equal inputs from health, social care and housing. We used to talk about the three-legged stool, which I fear is in dire danger of becoming a two-legged stool.

Those are the two elements that I think would strengthen the bill.

**Malcolm Chisholm:** I think that your final point will feature prominently in our discussions, as will the whole issue about acute budgets. However, I will not pursue that now, as other members have questions.

**Bob Doris (Glasgow) (SNP):** I think that Mr Eccles said that leadership on health and social care integration has been inconsistent over the past decade or so. I am sensitive to the need to respect local democracy in councils, but constituents regularly come to my surgery to talk about the malaise and the breakdown in relationships, for example when an elderly relative needed residential care or was in and out of hospital frequently. Work does not always seem to be joined up in the way that it should be—although there is some fantastic local practice on the ground in Glasgow.

As a member of Scotland’s Parliament, should I be considering whether there is a need for the bill? I know that the issue is one of outcomes for the individual, not structures. Is the time right to legislate, or should we wait for another 10, 15 or 20 years for some parts of Scotland to get on with the integration exercise that we hope would be happening without the need for legislation?

I will ask you, in a second, whether you think that the proposed legislation is proportionate, but can you comment first on the need for legislation, given the fact that it is not just about structures, although the structures are in there to enable things to happen? Is the time right for legislation in the first place?

**Andrew Eccles:** Yes. It puts down a marker, and it is important that the issue is not off the agenda. It is 12 years since the previous round of attempts to establish some of the issues, and there is a concern that they might start to disappear off the agenda. Having a bill puts down a marker, and there is no harm in that. The bill strikes me as open enough to interpretation regarding what localities might do, which is useful.

It is worth bearing in mind that integration is not a panacea. It will make things better on the ground, one imagines, if it is done well, but a whole range of issues exist alongside it, including unmet need and budgets. There has been some slightly wishful thinking in the past that if we get integration right, those issues will effectively disappear. I suspect, however, that your constituents will still be coming to you five years down the line, even if we get this right. Some of the other fiscal pressures are not going to disappear.

**Alison Petch:** If you had asked me the question 12 months ago, I would probably have said no. Now, the process has gone too far to stop. One therefore has to capitalise on the opportunities in the ways that we have been describing, and we should try to home in on elements such as the acute transition and the transition from hospital to community. The bill should be seen as a final attempt and a final opportunity to get things right. If people do not seize the opportunity, the cynicism
and scepticism will be very great in the future, and it will be difficult to revisit the matter, given the history. If you were now to withdraw from legislating—from viewing the bill as a catalyst for those areas that have perhaps not been at the forefront—some of the energy would be lost. It is too late to retreat from it.

**Andrew Eccles:** An important aspect is the expectation that Government may have of what can be achieved. That is not to say that we should not push the bill and that we should not hope for things to develop from it, but if we consider the history, we can see that one of the problems has been people being overambitious about what such proposals might achieve. That would scupper the bill. We need to think about it a bit more carefully, and more in relation to the longer term. We should be acutely aware that there are some areas of Scotland where there is truly excellent working between health and social care at the local level, and that there are other areas where, for whatever reason—it might be to do with previous attempts that have been made—there is a degree of scepticism. People are at different places. Expectations that do not necessarily match where the different areas are in terms of possible outcomes would kill things as regards the legislative process.

**Bob Doris:** On whether the bill is proportionate, many of the submissions have focused on structures. My reading of the bill and the political narrative around it is that this is not really about structures. Yes, structures must be established and signed off, and they have to be proportionate, but the point is that we must use those structures for the strategic commissioning of services and developing a more joined-up working approach, which is happening already in some parts of the country, but not in others. My hope is that the bill will ensure that that will happen in all parts of the country in a speedier and more strategic way. I do not want to draw you too much on the structures, but is the level of detail in the bill proportionate?

10:30

**Alison Petch:** I repeat what I said earlier: you can beef up some of the underpinning principles to the extent that you can introduce into the legislation some of the much more important areas that we have discussed. In people’s minds, it may well be that it is not about structures, but if we look at the bare bones of the bill, we will see that it inevitably tends to talk about the need to produce a plan. We have had community care plans, which people spent inordinate amounts of time producing. The critical thing is whether people go out and do something differently. You cannot legislate for implementation, but you can perhaps draft some phrasing—I am not an expert at all on this—that tries to reinforce the message that you have just given: that we recognise that it is not about structures. People can look at the bare bones of the bill and think, “Well, that may be what people are saying, but I don’t see much of that reflected in here.” The message tends to emerge more strongly in the policy memorandum, for example, but that is the danger of a bare-bone bill. In the past, there have been moves to have much more conversational introductions. I do not know whether that approach is a possibility.

**Andrew Eccles:** That is an interesting point. I suspect that there is that bareboneness precisely so that people do not get locked into a top-down, heavy approach that tells organisations how they will do things, especially given that different areas of Scotland are at quite different stages. However, the danger is that we will end up with something that is too light in terms of prescription. I would not necessarily prescribe procedures—again, I am cautious about what the outcome measures might be—but I would like to see more weight given to a recognition of learning from some of the research that has been done in the past 10 or 15 years. As Alison Petch said, that is in the policy memorandum to some extent. If the bill is light on structures and organisation—although they are certainly still in there—perhaps the idea of cultural change, which is missing but which needs to be in it, could be emphasised a little bit more. That is an important issue.

**Bob Doris:** Those comments lead me to think that the bill is probably proportionate. I refer in particular to what Professor Petch said. I think that she has said twice now that she would like to see more in the bill about the principles of integration. In our next evidence session, others, including the Convention of Scottish Local Authorities, will obviously have the opportunity to say more about their views. Some partners have said that they would like to see less about the principles and structures in the bill and have asked for that—they will have their own reasons for saying that. You have described the other side of the coin. You say, “Actually, you could say a little bit more about that, please, to beef it up.” and you call it a “bare-bone” bill. That gives me a little bit of assurance that the Government has perhaps steered a middle course to get the balance right.

I know that there is not a question in what I have said, but are there any comments on steering the middle course? I will not come back in with a supplementary question.

**Alison Petch:** At the end of the day, we must remember that the act would become the backcloth against which the activity would take place, but in respect of day-to-day relevance, whether on the front line or at more senior levels in organisations, legislation is not really what drives
day-to-day delivery. Therefore, as you have said, one perhaps has to steer a middle course. However, without repeating what I have said, there are one or two areas relating to budgets and the roles of housing and other partners in which you could be much more proactive.

Mark McDonald: You have given evidence that we cannot expect that just changing an organisation’s structure will enable it to deliver. We accept that; the culture is a huge element. On the other hand, you say that we cannot legislate for the culture in an organisation—we cannot legislate to make people enthusiastic, although it would be good if we could. Does simply having legislative underpinning increase the accountability of those whom we expect to deliver on the agenda?

Andrew Eccles: Yes—that will be the case by definition, given that organisations will have clear responsibilities.

Mark McDonald: A lot of the examples that have been cited of good intentions that failed to materialise in delivery in the past perhaps lacked the legislative underpinning. Such work was driven simply by the power of good intentions, whereas the bill mirrors the intention to deliver but also provides legislative underpinning. Might that make the current approach stronger than previous approaches, which did not have such underpinning?

Andrew Eccles: I am not sure that what you describe is my recollection. I was seconded into local government in 2001 and 2002, precisely at the time of the joint future work. I remember that a number of really quite directive circulars were issued about the expectation for organising protocols and who might have responsibilities.

You might be getting at the experience of community health and care partnerships in Glasgow, which perhaps provides an example of a lack of clarity about responsibility for decision making in the two organisations that were involved. Issues clearly arose there.

I am not sure that I read in the same way as you the comparison between what was expected for accountability last time and what is expected this time. I take your point that it is clear that there will be accountability, but I am not sure that that was problematic last time. It might be clearer this time because of the joint officer having sole responsibility, which CHCPs tried to do.

Alison Petch: We must avoid having false confidence that the bill will necessarily lead to a better solution. We must be cognisant of the experience in Northern Ireland, where structures did not necessarily deliver what was hoped for. I was a researcher and it is almost a searchable question to ask whether the bill will deliver better than a less mandated pattern for the future.

As I said, the fact that the bill has raised the profile might lead one to be optimistic, but it must be appreciated that hard work on all the other aspects that we have focused on is required. In itself, the bill will not create a magic solution.

Mark McDonald: I would not want to give the impression that I think that simply legislating will solve the problems that have existed. I merely suggest that increasing accountability might push the agenda forward more quickly.

Do we come down to the point that we are talking about the people in organisations? Do some organisations have people who are getting on and driving forward the agenda, while other organisations have people who are—for whatever reason—unable or unwilling to drive it forward?

Alison Petch: I would have thought that the former is about 80 per cent of the case. We must also bear in mind the question whether the proposed arrangements will have unintended consequences. What will be the impact on children’s services in some areas if they are not included in the partnership? As with any such development, there are gains and losses. We must have the people—the leaders—who can navigate that and deliver the solutions, regardless of what has been mandated in an area.

Mark McDonald: I take your point. COSLA says in its submission that it wants the bill to be tightly written to cover only adult health and social care. That would limit the ability to expand the model, if it proved successful. Perhaps we can touch on that in the next evidence session.

I think that I understand where you are coming from on the implication that outcomes can be counterproductive. However, I presume that the only two things that we can measure are the input and the outcomes. To me, the outcomes are more important—provided that we get the measures right, obviously—because that is what affects people at the sharp end. Can simply focusing on outcomes be counterproductive? Is how we select the outcomes that we measure the important point?

Andrew Eccles: Part of the general problem in public policy in the United Kingdom in the past 15 or 20 years has been importing what I would call context-free management, particularly into public sector agencies, as we broadly refer to health, social care and so on. The management processes and output processes probably work very well in particular organisations that manufacture motorcars or whatever, but importing ideas wholesale on an outcome basis seems problematic to me. I am not against the idea of outcomes per se, but the problem with emphasising them is that doing so can damage some very good, creative, interesting work.
Perhaps we need to start with the idea of doing something creative and positive with the facts as we see them on the ground, and then learn from that—and from mistakes made in doing it. You might be doing the right thing but doing it wrongly, but you can learn from that if you are doing it at the local level. If people are working towards a set of outcomes that do not make much sense or which have been transported in from another area, they are essentially always working on the wrong basis because they are working towards a series of outcomes that do not reflect the reality of what is happening on the ground.

**Alison Petch:** I think I need to make a fundamental clarification that will show where I might disagree with Andrew Eccles. We must distinguish between something being driven by the delivery of outcomes for the individual, which should be at the heart of the process that we are discussing, and perhaps the more traditional outcome-based accounting-type approach, which I think is the one that Andrew has questions about. The difficulty is that the word “outcomes” now means different things.

**Mark McDonald:** I entirely take on board that point. My concern is that in the past we have often measured the success of things by how much money gets thrown at them, rather than by results for individuals.

**Andrew Eccles:** In the past, we have measured the measurable, which is a process that often means avoiding dealing with complexity. A lot of managers might well be engaged precisely in the process of measuring the measurable as opposed to really getting to grips with complexity, which is sometimes not easily measured.

**Mark McDonald:** Do you think that we measure too much?

**Andrew Eccles:** Personally—certainly, given the sector that I come from—I think that we probably do and that we need to sit back. The interesting analysis of this area comes not from the UK but from people in continental Europe who do quite a lot of work on UK public policy. I would be happy to recommend some interesting studies that ask why Britain shapes its public policy as we do. Although the evidence base for the accounting approach to measuring the measurable shows that it is demonstrably problematic, we continue to do it. I think that that is partly because people have become very skilled at doing it in the past 15 or 20 years, so it is hard to retreat from that and think outside the box.

**Alison Petch:** The difference is perhaps epitomised in the distinction between measuring bed occupancy or delayed discharge, for example, and measuring the extent to which an individual who has been discharged from hospital arrives home having had a good experience and is not back in hospital two days later.

**Mark McDonald:** Is there not an inherent danger that if we say that we are not going to measure X, Y or Z, those of a cynical disposition will imply that we are not measuring that any more because we cannot meet the targets that we have set, or that we are trying to hide something from the general public? Is that not the inherent danger in reducing the number of measurements that take place?

**Andrew Eccles:** Maybe that is the cynicism that we need to get over.

The Convener: That did not sound like an endorsement, as was alluded to earlier, of the prescriptive nature of the bill.

HEAT targets and the use of outcomes have been criticised, but measurement must be a serious part of the bill. Measurement will be applied—some people think to a worrying degree, if it becomes prescriptive—because if people do not reach this, that or the other target, the minister will have the power to intervene.

10:45

**Alison Petch:** The proposed outcome measures for health and social care integration at the national level represent an attempt to grapple with the need for a more nuanced, sophisticated understanding of targets. The system is not perfect, by any means, but there has been an attempt to put greater emphasis on outcomes for the individual—not just where they are but how they experience care. That is a significant improvement, as far as I am concerned. There have been advances in trying to get more sophisticated measurement.

I absolutely agree with Mark McDonald about retreating completely from measuring outcomes. Measurement is much more about trying to get an understanding of the reality of the situation than it is about crude indicators.

**Andrew Eccles:** I agree; I also agree that there has been movement in that regard. My point was that attempts to set outcomes were historically very process driven. I am advising caution because different parts of Scotland are at quite different stages. I remember working with organisations a decade ago in which interesting and creative local practice quickly became usurped by the idea that people would be parachuted in to manage integration. There needs to be sensitivity around allowing things that are working reasonably well on the ground to flourish effectively.

Outcome measures are entirely useful in some cases, as Alison Petch said, but I am expressing
caution because they are often broadly based on accounting principles, which can be very counterproductive. The question is what the outcome measures will do and to what extent we take account of the fact that there are areas of Scotland that are in quite different places in relation to the point at which we might decide to intervene. That seems to me to be a pretty sensitive issue.

The Convener: Do you agree that outcomes partly change the culture and environment in which people work?

Andrew Eccles: It depends on the outcome. If the outcome is what is good for the individual, that might well change people, but a broader set of structural, organisational or procedural outcomes such as accompanied what we were doing 10 years ago can often be problematic and counterproductive.

The Convener: Outcomes are not necessarily bad in themselves, if they are defined and supported by the people who deliver and receive the service.

Alison Petch: That is key to the whole endeavour, and it brings us back to the new model of partnership working, which is about partnership not just among professionals but with individuals. If we are talking about how we motivate and provide opportunities to the workforce, particularly front-line workers, to work with individuals to consider how they can enable them to achieve the outcomes that they want and to have a better life, that is really what should be at the forefront of the approach—the panoply of mechanisms and structures should fall in behind that. That remains the vision that we must try to achieve; that is what should be driving the approach.

It is all about the cultural change that we have been talking about. We must not lose that in our discussions about the outcome-based accounting of the past and so on. From my reading of the bill and the policy memorandum, it seems to me that much of it is about making a difference for the individual.

The Convener: Whether or not the bill is proportionate, I think that everyone agrees that things could be better. We are all muddling towards a situation in which services are delivered better.

Perhaps one way to change culture is to stop thinking in terms of the armies of social workers, medics and so on—who are all human beings, after all, and everyone finds change difficult, wherever they work—and to think about giving people who receive care positive, enforceable rights. Would such an approach sufficiently change culture? Would starting from that point influence the targets, outcomes and so on? Rhoda Grant and Bob Doris talked about what MSPs deal with, such as how individuals are assessed, where they are placed, whether they get a 15-minute visit or a quality service and so on. Perhaps there should be enforceable rights for people at that point.

Alison Petch: There is a strong movement towards having a human rights focus in relation to care, which I absolutely endorse. However, just introducing such an approach will not change things overnight. We must recognise that there will be a long evolution.

During the past 30 or 40 years we have moved in the right direction. We throw up our hands in horror at things that happened 20 years ago, when people were still living in long-stay hospitals. Self-directed support is in place and we are starting to see heartening improvement. If endorsing such approaches can accelerate the move along that continuum, that is all to the good, but just putting the words in the bill will not make it happen.

Andrew Eccles: I agree. In effect, we already have a human rights approach. Article 8 of the European convention on human rights is about dignity, so in circumstances in which people’s health and social care is not safeguarding their dignity they have recourse on that basis. I am not sure that that helps us with the fundamental point about how we achieve integration of health and social care. Statutes might have their uses as motivators, triggers or whatever, but they will not fundamentally alter the most important issue, which is how we change the culture in relation to people’s ways of working.

The Convener: Do you expect the bill to be any more successful than previous bills that tried to address the issue?

Andrew Eccles: That is a big question. The attempt to be slightly less prescriptive about how people might achieve things at the local level is useful. The bill as it stands is a shell, into which much about leadership and changing attitudes must go. It is all in there—the bill talks about leadership and training—but I would like more emphasis on the sheer cultural shift that might be required to make things work.

The Convener: You just lost your academic status and slipped into giving a politician’s answer.

Andrew Eccles: In that case I will give you an academic’s answer: I do not know.

Alison Petch: I would like to think that professionals and the wider community in Scotland will build on the bill to move forward on integration. I am repeating myself when I say that I do not think that the bill will necessarily overcome challenges that have arisen in areas. It is not a magic bullet.
The Convener: We talked about the need for leadership and about attempts over a decade or more to address a situation that is well known to all of us. What have the learning institutions done in that decade to develop leaders and visionaries?

Andrew Eccles: The learning institutions have provided a very substantial research base on the whole area of integrated working. It is all out there—I brought with me a copy of stuff that Simon Caulkin has written on targets in public policy. There is a lot of material on that, and a lot of stuff has been written on integration.

I worked with integration managers in the past, and it struck me that people were so wrapped up in getting through the day-to-day business that they had no space to consider the research. I would say, “Precisely the area that you are talking about has been written about. You should have a look at the research.” The work is there, and it needs to be accessed. When I have worked with front-line managers, in particular, I have always been struck that they are under a lot of pressure and do not have much space to develop their knowledge of what is out there.

I am currently teaching social work managers, who have a powerful protected space of one day a week in which they can start to explore the stuff, a lot of which is new to them even though it has been out there for a while.

Alison Petch: I have a final anecdote for the committee. I used to be involved in a postgraduate course at the University of Glasgow, which brought together managers from a range of backgrounds, including statutory and independent agencies. They came in for a day a week, over a couple of years. The learning that they did together was incredibly powerful—it was not so much about what they heard from us. I remember a health board planner talking about the dreadful difficulties of people not emptying beds. Someone from social work said, “Imagine that that was your grandmother. Would you want her shifted overnight?”

We should make space and find finance for such interdisciplinary learning—I gather that finance is an issue—because it is a powerful experience.

The Convener: If there are no more questions from members, I thank the witnesses for their time and evidence.

10:57

Meeting suspended.

11:03

On resuming—

The Convener: We now move to our round-table session with local government representatives. As is the usual practice in such sessions, I invite everyone to introduce themselves.

Duncan Mackay (North Lanarkshire Council): I am the head of social work development in North Lanarkshire Council.

Bob Doris: I am an MSP for Glasgow and the committee’s deputy convener.

Soumen Sengupta (West Dunbartonshire Community Health and Care Partnership): Good morning. I am the head of strategy, planning and health improvement in West Dunbartonshire.

Nanette Milne: I am an MSP for North East Scotland.

Peter Gabbitas (City of Edinburgh Council): I am the director of health and social care in Edinburgh.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the MSP for Clydebank and Milngavie.

Susanne Harrison (City of Edinburgh Council): I am the integration programme manager in Edinburgh.

Rhoda Grant: I am an MSP for the Highlands and Islands.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

Ritchie Johnson (Aberdeenshire Council): I am the director of housing and social work in Aberdeenshire Council.

Malcolm Chisholm: I am the MSP for Edinburgh Northern and Leith.

Ron Culley (Convention of Scottish Local Authorities): I am the chief officer of health and social care for the Convention of Scottish Local Authorities.

Richard Lyle (Central Scotland) (SNP): I am an MSP for Central Scotland.

Councillor Peter Johnston (Convention of Scottish Local Authorities): I am the COSLA health and wellbeing spokesperson.

Mark McDonald: I am the MSP for Aberdeen Donside.

The Convener: I am Duncan McNeil, the MSP for Greenock and Inverclyde, and committee convener.

Bob Doris will begin the questioning.
Bob Doris: I have a general question. Some local authorities are further down the road to health and social care integration than others. The Public Bodies (Joint Working) (Scotland) Bill will put such integration on a statutory footing. For those witnesses who consider that they have already travelled far down that road, how does the bill dovetail with what you are doing?

Soumen Sengupta: I am not here to tell councils or others how to develop their business, particularly with regard to local democratic processes. I will therefore talk about the long track record of joint working between the council and the health board in West Dunbartonshire.

In October 2010, when we came to enact the community health and care partnership, there was a history of substantial joint working at all levels, particularly the front line, so it felt comfortable and right. That is not to say that staff did not have a lot of questions or that there were not concerns that had to be worked through; indeed, there were challenging issues, including the need to think about territory. However, we had a sound basis on which to do that and the partners involved were keen. Therefore, we, in common with a number of other areas, such as East Renfrewshire, have a much longer involvement in this work. In Inverclyde, which is in the convener’s constituency, integration at the structural level is well progressed.

We are probably in a position in which the bill will not make a substantive difference to how we do the day job. The day after the legislation is enacted, the world’s operational services will pretty much be the same as they were the day before.

The bill raises interesting opportunities on accountability. As we mentioned in our submission, we are keen to streamline accountabilities in the public sector arena that we work in. For all the opportunities that partnership working provides, and given each of the conditions we are trying to tackle, a person can find themselves trying to report to multiple stakeholders at different times. It needs to be clear who is accountable to whom and for what. A shared set of outcomes that relates to the spectrum of the health and social care agenda would also be powerful because it would provide a clarity of purpose for the organisation and the staff, and—we would hope—parity of expectations for our local community, and a clarity of fairness on what MSPs and other elected officials should expect from organisations and the leadership of those organisations.

The need to manage ambition was mentioned in the previous session. The bill is an ambitious step for Scotland, but we should not get overexcited about what a structural change or other changes in the bill will do. Those changes are only part of the solution; there is a lot more work to do.

I am sure that all areas—even those that are not as structurally integrated as we are—do similarly innovative work on the ground, that there is lots of joint working between staff, and that we all have examples of good practice that we could bring to the table.

The Convener: Panel members should come in when they want to.

Duncan Mackay: I caution the committee that there are partnerships that may appear to be more integrated than others, but those with integrated structures may not in practice, on the ground, be more integrated than those that do not have the same structures. The partnerships that have the same structures may or may not be achieving better outcomes than those that do not appear to have the same level of structural integration. By way of illustration, in North Lanarkshire, we have been working towards integration in many ways over many years. We have a suite of integrated services, such as day services for older people, as well as integrated equipment, and integrated adaptation and addiction teams. In fact, those services and the general partnership approach have been consistently well evaluated by external inspections—they were recognised as recently as 2011 by the Nuffield Trust as one of four worldwide exemplars of integrated working. It does not necessarily follow that the structural arrangements of a partnership—inevitably, there will be 32 variations across Scotland—lead to better outcomes for individuals. I caution the committee that, as members heard in the previous evidence session, there can be a somewhat tenuous connection between the structure and the intended outcomes.

Councillor Johnston: In answering the question, let me first put my remarks into context. From a COSLA perspective, we believe that the integration of health and social care is the cornerstone of public sector reform. We very much support the direction of travel. We recognise that an outcomes-based approach that uses resources flexibly, promotes co-production, early intervention and prevention and facilitates service integration is the way ahead.

Mr Doris is absolutely right that we start from a situation in which some local authorities and their NHS partners have already gone some way down this line. Those who know me will be aware that I am a member of West Lothian Council, which is one of the leading councils in this respect, as, likewise, is Highland Council, which has used a different model and has taken a lead agency approach. As my colleague Duncan Mackay has said, other councils have developed arrangements in a different way.
The experience of having all those different starting points leads COSLA strongly to take the view that the bill is in some parts too prescriptive, particularly on the issue of scope. As we argue strongly in our submission, the starting place for all partnerships should be adult social services, but the bill should provide local flexibility to allow the integration to evolve and develop not on the basis of structures imposed by ministers but through local flexibility, local knowledge and local leadership. As we heard earlier, joint working comes not through structures but through local leadership and local cultures developing. That is fundamental to the success of this project of further integrating health and social care.

Peter Gabbitas: In a way, I agree with my colleague from North Lanarkshire Council. I hesitated to respond to that first question on what progress we have made because, in terms of the bill, Edinburgh might seem to be very far forward on integration: I have been the joint director for eight years, West Lothian has had a joint director for a similar time period and, more recently, joint directors have been appointed in East Lothian and Midlothian, which are the other parts of the area that is coterminous with the NHS Lothian area, so we have joint directors in place. At the end of this month, we will have completed a whole year as a shadow health and social care partnership. In terms of what the bill is signalling as the direction of travel, we might seem to be very far forward.

However, I feel that we still have an awful long way to go on integration. There are examples across the country of really well integrated services, whereas in those areas that appear to be fairly well advanced in structural terms the position is very mixed. What counts, I think, is not so much the governance arrangements, although those are important. What I am interested in and passionate about is whether we are making a difference to the lives of the people whom we serve. Are we making our services more seamless? Are the people whom we serve able to see the cracks between the statutory services? Those are the things that I am passionate about.

Ritchie Johnson: I agree with the comments that both Duncan Mackay and Peter Johnston have made.

To give an illustration, in Aberdeenshire we do not have the same formal structural integration that has been described in areas such as Edinburgh. However, like many other councils, we can point to a lot of good joint working practices by joint working teams—particularly in a rural area, where it is essential in order to reflect rurality—and we are doing a whole lot of work around the issue.

Although we believe that, ultimately, legislation would not have been required to move us on, nonetheless the bill has been introduced and, from our perspective, we want to push on. As well as the structural elements, which are inevitably needed, it is even more important to backfill and to support the change with a series of initiatives on leadership, communication and culture, as the committee has already heard this morning. We need not just one approach but a series of things to make the change work and to make a difference. I keep challenging my team and my colleagues with questions about why we are doing this. We need to make a difference to the people who receive our services. If that is not what the change is about, we are missing something. I am not saying that anyone is suggesting that that is not what the bill is about, but we need to keep coming back to that question or we will get drawn into a lengthy debate about structures and principles. Although that might be interesting and of some importance, it is not the key tenet of the agenda. We have to focus on why we are doing this and challenge our teams regularly on that basis.

11:15

The Convener: If integration is going along swimmingly, why do we need the bill?

Ron Culley: I suppose that we could answer that question in a number of ways. In one sense, legislation is an admission of failure; we are saying that we have not been able to do something of our own volition and that we still have to overcome some barriers.

The committee has heard from my colleagues today that a lot of good work is being done locally that is knitting together practice between social work and health, and that will continue irrespective of the bill. However, the bill can address some barriers that still exist in the way in which the health service works with local government. I am thinking specifically of the situation in relation to integrated resources and the extent to which we can start to plan with a total resource for an entire population, particularly the way in which we can integrate the acute sector into that environment. After all, the non-integration of acute care not just with social work but with primary care has probably been the biggest failure of the past decade. Acute care has sat out on its own. One of the fundamental strengths of the integration agenda that the Government has advanced is that it is not prepared to see that happen any longer.

The reality is that, as we move forward in demanding financial circumstances, in what is likely to be a flat-cash situation for the next few years, we need to be smarter about how we use our total resource. Historically, we have probably invested too much in secondary care at the expense of social and primary care. If the bill allows us to be more imaginative in how we use
our total resource, and if we can begin to deploy our collective resources more effectively over time, that will be a success and it will justify the legislation, but there are a number of big caveats that relate to our capacity to do that.

Peter Gabbitas: A few reasons stand out as to why the bill is important and necessary. In terms of governance, as it has been described to me by council lawyers, the Local Government (Scotland) Act 1973 suggests that any committee that has been formed by the council has to be made up of two thirds of elected members and only one third of the alternatives. Different councils have interpreted that in different ways, but my council’s solicitors are quite clear about that. If we create a committee and try to establish a partnership body, we cannot do that if another organisation has two thirds of the votes on it. That is not an equitable distribution. There is therefore a governance issue.

There are also issues to do with assets and different accounting regimes, which arise not so much with the bill but with the regulations that will follow in due course. There are issues with the budgets that will, again, be addressed by regulations and the work that is being done on the back of the legislation.

The bill is therefore required for a number of reasons, but the biggest one for me is to do with community health partnerships. If we look at what they were asked to do by the original legislation, we see that one of their responsibilities was for commissioning and influencing acute services. However, community health partnerships were not established in a way that allowed them to do that effectively. How health and social care partnerships have been positioned and the responsibilities and power that are given to them could fundamentally change the relationship and power balance between primary and social care and the acute sector, and make that a much more equitable relationship than it ever was in community health partnerships. The bill is therefore very important from all those perspectives.

Malcolm Chisholm: There is a kind of continuity between the opening comments and those of the previous panel. We all agree that structural change is not going to deliver what we want, but we are probably going to end up talking about it a lot because a lot of the concerns of local authorities are in that area.

I am interested in what people like and do not like in the bill. My question is really for Peter Gabbitas. I was struck by the City of Edinburgh Council submission. Peter Gabbitas has told the committee some things that he likes about the bill, but the City of Edinburgh Council says —and I do not know whether this is true or not; it is an open question—that there is a gap between the original proposals and what is in the bill and that it has concerns about the position of the corporate bodies and the chief officers. That might move us into talking about structures and technicalities, but it is an important point. I wonder whether Peter Gabbitas could explain that and whether any other council has a similar concern. We all get the message that local authorities do not like the degree of prescription in the bill when it comes to local authorities, but I am interested in hearing any other concerns that councils might have. That is one that I picked out from the City of Edinburgh Council submission.

Peter Gabbitas: When we introduced ourselves at the beginning of this witness session, the convener described it as a session with people from local government, such as Councillor Johnston from COSLA. I am actually from the NHS and local government because I am already jointly accountable officer, and I see the issue through the lens of the NHS and the council.

We put before the committee an NHS Lothian submission, which contains issues and concerns that I will happily summarise, and I also put in front of the committee the corporate response from the council that took into account all the departments in the council, including people in corporate governance, legal, housing, and all sorts of other areas of the council. The response is a composite reflection of corporate concerns.

As the director of health and social care, I have a more narrow view, but I will try to summarise the concerns that are in the submission about how the bill is drafted. The first issue is about scope, which was touched on during the first discussion. The bill is not particularly prescriptive about acute services. That might well follow in the regulations, but there needs to be at least a minimum requirement around acute services. My colleagues in the NHS are more hesitant about that, and they are right to be concerned about it, but colleagues in local government would like the bill to be more specific about what acute services should be in it.

The NHS’s main concern is about the body corporate, its legal status, and its relationship with the parent body. 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.

Also, in relation to that, the bill does not say that the parent bodies are to appoint the jointly accountable officer. How the bill is written implies that the health and social care partnership is established and then it appoints the jointly accountable officer. In my case, it is kind of academic because the two parent bodies, NHS Lothian and the City of Edinburgh Council, already have a jointly accountable officer and it is me, but it is more about the principle and what the bill is saying about the power balance between the parent bodies and the organisation.

On delegation, it is not clear whether the parent bodies will retain ultimate responsibility. One of the tests for me would be that, if the health and social care partnership did something really awful to a patient, who would be legally accountable for that? Would it be the health and social care partnership or, in some way, would it be the two parent bodies, or would it be all three? That is not terribly clear from the bill.

There are other concerns about that power and authority, specifically from the NHS viewpoint. 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.

I think that that is a fair summary of the issues. Well, it is a summary—I do not know whether it is fair; that is for you to judge.

The Convener: Was Malcolm Chisholm alluding to the original consultation? I think that some of the written submissions claim that there has been a departure from the original consultation. Is that the point?

Malcolm Chisholm: That seems to be what some people are saying, but I do not have a view on that. However, it would be interesting to know what the witnesses think.

The Convener: Can Ron Culley address that aspect?

Ron Culley: Yes. 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.

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.

Peter Gabbitas went on to talk about many other areas in which the bill offers up powers to ministers. Again, we are concerned about that. We can look at the issue on two axes. One is the relationship between the NHS and local government. We were comfortable with that discussion and wanted to see reform advanced in that area. The other axis is the central/local dimension. We think that the bill will give far too much power to the centre. We want partnerships to be given more authority and responsibility to get on with the job. Our objection is not to legislation as such but to the way in which the bill has been framed.

Gil Paterson: My point is similar to what has just been said about the legislation. When thinking about issues like this, I always try to place myself in a context that I am comfortable with, which is the business community. If customers at the sharp end say that something needs to be changed, and the business representatives, middle management and upper management say the same, what are the directors going to do about it?

It has been said that legislation is sometimes like using a sledgehammer to crack a nut, but it can be used as a hammer to knock down a door or barrier in order to achieve ends that everyone is crying out for. However, I have not heard a single person say in evidence that there is a need for change and for integration to take place. Is legislation the only way for integration to take place? Let us be fair about it and not kid ourselves. Some people say that everybody is moving ahead on the issue. Why, all of a sudden, is everybody moving ahead on it? If integration is such a good idea and everybody thinks that it is needed, why has it taken so long to do it and why is the only way to make that happen legislation?
11:30

Soumen Sengupta: I will try to give part of an answer to that question. I suspect that colleagues will be able to chip in and flesh it out.

My understanding is that, across most of western Europe and in other countries, health and social care integration has been talked about over many years almost as the mother-lode solution to a wide range of problems. I think that, for all of us around the table, it is clearly not the magic bullet or panacea: that will have come across to members. Nonetheless, it is talked about as being a good thing if we could create a structure to get the public sector working that way.

In my thinking about that in our work I ask—as do my colleagues—the question that Peter Gabbitas talked eloquently about. What does integration mean for the end user? How will it make things better for the end user in the way that Ritchie Johnson talked about? It is not just about the acute side, although that is a big issue that we need to look at; it is as much about home care in district nursing, for example. What opportunities are there to provide seamless care to the same clients—patients and so on—such that multiple staff are not being used and we make the best use of resources? Those are the strategic commissioning decisions that we can talk about and which Ron Culley talked about earlier. There is a wide range of enabling elements in the bill, and it strikes me that it is about encouraging integration.

We have also talked about the undercooked aspects of the bill—the bits in which it seems to have not quite got its head round the ambition behind what it is talking about. Peter Gabbitas also eloquently covered that. It strikes me that that is down to the fact that, at the heart of the matter, we are talking about creating an instrument that allows serious commissioning—it is no longer about joint commissioning; it is just about commissioning—between two different types of public sector bodies: NHS territorial health boards and local authorities. Those bodies are set up to operate in different ways with different accountabilities and different scopes, which Ron Culley pointed out.

We know that local authorities organise their services and function in a range of ways—social work and education services, and social work and housing services. Sometimes services work together and sometimes they work apart. We get a bit hung up on trying to create connectivity between public sector bodies, which I think is because of the issues that Peter Gabbitas talked about.

The bill is trying to do something noble and progressive, but that comes a bit unstuck when we ask how we will do that and what the governance and accountability issues are. To some extent, the bill compensates for that by providing far too much detail on, for example, how to put together an integration plan, which seems to be very bureaucratic and procedural. The bill has not quite got its head around some of the big macro structural elements.

Ritchie Johnson: On the challenge around why legislation is needed if everything is already going swimmingly, I said earlier that our council's position is that we do not favour legislation, but that is not to say that we do not recognise that we need to do more collectively with health colleagues and other partners. It is about trying to unpick how we can get a better set of integrated services.

We have deliberately started talking about "integrated service delivery" rather than just "integration" as shorthand; "integration" sometimes implies structural discussions, and we do not want to focus too heavily on that. We come back to using "integrated service delivery".

We have taken that through our councillors, stakeholders and staff; we are looking at layers of issues. There is the macro element, which we have reflected on today and which involves national central Government and local government, and there are regional issues—for example, with NHS Grampian and the three local authorities in NHS Grampian's area. There are also CHP-level, council, service and locality issues. All that needs to be pulled together coherently if we are really going to really push the agenda forward. I think that most people would say that they are up for that, as is absolutely right, but it is about understanding that the landscape is fairly complex.

On governance, to pursue Peter Gabbitas's reference to the body corporate, the chief officer and their responsibilities, we have not fully got our heads around that, either. In Aberdeenshire, we are very close to confirming our position on the model, the scope and how to take matters forward, but we accept that we need to bottom out details on how things will work.

On Peter Gabbitas's example relating to something going wrong, scenario planning or scenario setting might be a helpful tool for asking, "What if ... ?" We could imagine a circumstance and ask how the body corporate would work in that circumstance. What would be the actual responsibility of the chief officer versus, potentially, a director of housing or social work, the council or the chief executive? It is about teasing out those relationships and understanding who ultimately makes the decision, how that works, and whether we have the balance right between empowering the local partnership and the
democratic accountability that some members will wish to retain.

Duncan Mackay: This is an interesting dilemma for parliamentarians. I think that we are hearing widespread support for the policy aspirations for integration, but I think that I am right in saying also that we have a piece of legislation that does not mention adult social care at any point. When Parliament is trying to legislate in that area, there is a dilemma: many of the aspirations could be achieved without legislation, but many might not be achieved with legislation. Officers in local authorities will need to know how to pick their way through the ambiguities in the bill, as it is currently framed, and in the aspirations to achieve the best possible outcomes for the citizens whom we serve.

Colleagues have touched briefly on acute care. My understanding is that it is a ministerial intention that significant elements of the acute sector need to be part of the integration arrangements if they are to work. Certainly, the policy memorandum for the bill is explicit that it sees two disconnects, one of which is the disconnect between acute and primary care. As it stands, the bill does not actually address that. I know that a national working group has been looking at the subject and that the views of some people on this panel will differ from those of NHS chief executives. However, from an operational perspective, fixing that disconnect is absolutely fundamental to realisation of the policy aspirations.

My local authority, North Lanarkshire Council, has three acute general hospitals, but because of the geography of the local authority, people are admitted to and discharged from seven hospitals in four different health board areas. Integration will not help us to manage those complexities. It would help us if part of the required arrangements recognised that people’s experience is so contingent on the acute sector working well and on building strong filters that prevent people from coming into the acute hospital environment when they do not need to. If the bill does not facilitate those things, it will not achieve the aspirations that we all share.

Mark McDonald: I have a question on the ministerial power. I understand the concerns that are being expressed, but there is a flip side to that. When the bill is rolled out and proves to be successful, if there is a desire to roll it out to include children’s services, for example, and the bill defines too narrowly a specific element of social care function that refers only to adult health and social care, we will find ourselves around this table again discussing more primary legislation to include children’s services. That will be like taking a sledgehammer to crack a nut, if the legislation works when we roll it out. How could the bill include that expansive element while retaining a focus that would assuage the concerns of local government?

I take the point about wanting the arrangements to develop organically at local level, but does not that leave us running the risk of finding ourselves in the same position as we found ourselves in at the outset of the current process, when we were sat around a table discussing why local authority A and health board A were pressing ahead with the agenda, but local authority B and health board B were not? Do we run the risk that some will press ahead with the agenda while others will need a bit of a legislative kick up the bum?

Ron Culley: I suppose that there are a few things to say. I will be clear about the COSLA position. We are in favour of local partnerships being able to secure additional service areas coming into the integrated partnership—there are too many of our councils that have already integrated children’s services in their arrangements.

Our objection is not to the type of expansion that is done in the context of local circumstances; we object to the potential for a Scottish minister to say, “We require you to integrate children’s services.” The reason for our objection is that such integration was never a part of our discussion with the Scottish Government over the past two years in advance of the bill, nor is it a part of the policy memorandum. The policy memorandum is clear that the bill’s focus is on adult social care and health services.

We welcome the opportunity that Mark McDonald speaks of, but we do not want the minister—or any future minister—to have the potential ability to force people down that line when it was not consulted on and is not part of the policy memorandum.

In terms of local arrangements, we are comfortable with the legislative framework guiding activity over the next period, but we want an enabling legislative framework in which local partnerships are empowered to use that total resource imaginatively. We think that there are benefits to the bill, but a directive approach will not work.

We want to invest our time and energy in the commissioning agenda, and we want 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. The way we will get there is by writing enabling legislation. It is not about taking powers to the centre, but the opposite: giving powers to localities and saying, “That’s your total resource—use it imaginatively in order to meet the outcomes of
your local population.” That is how we will get success.

Councillor Johnston: Mark McDonald has clearly hit on a live and difficult issue. I am glad to hear that he recognises the importance of allowing these things, in his words, “to develop organically”. It is interesting that the bill requires that the integration plan be underpinned by substantial locality involvement and consultation. That makes it clear that it is local communities, from the bottom up, that are going to drive the changes.

I am here wearing my COSLA hat, not my West Lothian Council hat; our council has integrated children’s services. I emphasise again that integration in West Lothian evolved over time, through people building up relationships and working together, which is the only way we will do this. Imposing a structure centrally will not work—in fact, it will hinder genuine cultural change, and the ability to integrate services locally and deliver joined-up services, which is what we all want.

That is where COSLA is coming from. We want flexibility to allow local communities, working in partnership, to shape the future.

Bob Doris: Mark McDonald was quite right to tease out more of the dynamics regarding the scope of the bill and the policy intention, and I am sure that the committee will reflect on that. Mr Culley and Mr Johnston talked about the need for “enabling” legislation, but such integration has been enabled for a long time—some places just have not done it. Mr Johnston rightly said that the bill is structured in such a way that the requirements on local authorities and health board partners are that the dynamic involve a bottom-up approach with huge consultation at local level.

The point of the bill is to give direction where there has been no change at local level, otherwise there is no point in having legislation in the first place. We could pass a bill that says, “Here’s what we’d like you to do, but if you don’t do any of it, the minister cannot step in.” What would be the point of that?

11:45

I refer you to section 39, “Default power of Scottish Ministers”; where a lot of the issues may emerge. If local authorities and health board partners cannot get around the table and agree a plan—I think that they will; I do not think that the power will ever have to be used—at some point the Scottish ministers should, surely to goodness, have the power to step in and make it happen. Maybe we can have a debate about whether—

The Convener: Can we just get a response? There are four people waiting to speak, including your colleagues. You have made the point quite well. Let us get a response to that.

Ron Culley: We do not disagree with that. Should Scottish ministers have the capacity to ensure that the legislation is followed? Of course they should—absolutely. We disagree with how the policy intention is articulated in the bill. We think that there is a drift, and we want to work with the Government and Parliament to correct that.

Bob Doris: Okay.

The Convener: Is there a clash of two cultures? We have 32 local authorities and a more centralised set-up for health through the minister. Is there a drift because of that? I do not mean a conflict of interests, but the cabinet secretary’s interest is in defending his portfolio’s budget, and he is more susceptible, on a daily basis, to being lobbied and to hearing anxieties from the acute sector. Many of us politicians chase after that and put a lot of pressure on the cabinet secretary to deliver. Does some of the drift come about through that?

Ron Culley: The NHS is a managed service and local governments are democratic institutions, so your observation probably has some weight. Ultimately, we want to ensure simply that the bill does what it says on the tin. The amendments that we would like to lodge, or see others lodge, would result in a bill that we would be more comfortable with—a bill that is in parts more empowering, less directive and less prescriptive.

Use of authority at national level is clearly important in underpinning any legislation—we absolutely accept that. What gives us serious concern is the introduction of discretionary powers, which we think are absolutely not necessary. There needs to be a legislative framework that we can all work within, but partnerships must be allowed to get on with the job. That is all that we are asking for.

Rhoda Grant: The discussion has moved on and we are getting to the nub of the issue, which is about having a bill to facilitate joint working rather than to dictate how it happens. That takes us back to the aim of the bill. We have been talking about shifting the balance of care from the acute sector to primary and home care. If we are going to do more of that, we can do a huge amount using telemedicine and the like, which home carers could help to facilitate. There could be a real opportunity to shift the balance in that way.

How can we do that? Some local authorities have undertaken an awful lot of work to push that forward, and there may be things in the bill that you think are blocking that, and which we need to look at. How can we take along with that move and change those who are more reticent, who perhaps do not have good working relationships
on the ground? How can the Government ensure that the same standard of care is available to Joe Bloggs regardless of which local authority or health board area he is in?

**Peter Gabbitas:** On that last point, my chief executive in health made me jointly accountable, with the director of nursing services, for unscheduled, or emergency, care. She manages the acute component of that and I manage the primary care, social care and community health component.

I will give an example of the things that we are doing to shift the balance. We are about to introduce step-down beds. Many other authorities have also done that, but what might be different about Lothian is that funding for that is coming from the acute sector. We have done the detailed calculations that say that we can manage with fewer acute beds if we have the step-down facility and the correct flow through. In social care, we are commissioning that. It is partly being commissioned by the private sector and partly being provided internally, but the funding ultimately comes from the acute sector. That is all happening without legislation; we are just doing it anyway.

**Soumen Sengupta:** I was going to pick up on a variation of that. Part of the way that we address the matter is by having a smaller number of individuals who are accountable for the totality of the work, as in the example that Peter Gabbitas talked about, where two extremely senior managers are responsible for the totality of the activity rather than three, four or five being responsible.

In our neck of the woods, at a much more local level, if someone has an issue with residential care and someone has an issue about the district nursing input, the same head of service—let alone the same director—will have responsibility for that, can be contacted about it and is empowered to deal with it because they have responsibility for the relevant budget, albeit that, at the moment, they are not pooled budgets but aligned budgets.

That provides a facility whereby, rather than there being 20 people to deal with an issue, there is one director—a single officer—and their team. That should create synergies and efficiencies in driving through change.

However, at the same time, that requires a marriage of solutions. As everyone has said, these are wicked issues. That has come through repeatedly from all our submissions. It is a case of, “How do you eat an elephant? One bite at a time.” The bill is an important bite, but it is only one part of the process and there are lots of other things that have to go on at the same time.

**Ron Culley:** The debate about shifting the balance of care is pivotal. One of the reasons why we have come down so hard in favour of the introduction of acute budgets to the integrated resource is that without that, it will be difficult to redesign services.

I will make a slightly wider point. Across the NHS and local government and, indeed, into the third and private sectors, there is a fairly widely shared view that, into the future, there will simply not be enough money to cope with the change in structure of our population and increasing levels of demand. Investing in prevention and reconfiguring how we provide services will all help, but will never eliminate the basic problem, which we will need to address in time. That is not necessarily something that can be solved through the bill, but we want the Parliament to be aware that, over the next decade, we need a solution that is not only about how we optimise the provision of care.

There has to be a fundamental discussion about our expectations as a society, what the relationship between the citizen and the state should be in the future and how we pay for our care. Let us not lose sight of that as we move forward.

**The Convener:** We heard half an hour ago that the cultural change that is necessary can take a decade or 20 years.

**Ron Culley:** Yes.

**The Convener:** How do you square that with what you just said?

**Ron Culley:** We have always said that we need both. We need to change the way in which we deliver services. That is why we are in favour of integration to ensure that there is closer working between the NHS, local government and our partners in the third sector and the private sector. However, although that is necessary, it is not a sufficient guarantee of change. Alongside that, we need a more fundamental debate about how we fund care in the future, because it is just not sustainable.

**The Convener:** Does that not play back to Bob Doris’s point that the imperative has existed for the past 10 years but the pace did not match the necessity to go forward?

**Ron Culley:** We accept that half of the argument. We accept that there is an opportunity in the bill to achieve a step change. That is fine, but there is another half of the argument that is not being heard and is being buried. That is, to put it straightforwardly, that there is not enough money in the pot for the future.

**The Convener:** Does anyone else have a comment? I will take witnesses first, but a couple of members are waiting, too.
Duncan Mackay: In relation to reshaping care and the balance of care of older people, it is important that the committee recognises that the proportion of older people in Scotland who are in care homes is significantly lower than it was 10 years ago. Some partnerships have performed successfully in reducing that proportion to a substantially lower level through commissioning a series of intensive alternatives, or intensive alternatives along with preventive measures—that responds directly to Rhoda Grant’s question.

Those partnerships that have pushed the level of older people in care homes down to perhaps 25 people per 1,000—the Scottish average is 35 per 1,000—have reached the position that some activities are beyond our influence. Generally, they lie not in primary care—there is often good, strong partnership working between primary care and community social work services—but in the acute sector. That merits further analysis in the context of the bill.

Typically, people arrive at an acute hospital by one of four routes. One route is to arrive at the door, which raises the question whether they arrived there just because the lights were on, as one report put it, and whether they could have had better access to a general practitioner or other support, advice and treatment that would have prevented their arrival at the door.

Another route is through GPs, who are, as the committee knows, self-employed contractors under the national contract, over which there is limited local influence and no influence at all from a purely local authority perspective. Other routes are through NHS 24, over which local integrated arrangements have limited influence, and through the Scottish Ambulance Service, over which there is also limited local influence. The bill must address how to realise the policy aspirations in the context of those routes into hospital, instead of being silent on that.

Peter Gabbitas: I return to what Ron Culley said. If it is not already obvious, I say that I am passionate about integration and about shifting the balance of care, not least because our clients—or service users or patients—tell us that they do not want care in an institutional setting. If it is possible for them to have care in their home, that is their strongly expressed preference.

I am passionate about integration—I believe firmly in it—but it will not solve some of our fundamental challenges, given the amount of resources that we have and the demographic change that is coming. Integration can make a positive contribution, but it will not solve those fundamental problems. I am keen for us to remain sighted on that.

Ritchie Johnson: I will expand on what Ron Culley said, although I will not revisit the points that he made. A wider question concerns community planning as an approach and the focus on prevention to support shifting the balance of care. I agree with Peter Gabbitas that integration can help us to get in and about some of the challenges more directly, but it will not necessarily automatically solve them.

The change plans are examples of efforts to shift the balance of care. The sustainability of some projects that have been set up as part of that and which are intended to tackle earlier intervention work is still uncertain.

The focus of integration is on adult health and social care, but a range of partners, such as housing, parts of children’s services and criminal justice services, which Duncan Mackay mentioned, can contribute to delivering the outcomes. Partnerships will have a formal set of responsibilities, but we must not lose sight of the wider world, which can influence and shape matters. That might come through joint commissioning strategies. Housing is an important element.

12:00

Nanette Milne: I am not sure how relevant my question is to the panel. Peter Gabbitas mentioned community health partnerships. One reason why they failed fairly early was that they failed to engage with GPs. The hope is that that will be improved this time round. We have not heard much about that in evidence so far. The other groups that we have not heard much about so far are carers and the people on the receiving end, who are the reason for the bill being introduced.

What do people round the table think will happen locally? Will the bill help to facilitate an improvement?

Soumen Sengupta: I will try to answer both questions. On the first one, colleagues round the table might have a different view—my position is different from that of Peter Gabbitas, as I am also an NHS officer. Many of the issues come down to looking at the relationship with general practice with regard to the model that Duncan Mackay spoke about. The leadership and management of the current and future partnerships have a responsibility to engage with professionals of all stripes and persuasions, including clinical professionals and GPs.

An interesting conversation is also 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 poses 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.

There are a range of tensions and those are difficult conversations, but it is terribly easy for some of our clinical colleagues to say, “We have not been sufficiently engaged, because something was done that we did not like.” There is an onus on all of us to do all this better.

In terms of patients, carers, and service users more generally, I am aware that to an extent the bill is one of a number of pieces of legislation that relate to the partnerships. Another one is the proposed community empowerment and renewal bill, which gives some powers to all public bodies. In effect, it just clarifies powers or obligations that are already in place for everybody in how we work and engage with our local communities. I am sure that everyone round the table will be able to give lots of examples of us working hard to do that, but complaints that we get and complaints that your constituents bring to you show that there are always instances when we could do better.

However, in addition to there not being enough financial resource across the public service, there are a range of different and increasing expectations. That ties in with Ron Culley’s point. The issue is how we have a conversation with communities at large about what people are entitled to and should be expected to get from within the total available resources, so that those who need it the most get it, which means that, frankly, other people who are not in as much need might have to wait a bit longer or do not get something to the same extent. We will not be able to avoid difficult conversations, irrespective of whether the new arrangements are introduced.

Peter Gabbitas: Nanette Milne’s observation about CHPs and primary care is right. I have recently talked to a lot of GPs about what the integration agenda might offer. As somebody who was responsible for Edinburgh’s CHP for many years, I do not think that we effectively harnessed the hearts and minds of GPs in Edinburgh. I recognise that failing and we 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 cooperatives.

Also, we have not fundamentally addressed some policy issues. We have recently moved from a national contract to a Scottish contract, but the change is around the margins, because it is still a national Scottish contract and the number of things that we can determine locally is minimal. If we swapped the balance between what is determined nationally and what is up for local negotiation, 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.

Having said that, I am sure that, if you took evidence from the BMA, you would find that it was horrified at the thought of moving away from a national contract. It took a lot of persuasion to get the GPs into a Scottish contract, let alone a more local one. However, that would 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—there could be an 80:20 split, for example, with 20 per cent determined locally—would create a reason to get very active with primary care.

I talked a little about end users, but we have not talked about carers. Carers are fundamental. Everyone here knows the numbers as well as I do but, as I have often said, if carers just decided tonight to stop caring, the entire system would crash. We can never do enough to support carers. We are trying to do a lot more, and I am sure that every authority is doing the same. In the past few years my authority has dedicated extra money for carers, on top of any of the national things.

There is another area that we have not talked about and which was not talked about in the previous evidence session, either. So far, the conversation has largely been about two sets of employers: the NHS and local government. We have not talked about the role that the private and voluntary sectors play, which is fundamental. Some 55 per cent of my social care budget relates to external provision. In social care, 55 per cent of the service is externally commissioned whereas, in the health service, about 100 per cent is internally commissioned. That creates issues in relation to how we will develop integration plans. That is an important dimension, which we have not touched on at all.

Ron Culley: I agree with all of that.

We have been critical of elements of the bill, but it promotes a positive idea in respect of locality planning and it will put legislative force behind the approach. That will require health and social care partnerships to give thought to how they organise themselves locally—it is clear that they already do that.

In relation to something that Ritchie Johnson said, we are at a pivotal moment, as we have the bill that we are considering, and the forthcoming community empowerment and renewal bill, which will renew community planning. At the heart of that is not just the superstructure and how we plan
more effectively for localities using the total resource, but how we engage with communities and give life to the principles that Christie set out in his report.

When we engage with communities, whether we are involving general practitioners, carers or others, we must ensure that we do so consistently across localities, to ensure that we do not have a situation in which the health and care people come to talk to the community on Monday, the leisure people come on Tuesday, someone else comes on Wednesday and so on. Community planning has the potential to achieve that. We have always argued that the areas need to be strongly linked. At locality level, we can begin to make inroads into that and see arrangements develop.

Ritchie Johnson: We were asked about the part of service users and patients in all this. National outcome measures will be confirmed, but locally we have asked how we will know that our investment has made a difference, if we have invested in a different set of cultures, with a different set of expectations about services. We are considering how we can ask the people who directly use services what their experience is now, so that we can compare it with their experience in one, two or five years’ time—so that we have before-and-after scenarios. For us, anyway, we need to get local intelligence so that we can understand the impact of the investment that we are about to make in the new partnership arrangements.

The Convener: What is in the bill for carers? How will it change their lives?

Peter Gabbitas: I am not aware that there is anything specific about carers. I go back to my starting point, which was on our aspirations for integration. We want to create more joined-up services. Quite often, the carer or the person who receives care has to co-ordinate services in their home. I hope that, as a result of the work that we are undertaking in Edinburgh, we can change that fundamentally, so that we are the ones who co-ordinate care, and we do it far more effectively. I often think about the person who is juggling home care and district nursing appointments, and the variety of people who might go into a person’s home. Individual carers should not have to do that, and it is our responsibility to make that more effective and seamless. The bill’s aspiration and its policy intent is to try to make that much more joined up and effective.

The Convener: Should the bill therefore say more about carers’ and patients’ rights? Should there be more positive enforceable rights in the bill to help to change that culture? If we accept that legislation, shifting budgets and working together can do it in part, why not have greater enforceable rights for patients? We had an answer to that in the private session. It was not a very good one.

Ron Culley: You have put me under pressure now. I think that the answer lies in good commissioning practice. Rather than identifying somewhat rigidly what people can expect, we should put our energy into good commissioning practice. As committee members know, that is developing throughout Scotland.

The committee has heard reports in the past that have been critical of commissioning capacity in social work and health, and we recognise that that is an area for improvement. Support for carers must be articulated through the creative use of resources. The idea of disinvesting to reinvest has been mentioned a couple of times. That is about trying to get more money upstream to support carers and the people in their lives and to ensure that carers do not have to draw on formal services, especially the more expensive ones in secondary care.

Good commissioning plans will be able to take us in that direction. Crucially, that will be based on an analysis of local population need and will be able to engage with local groups of carers and other populations. That is where the answer lies, rather than in a fairly rigid articulation of entitlement.

The Convener: That interests me because, when I speak to the people who are involved, they do not like the idea of enforceable patients’ rights. That is what encourages me to keep asking the question. We know about the importance of continuity of care in health—that is well established. However, it does not apply in the community, where people can have several carers in and out of their home, including strangers, and different people at the weekends. Why does it not apply? We are talking about the right to be treated by an appropriately qualified person and not somebody who has just been recruited at the weekend.

A number of issues come to us through casework that would not arise in a hospital or other national health service setting, although sometimes such cases do occur. If more people are to be treated in the community and if those people are not protected by the rights that they would have had in a hospital setting, there is an inequity and a worry there. There is a perception that they will get something less valuable and not of the same quality. Unfortunately, in some cases, commissioning and procurement have worked to people’s detriment.

Soumen Sengupta is up next, but I am glad to see that Ron Culley wants back in again.

Soumen Sengupta: I just have an observation. There is the Patient Rights (Scotland) Act 2011, so
there are other legal instruments that address that kind of issue.

Picking up on Ron Culley’s point about the commissioning plan, that comes down to the quality of leadership and management in a particular area, irrespective of the management structure around the provision of services. Again, the issue is whether we would want that in legislation and whether that is the policy intent. That issue is really down to the calibre of the people who are on the ground providing the service, and how they provide it.

Everyone says that they know the value of continuity of care. At the same time, everyone has talked about scope for innovation. One downside and unintended consequence of being too prescriptive about entitlements is that it negates the scope for innovation in service models, particularly over time and given that needs and resources will vary between areas.

12:15

Ron Culley: I agree absolutely. I understand why people search for guarantees and why it is attractive for parliamentarians and other politicians to discuss the language of guarantees. The challenge is that guarantees create rigidity in the use of public sector resources, whereas the bill’s major strength is that it creates flexibility in the use of those resources.

We can look at the total pot and use the money differently, but that is hard if everything is nailed down. That is why I think that, if we ensure that we have flexibility and if we build the capacity to improve in the commissioning agenda—I agree that we have more to do on that—support will gradually improve for carers and other population groups who absolutely require it.

The Convener: We have a focus on what care recipients get. Two years ago, the committee completed a very good report on the care of elderly people, in which we identified issues with commissioning, procurement, the quality of the workforce, what should be expected and how we train and pay the workforce. That is a good read for the holidays.

Malcolm Chisholm: One of the strongest themes in all today’s submissions and statements is that acute care and particularly its resources must be centrally involved. That is one of the most interesting aspects of the bill, so I am interested in the model that will be used.

Acute care could be involved in a good way or a bad way. It must be involved, but I know that some in the health service fear that, if we went for the body corporate model and acute care was not part of that, we would be almost in danger of reintroducing a commissioner-provider split in Scotland, whereby 32 bodies corporate would have to negotiate with health boards. We do not want that in Scotland, but we want the acute sector and its resources to be involved. What model do people have in their heads?

The most important thing in health is to shift the balance of care but, if we add up shifting the balance of care and the demography, that shows that we will not be able to reduce in absolute terms acute health service budgets. That applies particularly strongly in Lothian, whose elderly population is to increase massively more than that elsewhere—it is to double in the next few decades.

Peter Gabbitas says that we have step-down beds that the NHS has paid for, but we also have extra acute beds that the NHS has paid for. As we shift the balance of care, we will not be able to reduce acute budgets, because of the demography. That must be taken into account. Some of the submissions suggest that people think that the acute sector will be able to reduce its resources, but I do not see that happening in this part of the world, although it might be able to happen in other parts of Scotland.

In view of those factors, what model do people have in mind for the acute sector’s involvement?

Peter Gabbitas: I agree absolutely that we very much aspire to shift the balance of care so that fewer of our resources are used in the acute sector and in institutional settings. There is clear evidence that we are doing that from the national performance indicators. However, given the overall challenges and the demography that we face, it will be incredibly challenging to maintain the acute sector with the number of beds right now.

We have looked at that strategically in our work on a whole-system comprehensive plan. That plan shows that, if the currently rising trend in emergency medical admissions continues unabated—clearly, we do not want that to happen—we will require 800 more beds within the system. The issue is about the extent to which we might be able to affect that gradient, given that it would be an heroic and foolish assumption to think that we could reduce it to zero. Whatever the extent to which all our work on integration, on better unscheduled care, on providing alternatives to admission and on getting people through the system faster reduces that gradient, the gradient will still be there. Therefore, no one should have the notion that massive sums of money could be saved in the acute sector and shifted over into health and social care. Certainly, from all the analysis that we have done within Lothian, that is not the case. However, we want to work collectively to see how we can cope with the
pressures that are already in the system and that will continue over the next 10 to 15 years.

On the question which would be the best model, I do not have the model in my head and I have yet to meet the person who does—it may be that there are such people. I feel that we need to look at the issues in a whole-system way, so the acute sector certainly needs to be around the table and the health and social care partnerships need to have much more influence over acute spending than the community health partnerships had. However, at present I could not move away from that statement to say how we actually do that. We make it work in Lothian, but I could not say prescriptively what the model looks like right now.

Another issue, as Duncan Mackay said in respect of North Lanarkshire, is that whereas matters are relatively straightforward in relation to Edinburgh residents—the vast majority, if not all, of whom are cared for in Edinburgh—our Edinburgh hospitals also support people from East Lothian, Midlothian and West Lothian and, in addition, provide some services for south-east Scotland and certain services for the whole of Scotland. Acute care really has three different dimensions: tertiary specialist care, which health and social care partnerships are not involved in; scheduled care, which we are involved in in trying to influence demand, so the primary care component is important, because it makes the referrals; and thirdly—the three dimensions split into roughly equal thirds—unscheduled care or emergency medical admissions, which is the most important dimension for the health and social care partnerships to be getting in about. I gave an example of such involvement earlier today.

The Convener: Ron Culley wants a minimum share of the acute budget to go to the integrated budget. Is that not the case, Ron?

Ron Culley: Absolutely.

The Convener: Let us hear it then.

Ron Culley: This is a pivotal question, so I will make a number of observations about it.

First, under the body corporate model as that is constructed in the bill, the joint board will be relatively insulated from the two parent bodies. In other words, the bill invests power and authority in the joint board to design a commissioning plan and to see it being implemented. My NHS colleagues are slightly nervous about that because it will be within the gift of the joint board to say that it wants to use the acute sector differently—for example, it might not want to use the acute sector as much. The bill brings together all those collective resources into a single place and allows the joint board to make that type of decision. The fears emerge because the health board will not need to sign off on the commissioning plan.

In other words, the worry is that the budget for the acute sector will be disaggregated—after all, most health boards have more than one partnership within their territory—among a number of partnerships and then reaggregated based on the partnerships’ preferred commissioning model and consumption patterns. All of that might not add up to the amount of money that is needed to run the hospitals. That is a genuine issue that we need to get past, but we have been working on it and I think that there will be a solution to it. However, I am also confident that the solution will not be that the acute sector retreats into something else and sits aside from all this. I think that how we use acute resources has to be at the heart of this.

Over the past few years, the work that has been undertaken on the integrated resource framework demonstrates that there is huge variation among GP practices in their patterns of consumption, including in their referrals to the acute sector. The argument is that reducing such variation will free up some capacity to use resources differently.

However, the bigger point—and I think that on this matter Mr Chisholm has come to the same logical conclusion that we have come to—is that because of the population’s changing structure, integration in and of itself will not solve this problem. Over time, therefore, we will need to have a conversation about people’s willingness to pay for care into their older age.

The Convener: But you are sticking to your argument that we need to take a minimum amount of money out of the acute budget for the redesign to happen.

Ron Culley: Absolutely. 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.

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.

The Convener: What would a minimum figure be, and who would work it out?

Ron Culley: Peter Gabbitas and I would do it. [Laughter.]
The Convener: I am sure you would, but I am also sure that people in the acute sector would not agree with you.

Duncan Mackay: This is such a difficult question to answer and we are all wrestling with solutions. However, any analysis of the problem must start with an examination of the things that can happen only in an acute hospital environment and the things that happen in such an environment that could happen elsewhere. There will be points of clarity at both ends of the spectrum and points of debate and grey areas in the middle. However, if we do not do that, we will start from the quite pessimistic position that we cannot do anything that happens in an acute hospital anywhere else. If we assume that, we will not be able to explore, say, telehealth, the potential of which is untapped in large parts of Scotland and better developed in others. We have to start from the position that I have outlined before we can reach any meaningful conclusion about the organisation of services, and we also have to look at this as part of a whole system of which the acute sector is a critical element.

One of the issues in the acute and primary care sector is that often old-age psychiatry sits in one area and geriatric medicine in another. Many of the people who are supported and treated through the geriatric strand of activity will have significant cognitive problems, dementia and so on and I suspect that, if we got a group of them in a room and tried to guess which side of the house they were being treated through, that would not always be a straightforward task. That quite significant—and certainly challenging—area of potential integration and development has probably been explored more in some health board areas than in others.

In response to the convener’s question about what would be a minimum, one could say that it is just geriatric specialties and care of the elderly medicine, but that is a very small part of the service provided by hospitals and, indeed, a very small part of most older people’s experiences. Most older people will not go near the specialty—and nor should they. However, things will happen elsewhere in the acute system. Typically, someone with dementia who has been living well at home, often with support from family members or with statutory support, will fall and break their hip. The orthopaedic surgeon who treats them—and who will not necessarily have expertise in and knowledge of dementia—will identify the person as having dementia and will say to the family, “Your mother’s got significant dementia. I don’t think that she should be living at home.” That starts off a whole journey, because no dementia specialist might have been anywhere near that person.

When we start to talk about minimums, therefore, things get difficult. I know that it is easy to set out a general anecdotal position, but such experiences will be familiar to many people who rely on health and social work services. That is the kind of interrogation that we need before we can reach a meaningful conclusion about which parts of the acute system should be included, but I think that if no part of the acute system is included we will struggle to achieve the policy’s goals.

12:30

Soumen Sengupta: I very much echo other people’s comments, but I think that three other points are worth mentioning. First, I am fairly confident that my NHS acute colleagues recognise such issues; they are not walking away from them and, indeed, are spending a lot of time thinking about them. Certainly in my health board area NHS Greater Glasgow and Clyde has undertaken a substantial clinical services review in order to quantify and grapple with these very issues with a view to reporting later in the year. After all, there are no easy answers to these questions.

Secondly, with regard to existing arrangements or indeed the new partnerships, I cannot imagine any senior management or leadership team having any vested interest in, in effect, fracturing acute service provision. I believe that everyone is acutely—no pun intended—aware of the need to think about not only how these changes are made but how they might work with other colleagues on making those changes. Preliminary scoping work has been undertaken in Inverclyde’s community health and care partnership on its relationship with the local hospital and whether there are any opportunities to put things on a positive footing.

Thirdly, I know from work that we have been doing and conversations that I have had with clinical colleagues that an issue that keeps emerging is the relationship between GPs, acting in effect as gatekeepers, and their acute consultant counterparts in other services. To some extent, that ties into Duncan Mackay’s comments. If locality planning promises anything, it is the ability to facilitate and strengthen, through the use of information technology and other means, direct relationships and communication between clinical staff working in primary care, including GPs, and our acute clinical colleagues across the board, to ensure that patients are not only supported properly on a seamless pathway but on the right pathway. Of course, that will involve understanding that these people are highly skilled and technically capable individuals who are able to work outwith their own narrow specialties and can exercise quite proper clinical judgments on some of these matters. We simply need to facilitate that.
Ritchie Johnson: It is difficult to define a minimum level of acute service and no one has an easy answer to that question. However, as I said earlier, we need to concentrate on the basic question of what we are doing this for, what we are seeking to integrate and what we want to improve; that might be a way forward and help to inform the debate about which components of the acute service might be better in scope than out of scope. Instead of focusing on the territorial or budgetary components of the issue, we need to come back to outcomes, what will make a difference to people receiving our services jointly, what should be brought into scope and which parts of the acute service would fall into that sector.

The Convener: We have come to the end of the session and I thank everyone for their attendance, participation, views and written evidence. I would like to think that, as far as the evidence is concerned, this is an on-going situation and if you read anything that you strongly agree or—as is more likely—strongly disagree with, we would be keen to hear your comments via the clerks.

Meeting closed at 12:34.
Do you agree with the general principles of the Bill and its provision?

Yes. The general principles and provision are welcomed and follow on from the previous consultation on the Scottish Government’s proposals, responses made, and the Scottish Government’s subsequent response to these.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The Bill sets out a coherent framework within which integration can be progressed but leaves room for local partnerships to develop “best fit” solutions within statutory boundaries. It is felt that this strikes a good balance and it is believed will help to achieve the stated policy objectives.

The extent to which the stated policy objectives will be achieved will be largely determined by two factors: (1) moving from a focus on outcomes at a high strategic level to personal outcomes for individuals to ensure seamlessness at point of service delivery (2) effective locality plans which link to, and heavily influence the Integration Authority strategic plans.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths.

The coherence of the policy objectives is a key strength. They will have to be followed through at a personal and locality level supported by an approach which values enablement and coproduction.

Aspects of the policy memorandum are welcome reminders:

- “Integration is not an end in itself – it will only improve the experience of people using services when partner organisations work together to ensure that services are being integrated as an effective means for achieving better outcomes”;

- “legislation alone will not achieve the scale or improvement that is required . . . Leadership is key, locally and nationally . . .”

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.

It may be that the following will be picked up in regulations etc but as it stands, the Bill could be strengthened in the following areas:

a) public accountability arrangements – section 33 mentions a performance report. It may be helpful to link this to a focus on outcomes for avoidance of doubt;
b) Statutory public engagement responsibilities – for instance it would be helpful to clarify the position of Public Partnership Forums (PPFs). In Ayrshire, the PPFs have proven to be very effective support to public engagement arrangements across the totality of health provision;

c) Consultation arrangements – various references are made to issues such as the preparation of the integration plan but there is a substantive issue to be addressed concerning any implications for consultation arrangements in relation to proposals for service change made by the Integration Authority;

d) Following on from this, it may be helpful to clarify approval processes in instances where a strategic plan proposes major service change. In particular whether the Cabinet Secretary will continue to hold what would effectively be veto powers over the Integration Authority’s plans;

e) Whilst it is helpful that the Bill makes consistent reference to integration planning principles these are silent on the need to ensure effective clinical / care governance;

f) Staff governance is a statutory requirement of NHS Boards and the Bill is fairly silent on what arrangements (if any) Integration Authorities will be required to put in place.

g) There is a need to be more explicit about how the Integration Authority will be scrutinised jointly, by external scrutiny agencies;

h) In terms of analytical review of the Bill as a whole, there may be a case for considering whether the balance between what is on the face of the Bill and what will be in regulations could be improved. For instance while regulations will define the scope of integration, it is on the face of the Bill that the responsibilities of a Chief Officer are subject to the agreement of Scottish Ministers.

What are the efficiencies and benefits that you anticipate will arise from your organisation from the delivery of integration plans?

Efficiencies and benefits are anticipated to arise as follows:

a) The focus on outcomes (providing this is reflected in performance regimes);

b) The introduction of locality planning – this should streamline community engagement across the four sectors and maximise the opportunities for an assets based approach while engaging local users, carers and professionals in an agenda which is real for them. It should also bring a sharper focus on tackling health inequalities;

c) The principle of joint and equal responsibility – this should help reduce “hand offs” between the statutory agencies;
d) the engagement of the third and independent sectors as strategic partners – this is already helping to shape effective plans in services for older people;

e) a logical framework reflected in the flow of the Bill from the model of integration to the integration plan to the strategic plan with consistent integration planning principles throughout – this will bring a much higher level of consistency and focus to joint endeavours;

f) an improved approach to making investment and disinvestment decisions based on a clear process and evidence base and best use of integrated resources;

g) greater potential for a joint strategic commissioning process which is based on improving outcomes at both a strategic and individual level, supports effective service change and views issues from a user’s perspective.

What effect do you anticipate integration plans will have on outcomes for those receiving services?

Integration plans will bring a rigour to setting out what the Partnership is responsible for and how it will be funded. Coupled with the strategic plan setting out how the Partnership will deliver its responsibilities it will give greater transparency to how all of this directly relates to improving outcomes. Crucially, however, it must also link to effective locality plans which should capture how refreshed relationships between the statutory, third and independent sectors and local communities can also improve outcomes.

Other Comments
There will be a need to ensure that there is sufficient Non-Executive Director capacity within NHS Boards to support the effective running of the Integration Authorities. This may be a particular challenge for NHS Boards with several Local Authorities within their Board area.

NHS Ayrshire and Arran
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

NHS Dumfries and Galloway

Introduction
NHS Dumfries and Galloway has a good history of joint working with its Council partners in the provision of health and social care services. For over 10 years this joint working has seen our partnership make significant progress in driving forward care and support in the community and ensuring the development of services that supported adults, including those with a Learning Disability, Mental Health problem as well as Older Adults, in having access to a range of community services and support.

We recognise the significant opportunities challenges that face our society that result from the changing demographics and we have agreed key principles with our partners in addressing these through significant change programmes in this region. Our principles include the development of locality planning and delivery, delivery as close to home as possible, underpinned by technology where appropriate and by person-centredness. Our change programmes which are driving these principles forward include the development of our Reshaping Care for Older People programme – Putting You First, the development of care and treatment pathways that will underpin our planned new District General Hospital and ongoing partnerships with the Council to provide re-ablement, anticipatory care and early intervention support.

This response builds on our joint submission to the Scottish Government’s consultation on their proposals to integrate adult health and social care and on the principles for integration agreed with our council partners.

Do you agree with the general principles of the Bill and its provisions?

As a result of both our joint working in the past and the current range of work taking place now, we have, as a partnership, delivered good outcomes against national standards and benchmarks. This includes our partnership providing among the highest level of intensive homecare for the over 65s in Scotland – enabling more older people to remain at home with the care and support they need and maintenance of generally low levels of delayed discharge from an acute setting – demonstrating joint working to enable people home from hospital when they no longer need to be there.

We recognise that there are inconsistencies of provision and outcomes for people across Scotland and one of the principles of the Bill is to reduce this level of variation through legislation and to use legislative levers to improve the quality and consistency of health and social care across the country. To this extent we are in broad agreement with the principles and scope of the Bill. However, in our joint response to the consultation, our view was that any legislation should be
permissive rather than prescriptive in setting out the models for integration – recognising the real differences in the configuration of partnerships across Scotland and the opportunities for innovation and local responses. We note however that the Bill, as it stands, sets out only 2 permissible models under the proposed legislation.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The Bill has been developed against a context of unprecedented demographic and financial challenge. While we agree that there is scope across Scotland to improve outcomes for people through an integrated approach a concern is that the structural changes demanded by this legislation, which will potentially put in place new layers of decision making and governance, will prove a distraction in relation to the pressing need to deliver transformation on the ground, at pace and in a short timescale and in the context of ongoing financial efficiencies. Every support should be provided to partnerships to ensure the focus on outcomes and transformation rather than transactional and structural change.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

We consider the following to be the key strengths of the Bill:

- Opportunity within its current structure and permissions to enable a ‘life-course’ approach and through that address the significant challenge of health inequalities in Scotland;
- The focus on outcomes rather than outputs;
- The focus on developing transparent and trusting relationships between Council and NHS Partners;
- The clear direction of travel in regard to supporting shifts toward prevention, early intervention and in the balance of care;
- 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;
- The locality focus that delivers the agreed strategic aims in a way that makes sense locally and which takes account of different local contexts;
- The strong ethos on partnership, personalised and person centred approaches and on consultation and involvement at every level.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

In a number of ways we have been here before and we should celebrate the real progress made under Joint Future as well as learning from its shortcomings. One aspect of this has to be the consideration of both harmonised terms and
conditions for staff and the development of genuinely joint IT systems that are focussed on the individual, rather than the needs of the system or a single organisation. Maintaining current systems may reinforce current cultures rather than supporting the real cultural change and transformation that we require to address the challenges and opportunities ahead.

Further challenges arise from some lack of clarity on the reporting role of the structures set out in the Bill and while more guidance has been flagged this should be made available to keep pace with the work partnerships are already undertaking on the ground.

- **What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

In common with other Health Boards and partnerships, NHS Dumfries and Galloway has a well developed efficiencies programme that supports us in setting and delivering efficiencies targets year on year. In this context it is difficult to identify immediate efficiencies and benefits over and above those that we have already identified through effective joint working across our *Putting You First* programme and through our joint finance group agenda with the local authority.

We recognise a number of significant challenges and pressures that may arise in the implementation of this work in relation to programme management, management re-structuring and in delivering the depth of engagement and involvement commensurate with the provisions of the Bill.

It should also be recognised that while efficiencies are anticipated in the Bill and its accompanying papers, that this is essentially an approach to delivery of improved outcomes and better quality. That notwithstanding, in the longer term we would anticipate efficiencies and benefits being sought and developed in areas suggested in the financial memorandum e.g.:

- Efficiencies through a focussed approach to anticipatory care, prevention, avoidance of unplanned admissions to acute care and early intervention;
- Efficiencies through shared services, rationalisation of the shared estate and shared/joint management opportunities being sought;
- Locality focussed efficiencies through a geographic approach to commissioning and service provision;
- Partnerships and service development with the 3rd and Independent sectors in delivering innovative approaches to care and support; and
- A focus on de-commissioning through the strategic planning process.
**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

Our ambitions in developing locally integrated services are aligned to those set out in the Bill. We anticipate being able to develop seamless pathways of care and support that minimise delays and duplications in care and support and which are safe, person-centred and of a high quality. We anticipate an integration plan that sets out how we as a partnership will maintain good outcomes in relation to prevention of unplanned admission, maintaining low levels or no delayed discharges and which support our targets in reducing length of stay.

We are already underway in evaluating people’s experience and views of care and support through our *Putting You First* programme and this evaluation will support our understanding of the effect that integration will have on the people that use services, enabling us to adapt and change as necessary in light of these findings. We anticipate an increasingly personalise and person centred approach that is locally delivered wherever possible and where people experience a system that is built around their needs and therefore easier and smoother to navigate.

**NHS Dumfries and Galloway**  
2 August 2013
Introduction and General Points

1. Scottish Care welcomes this opportunity to contribute to the Health and Sport Committee’s scrutiny of the draft Public Bodies (Joint Working) (Scotland) Bill. Please find below some points of general comment together with our response to the specific questions as requested. We would also be happy to provide any supplementary information the Committee might wish or to participate in any evidence sessions the Committee might hold.

2. Scottish Care is the representative body for private and voluntary sector providers of Care Home and Care at Home Services across the country. In relation to older people’s care, this sector provides 85% of the care home places in Scotland and over 50% of care at home. There are more older people in care homes any night of the week than in hospitals, and more social care workers employed in the private and voluntary sectors than in the public sector (See attached for more detail). The thrust of integration has to reflect this and focus on the joint working of all service provision and not just of the public bodies. In our view the title of the Bill could more usefully be *The Public Services (Joint Working) (Scotland) Bill*, embodying from the outset that the non-statutory (private and voluntary sector) organisations are an integral part of service delivery and essential parties to the new arrangements. Without this being signalled on the face of the Bill, the danger is that some of the progress, ownership and momentum made under the Change Fund, which has been premised on a 4-way partnership, may be lost.

3. The mundane title of the Bill might also tend to obscure the fact that its impact is potentially transformational in terms of the Health and Social Care landscape in Scotland. Although its reach is initially confined to Adult Services, it is hard to see how this can happen without corresponding changes in other areas of provision, and this is borne out with the initial experience of change in Highland. Accordingly, it is crucially important that the Bill is fit for purpose and does all that it needs to do at this stage. We need to get it right. It also has to progress in a way which maintains the broad-based political, professional and public consensus around the need for change and the merits of greater integration.

4. In our view the Public Bodies Bill cannot be seen in isolation - it is one plank, albeit a very central one, of the Government's wider strategy for Health and Social Care reform. It therefore has to clearly articulate with the other key elements of Reshaping Care, Self-Directed Support, Strategic Joint Commissioning, the Change Fund, the National Dementia Strategy, Housing, etc. The chances of joined-up working are
likely to be significantly enhanced if we start from a position of joined-up policy. Some reference to this connectedness within the Bill would therefore be desirable.

5. From a provider perspective, we are concerned that the Bill contains some inconsistent and possibly injudicious use of language in referring to the private and voluntary sectors as commercial and non-commercial providers of social care. In relation to Reshaping Care the terminology used has been the Independent and Third sectors, and it would at least be consistent to continue that usage. Given they are all providing public care, the most neutral distinction would be between statutory and non-statutory and then to use private and voluntary if there is a particular need to distinguish further within the non-statutory category. To the extent that the term commercial is useful it would apply to all care providers, given their need to operate effectively as businesses, to cover cost, and to achieve some element of return for reinvestment.

6. Much of the success of integration and the delivery of improved outcomes will depend on the on-going development of the workforce and again, this needs to be carried out on a cross-sectoral basis, looking at the overall staffing requirement, recruitment and retention, the harmonisation of roles, greater flexibility, and clarity of terms and conditions. We recognise that this may well feature in subsequent guidance, but feel that some requirement to have a comprehensive Workforce Plan as part of the Integration Plan could be referred to in the Bill itself.

7. The non-statutory providers of social care services believe that greater integration is the way forward, although as highlighted they feel dangerously left out of the Bill. The required integration cannot simply be between the public bodies. We also believe that integration, if done properly, can deliver improved outcomes for service users, and although in itself not a complete answer to the emerging care gap could at least allow us to make more rational and efficient use of the existing resource pot. We do not want this to be seen down the line as a missed opportunity.

Scottish Care’s Response to Questions Posed by the Health and Sport Committee

1. Do you agree with the general principles of the Bill and its provisions?
Scottish Care supports the policy ambition to improve the quality and consistency of health and social care and believes that to give people the best possible access to and experience of services they require, we must all be working together. We agree with elements of the current Integration Planning Principles, including a need for service user-focused integration and anticipatory and preventative care. However, Scottish Care believes that these alone are weak as a set of guiding principles.
The principles of the Bill need to be expanded in order to strengthen the roles of non-statutory partners. An explicit principle of the Bill must be the full involvement of non-statutory partners in the planning and delivery of services. The private and voluntary sectors are significant providers of social care - in 2012, these sectors provided 88% of care home places and 51% of home care hours for older people (Commissioning Social Care, Audit Scotland, 2012) – and must be recognised as such for meaningful integration of health and social care services to take place.

The Bill’s principles need a stronger emphasis on quality. Whilst improvement in the quality of health and social care services is a prominent theme in the Policy Memorandum, this fails to resonate in the Bill and must be corrected. Otherwise, the ambitions for integration risk getting lost amongst the specific functions involved in making joint working a reality. As Scottish Care continues to argue, quality must be positioned at the forefront of all decisions around health and social care delivery but is often lost, particularly in commissioning, to the issues of cost, time and task. The Bill provides an opportunity to direct future planning and delivery in the right way, but only if quality is embedded as a key principle.

Similarly, Scottish Care recommends that the principles of the Bill are amended to incorporate a human-rights based approach. The Integration Planning Principles and the Policy Memorandum strongly advocate integration based on the needs and outcomes of individuals. By embedding the human rights principles of participation, accountability, equality, empowerment and legality into the Bill, the legislation would more readily articulate with other initiatives such as Scotland’s National Dementia Strategy and would align itself more effectively with the national drive to better recognise the rights of individuals.

Finally, the principles of the Bill need to be explicitly aligned with those of the Change Fund and Reshaping Care for Older People. These include:

- Commitment to working in partnership to find positive solutions to local challenges
- Commitment to pursuing best value and added-value service developments, with flexible responses to changing patterns of need
- Commitment to working with all sectors in local and regional capacity planning
- Commitment to ensuring that the drive for quality and the centrality of people who use services remains the top priority within a focus on delivering national, local and personalised outcomes
- Commitment to developing preventative approaches and anticipatory care planning, together with community capacity building.

Given that the Change Fund and Reshaping Care for Older People initiatives have, to an extent, functioned as a testing ground for much of the joint working agenda, it seems logical and important that this legislation builds on what has already been established.
2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
Scottish Care recognises the importance of correctly legislating for joint working of the statutory agencies as a means of driving this new model for service planning and delivery. However, the Public Bodies Bill will only go so far in achieving its policy objectives if it maintains its narrow focus on the joint working of public bodies and fails to recognise the role of non-statutory partners. Whilst the Policy Memorandum is clear that joint working needs to take place with these partners, they are entirely unlegislated for in the Bill. Scottish Care feels there must be more read-across between the policy and legislation.

Whilst we recognise that forthcoming statutory guidance and regulations will most likely strengthen the roles of non-statutory partners and that not everything must or should be built into legislation, the total lack of reference to them is an obvious weakness here. Having felt encouraged by their involvement in Reshaping Care for Older People and the Change Fund, providers are likely to feel that the shape of the Bill itself is a retrograde step for real partnership working across all sectors.

3. Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths
As afore mentioned, Scottish Care believes that the Policy Memorandum for the Public Bodies (Joint Working) (Scotland) Bill is actually relatively positive in its ambitions. Scottish Care welcomes its intentions to improve services and outcomes for people, and is encouraged that the need for integration outlined is not based primarily on financial drivers. It is important to recognise that the priority for integration is the people whose quality of life depends on the services that are provided for them, and is not solely about attempting to address a diminished resource pot. The Policy Memorandum is also progressive in its acknowledgement of the importance of partnership working beyond local authorities and Health Boards.

Scottish Care also welcomes the options afforded to local areas in choosing a model for integration, whether that is the body corporate model or delegation of functions. Whilst the choice of model at a local level is not of principle concern to us, we would want to emphasise that our core concern of establishing the full representation and participation of non-statutory partners is applicable to all models.

4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
There are a number of areas in the Bill that must be strengthened if joint working is to be effective and meaningful:

**Governance, Planning and Delivery Structure**
- There needs to be more clarity on the position of non-statutory partners on integration joint boards, and this area of the Bill ought to be more explicit. Further consideration must be given to membership on integration joint boards, and there must be explicit listing of who Scottish Ministers see fit to joint them. This is currently too vague.
• Consideration must be given to who holds voting and veto rights on integration joint boards. At present, Scottish Care is concerned that the lack of these rights out-with statutory partners represents a regressive step in meaningful joint working.

Consultation and Engagement
• There must be a stronger guarantee that non-statutory partners will have a significant voice and contribution in the planning and delivery of integrated health and social care.
• A clear area of concern within the Bill is the ability of local authorities and Health Boards to make changes to an approved integration plan without consultation – this must be amended to ensure that consultation on changes is compulsory.
• As significant providers of social care in most local authority areas, non-statutory partners need to be included as guaranteed members of strategic planning consultation groups rather than leaving their inclusion uncertain.

Regulation and Commissioning
• Regulation and commissioning will be key to the success of integration and its ambition to improve outcomes for people who use health and social care services.
• Scottish Care welcomes the section in the Policy Memorandum covering the joint scrutiny roles of Healthcare Improvement Scotland and the Care Inspectorate. However, due to the importance of this scrutiny, we would want to see mention made of it on the face of the Bill.
• A more explicit link with Joint Strategic Commissioning needs to be made, along with the development of clear national standards and a regulatory framework. Scottish Care continues to advocate the need for this, as we have expressed previously to the Committee.

Performance Reports
• Scottish Care welcomes the requirement to review and reflect on the delivery of integration on a regular basis. However, we feel that the required reporting needs to go beyond an assessment of specific integration functions and instead needs to evidence on an on-going basis how integration is improving outcomes for people. As the Bill itself indicates, further decisions need to be taken around the form, content and publishing time of performance reports rather than leaving this to political decision making at a local or national level.

Integrated Budgets
• Services need to be underpinned by flexible and sustainable finance, which prioritises the needs and outcomes of service users over the organisations which deliver them. There must be a guarantee that integrated budgets will reflect what is required to meet outcomes for people effectively and to encourage a diverse local market for choice, rather than sustaining vested interests.
• The Bill requires greater clarity and tie-in with the Self Directed Support Act around integrated budgets. The section of the SDS Act on Joint Approaches and Pooled Budgets (Section 8) is strong and progressive, and should be drawn on to inform this Bill.

• The Policy Memorandum makes mention of the need to focus on unplanned admissions. Unless a model for shifting resources from the acute sector to the community is sought and detailed, integration will not achieve effective change for people who use services. Evidence from Reshaping Care for Older People and the Change Fund shows a limited shift in resources from the acute sector so far. At present, the total budget for social care in Scotland is less than what is spent on unplanned admissions to hospital. Most partnerships will need to increase spend on social care, but this will require effective mechanisms for a shift in resource. Local partnerships must therefore have total control over expenditure decisions covering both investment and disinvestment.

Decision-Making

• ‘Significant decisions’ is an area of concern for Scottish Care. At present, the Bill states that “a significant decision means a decision which the integration authority considers might significantly affect the provision of a service provided in pursuance of the integration functions in the area of the local authority” (Section 30(2)). This raises questions of who makes these decisions within the integration authority and what is considered significant. We know from experience that changes or decisions that might seem minor to those planning or delivering a service can have huge consequences for an individual and the achievement of their outcomes. Further clarity is needed around whether ‘significant decisions’ would include tendering exercises, which again can massively affect the experience of care and support for an individual. The Bill must strengthen the right of people, including providers and service users, to be consulted on when ‘significant decisions’ are to be made. However, Scottish Care would argue that the best solution to this problem would be if non-statutory partners were guaranteed places on integration joint boards, where these decisions would be made.

• More clarity on what grounds an integration plan will be approved or refused by Scottish Ministers is required. In our view, evidencing clear involvement and engagement with non-statutory partners should form part of the criteria for making this decision.

5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

Scottish Care cannot say at this time what efficiencies and benefits may arise from integration plans for non-statutory partners. This is because the Bill as proposed leaves us unsure as to whether these partners will hold a stronger or weaker position locally than they have in recent times. Through Reshaping Care for Older People and the creation of Joint Strategic Commissioning Plans, the
Independent and Third sectors have experienced progress in true partnership working, even if this has not been without its challenges.

Acting as sign-off partners for joint commissioning plans and having direct involvement in local decisions in Reshaping Care for Older People and the Change Fund is positive recognition of the non-statutory partners’ crucial roles in the strategic planning and delivery of services. However, the Public Bodies Bill as it stands suggests that the non-statutory partners may be reduced to ‘consultees’ which, instead of building on recent progress, would be a backward step.

If not amended, the opportunity to build on the lessons learned from Reshaping Care for Older People thus far would be lost and we would find this hugely disappointing. Should the necessary changes be enacted and the position of the sectors strengthened, non-statutory partners could be fully involved in local partnerships meaning the potential for integration to truly improve services and outcomes for people who use services would be optimised. This would reap benefits for all partners.

6. What effect do you anticipate integration plans will have on outcomes for those receiving services?

Again, if the necessary changes are made to the Bill to reflect the roles of non-statutory organisations, integration plans have the potential to improve services in terms of choice, quality, delivery and journeys through health and social care. Effective integration legislation, planning, principles, delivery and commissioning must be effective in creating a more level playing field for services across all sectors, allowing for true market diversity and choice for individuals. This will be especially important as Self-Directed Support is enacted in 2014. Services must also be made more sustainable, with investment in staff, training, facilities and new models of care in order to reflect the changing requirements from health and social care as the population ages and complex needs become more prominent.

If the necessary changes are made to the Public Bodies (Joint Working) (Scotland) Bill to ensure it progresses health and social care integration in a holistic and positive manner, Scottish Care would be confident that it will demonstrably improve services, outcomes and sustainability. However, this will only happen in the Bill focuses broadly on the delivery of public services by all partners and not narrowly on the role of public bodies.

Scottish Care
2 August 2013
Public Bodies (Joint Working) Scotland Bill

Coalition of Care and Support Providers in Scotland

CCPS welcomes the opportunity to contribute to the Committee’s stage 1 scrutiny of the Public Bodies (Joint Working) Scotland Bill (the ‘Bill’) and is pleased to submit this short paper. We take each of the committee’s questions in turn.

**Do you agree with the general principles of the Bill and its provisions?**

The consultation document on the integration of health and social care issued in May 2012 set out four key principles of integration, all of which we support and all of which are given expression in the Bill; the Bill itself sets out a further suite of principles (in ss.4 and 25) to guide integration planning and delivery respectively, and again we would support these.

We would however want to highlight a significant omission, which relates to the quality of care and support. The policy memorandum is clear (at para 9) that the legislation aims to tackle the variations in quality of care across Scotland, yet quality is not included in any of the principles relating to the Bill (nor indeed, to our reading, does the word appear anywhere in the document). We are aware that the Bill contains provisions relating to the prescribing of national outcomes, however we believe that these should stand alongside, and be supported by, requirements in respect of service quality. In particular, the National Care Standards for social care (and parallel health care quality standards) should be clearly referenced in the Bill, with a duty on integration authorities to ensure that they are met.

Meanwhile it has long been our view that involving people in the design of their care and support, and enabling them to exercise appropriate control over how it is delivered, must be at the heart of integration in order to drive change and achieve better outcomes. In our view, the principles for integration and delivery (in ss. 4 and 25, as above) do not adequately reflect the importance of such involvement.

**To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**

In our consultation response, and in our previous evidence to committee, we expressed the view that integration should be seen as a means to an end, and not an end in itself. Similarly, we believe that whilst the ‘technical’ aspects of integration with which the Bill is primarily concerned will contribute to the policy objectives, they will not be sufficient in themselves to bring them about, not least because (as noted above) the Bill is silent on the matter of quality; and also because a great deal of the change that is required is ‘cultural’ rather than...
technical. As we have stated in earlier evidence, we have some concerns that the objective of transformational change resulting in improved outcomes for people with care and support needs may become lost, as the statutory authorities become immersed in the detail of agreeing new arrangements around structures, accountabilities, budgets, workforce, and so on, all of which constitute the primary focus of the Bill.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

- The requirement for statutory health and social care partners to work together; to engage in joint strategic commissioning; and to integrate their budgets (as opposed to previous legislative instruments which enabled partners to do these things, but did not require them to be done).

- National outcomes as the key focus for integration authorities (although see our further comments below).

- The emphasis on joint strategic commissioning – referred to in the Bill as ‘strategic planning’ – as a driver for change (although we believe that requirements for authorities to involve non-statutory partners need to be significantly strengthened, as we note below).

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

- The Bill ought clearly to establish as key principles for integration authorities both quality of care and support and the involvement of individuals in the design and delivery of that care and support, as noted above.

- 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. The Health and Sport Committee has supported CCPS in promoting the view that poorly commissioned care poses as much of a risk as poorly delivered care: it is therefore a major disappointment that whilst the policy memorandum is specific on the need for independent scrutiny of strategic commissioning, the Bill itself makes no reference to it.

- Linked to the above, the Bill should make it clear that integration authorities will be held accountable for the agreed national outcomes: as it stands, the Bill makes provision for such outcomes to be prescribed by Ministers, but does not require integration authorities to achieve them (only to ‘have regard’ to them in integration and strategic planning processes).

- 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. Otherwise, the effect of the Bill will be to ‘downgrade’ the third sector (and indeed the private sector) from the status it has already been accorded in respect of similar processes for Reshaping Care for Older People and the Change Fund, where relevant plans must be signed off by four partners equally: the NHS Board, the local authority, the third and the private sectors. To underline this point, we note that the Financial Memorandum identifies the costs of clinical involvement in locality planning (estimated at £3 million, points 88 and 89) but no cost is identified for involvement of the third sector in either locality or strategic planning, which perhaps tells its own story.

- It remains a matter of concern for CCPS, whose members cover the full range of care and support services, that the policy objectives set out in the memorandum are almost wholly based on issues relating to health and care services for older people, whilst the Bill applies to services for all adults and, at an authority’s discretion, children and families (and other groups) as well as linked areas of activity such as housing and education. We remain concerned that the proposals for integration have not been clearly ‘proofed’ to ensure that they are fit for purpose in relation to the challenges and issues for service provision in respect of these other groups and areas of activity.

- Linked to the above point, the Bill’s requirements for integration and strategic planning do not appear to be sufficiently co-ordinated with related legislative instruments (both existing and proposed). We are aware, for example, that the Joint Improvement Team (JIT)’s recent survey of progress on integration indicated that a fair number of partnerships are considering including children’s services in their integration plans. This raises a question about how integration plans in these areas should interact with the requirements set out in the Children and Young People (Scotland) Bill with respect to children’s services planning, and/or to requirements regarding community planning more generally. There is a risk that these various pieces of legislation will lead to a multi-layered, yet unco-ordinated, set of planning requirements for public authorities.

- There appears to be a great deal of discretion accorded to the statutory partners in respect of the elements of their respective budgets that will be put into the integrated ‘pot’. As we have said previously in our evidence to committee on the Scottish Budget, we remain concerned that at Scottish Government level, the ‘health’ budget and the ‘care’ budget are treated entirely separately, with the former relatively well protected and the latter (included within the local government settlement) more vulnerable. It is not entirely clear to us, given the policy objectives of the Bill, why the Scottish Government is not prepared to be more prescriptive about which elements of
each budget should be integrated (nor indeed why it does not itself integrate these budgets at a strategic level, before disbursing them to local partners).

**What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

It is difficult at this stage to predict the impact of integration on third sector providers.

If joint strategic commissioning is effective and successful at (a) prioritising more ‘upstream’ and preventive support that helps people to stay well and out of the care ‘system’, and (b) embracing the sector as a key partner in the achievement of the national outcomes, then we might anticipate a greater volume of investment and activity. If, on the other hand, a combined (and thus even more powerful) health and care public sector treats the third sector purely as a supplier of pre-specified services, and continues to apply downward pressure to contract prices through competitive tendering, then the picture is likely to be very different.

In this regard, it is interesting to note that neither the Bill nor the policy memorandum make any reference at all to one of the key issues raised in our earlier consultation response, namely that the integration project brings together two fundamentally different environments — an NHS free at the point of use and delivered directly by public bodies, and a social care system that charges individuals for services which are delivered by a range of providers according to market principles — without adequately addressing the implications.

If the NHS budget is (as Ministers have said) to ‘lose its identity’ within an integrated pot, then it is entirely possible that that budget may be spent purchasing care services from third or private sector organisations operating in the social care market. This being the case, it is not clear why the same budget should not also be used to purchase health services from these sectors also. Similarly, parts of the ‘NHS’ budget may be used to commission social care services, for which individuals may be charged, with implications for the principle of an NHS free at the point of use.

We are not convinced that the Scottish Government has adequately addressed these possibilities or their ramifications for social policy.

**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

As we have previously stated, we are enthusiastic about the potential of joint strategic commissioning to begin to reorient investment and activity towards the achievement of outcomes for communities and individuals (although at the risk of repeating ourselves, we believe that integration authorities should also be given clear duties in respect of quality, as well as the achievement of outcomes; and
again, that independent scrutiny, as well as self-reporting, is crucial in this respect).

In addition, as stated above, we believe that the involvement of individuals in the design and delivery of their care and support is crucial to better outcomes, and that this principle should be reflected in the Bill and consequently in integration plans.

In this respect, we would repeat our view expressed in previous evidence to committee and in our consultation response, that there needs to be much greater clarity about the extent to which joint working arrangements will ensure that where appropriate, integrated functions are not excluded from the provisions of the Social Care (Self Directed Support) (Scotland) Act; and that strategic planning promotes market diversity in accordance with s.19 of that legislation.

CCPS August 2013

About CCPS
CCPS is the coalition of care and support providers in Scotland. Its membership comprises more than 70 of the most substantial third sector providers of care and support, supporting approximately 270,000 people and their families, employing over 45,000 staff, and managing a combined total annual income in 2009-2010 of over £1.2 billion, of which an average of 73% per member organisation relates to publicly funded service provision.

Care and support in the third sector
The third sector is at the forefront of quality care and support in Scotland. More than a third of all care and support services registered with the Care Inspectorate are provided by third sector organisations. In many areas of care and support for adults and older people – including care home provision, care at home and housing support – third sector services receive a higher proportion of ‘very good’ and ‘excellent’ quality gradings from the Care Inspectorate than their counterparts in either the public or the private sector.

Coalition of Care and Support Providers in Scotland
2 August 2013
Public Bodies (Joint Working) Scotland bill

Scottish Council for Voluntary Organisations

Summary
The response from the Scottish Council for Voluntary Organisations (SCVO) reflects perspectives from a range of SCVO members. Many of us highlight similar points, namely:

- The role and contribution of the third sector in the creation of more integrated services has not been adequately recognised in the Bill or associated deliberations.
- The risk that the third sector’s expertise and strategic contribution to reshaping care and joint commissioning could be lost.
- The role of the sector in facilitating high level representation for people with disabilities, carers and families in the services designed for them.
- The need for effective co-production – with disabled people, carers and communities at the heart of creating integration plans and the kinds of services which help people to live the fullest lives possible.
- Plans to integrate health and social care do not tackle existing challenges arising from squeezed public finances – e.g. increased use of charging and tightening eligibility criteria in social care;
- The operating environment for the third sector remains challenging, stretched further by welfare reform. This will impact on the sector’s ability to contribute to the development of more holistic and integrated services, when it has much to offer.

We call on the Health and Sport Committee and the wider Parliament to consider what the Bill is trying to achieve. Is the Bill in its current format enough? Are there other ways in which the policy intentions might be achieved? And how do we drive the shift in power needed to truly reform and create public services which are “...built around people and communities, their... aspirations, capacities and skills”?

Any policy intentions which seek to kick start the momentum needed to bring about a real shift from top-down services towards investment in communities, which help to nurture self-help, resilience and the approach outlined by the Christie Commission would be welcomed by the third sector. Yet, from a third sector perspective, the Bill as it stands - and indeed legislation alone - may not be sufficient to bring about the scale and nature of change required.

Introduction
SCVO welcomes the opportunity to make a written submission to the Health and Sport Committee as it begins to consider the Public Bodies Bill.

Major change is required in the way Scotland approaches the health and wellbeing of its population if we are, as a nation, to improve and flourish.

The current public service environment with the ageing demographic, shrinking public expenditure, an assault on social security, constitutional

---

1 http://www.scotland.gov.uk/Publications/2011/06/27154527/10
uncertainty and institutional ‘territorialism’ presents a major challenge that should not be shirked. Guidance on how to approach the challenge exists in the form of the recommendations from the Christie Commission, which the third sector fully supports. Nothing should be used as an excuse to detract from putting people at the centre of public services, and enabling communities, themselves, to achieve their aspirations. This should underpin the Public Bodies Bill.

SCVO will address each of the questions posed by the Health and Sport Committee in the scrutiny of the Bill and, in addition, wider issues arising from the Business Regulatory Impact assessment and the impact of the UK welfare reform agenda.

Question 1: Do you agree with the general principles of the Bill and its provisions?

Outcomes and assets

By its very nature, the third sector will focus on ensuring that services are person-centred, asset based and sustainable. This focus is not well reflected in the Bill e.g. in terms of guiding principles. We support the Christie Commission proposition that what happens on the front line is more important than any changes to the infrastructure.

The draft principles allude to the vision for public services envisaged by the Christie Commission but don’t go far enough to take forward that vision, specifically:

- public services that are built around people and communities, their needs, aspirations, capacities and skills, and which work to build up their autonomy and resilience;
- public service organisations prioritise prevention, reduce inequalities and promote equality; and
- public services which are open, transparent and accountable.

The first point above highlights the shortcomings in the Bill, where its draft principles focus on needs, and not outcomes or the assets that people and communities bring, and how health and care interventions can help people to live independently, achieve their goals and live well. The fact that the Bill is called “the Public Bodies Bill” also sends the wrong message about the aspirations underpinning it.

We would also argue that the final Bill principles should sit at the beginning of the Bill – shaping how partners read and take forward its provisions.

The principles as they stand set a negative tone, and one which endorses the current systems of eligibility, risk aversion, ‘medical’ models and views of disability and long term conditions. We would argue strongly for the draft principles to reflect the Christie principles more clearly. One of the key policy intentions behind the Bill is improved quality of services – yet this is missing as a bill principle. A stronger reflection of key human rights would provide a positive focus on the key things which matter in achieving better health and wellbeing for people.

---

2 Ibid.
Shifting power - third sector, service user and carer involvement
As a matter of principle the sector, alongside disabled people, carers families and others with an interest, should be represented at the highest levels in developing and monitoring integration plans, directing resources, and filtering through to delivery. From a third sector perspective there are a number of avenues of involvement: – a voice for people who are vulnerable, disadvantaged or marginalised; a bringer of knowledge and expertise and a provider of a wide range of services and supports.

Successful implementation of the policy intentions behind this Bill can be facilitated by ensuring that disabled people, older people, unpaid carers, families and relevant support organisations have a clear role in developing and shaping integrated services. That involvement cannot be tokenistic - this is about bringing the principle of co-production to life.

Therefore there should be third sector, service user and carer representatives at the table, with links to wider constituencies who can support them in this role. Third sector colleagues will call for sector voting rights and the ability to ‘sign off’ integration plans. Arguments made by statutory partners that this risks the delivery of statutory services do not give the sector and disabled people/carers the parity of esteem or respect that they deserve as we seek to achieve the goal of holistic, integrated services.

However, we must consider what would happen in the event of these representatives being unable to support integration plans or specific decisions about services. There are a number of options in this context:

- A wider consultation on a decision or plan which is ‘in dispute’ – if duties to consult in the Bill are adhered to, then these processes and time/support for wider constituent involvement should already be in place.
- The ability of statutory partners to refer the plan or decision to their own lines of accountability or for non-statutory partners, such as the third sector, to refer to Ministers.
- A right of veto which would effectively mean that the integration plan needs to be revised to enable non-statutory partners such as the third sector to ‘sign off’.

It is important that we learn from the Reshaping Care change fund process where on a number of occasions, third sector partners found themselves unable to support local change plans.

Third sector organisations will also argue for a principle of engagement within the Bill which focuses on involvement in planning, delivery and monitoring of integration – this would seem to be a sensible and worthwhile proposal.

A major shift to bottom-up, asset and rights based approaches in planning and delivery is required. The Bill must set the tone – alongside other policy/legislation, it must facilitate a shift of power back to people at the receiving end of the services to be ‘integrated’. The focus on independent living and participation encouraged within the self-directed support legislation would sit well the intentions behind the Public Bodies Bill.
There is however, real ambiguity around where, how and how much resources will be transferred to achieve this shift. As highlighted by CCPS in its response, leadership from Scottish Government is lacking – it could have sought to integrate key budgets at strategic level before they are directed to local partnerships.

There is still an opportunity to consider this. There is also a potential opportunity to find ways to bring together Community Care Grants and potentially a ‘devolved’ Independent Living Fund along with other investments in integration and self-directed support. This would ensure a more connected pot of money which supports the goals of wellbeing and independent living – helping to achieve the upstream shift intended through Reshaping Care.\(^3\).

In any case, restatement of the principles underpinning the self-directed support legislation at the front of the Public Bodies Bill could be a positive starting point.

**A wider view of health and social care - Prevention and communities**

Prevention and creating stronger communities must be central components in achieving integrated and effective health and social care services. A public service approach which puts people at the centre can be more efficient, and support lasting outcomes. This is because it reduces duplication in provision, and allows better availability of the right services at an earlier, more cost-effective stage.

Putting people at the centre therefore sits at the heart of a preventative approach. If this is coupled with a community-based approach to prevention, it will unlock a much wider range of community-based activities. These activities include lunch clubs, self-help groups, art and sport therapy, community transport, care and repair, befriending etc. All of these activities support people and help them to achieve their aspirations and quality of life, long before they get to the stage of needing formal health or social care. A strong example is the economic and social value of support to unpaid carers – there is an increasing evidence base that shows how this can prevent/delay statutory intervention and admission to emergency and institutional care, both for the carer and for the disabled person\(^4\).

There are many examples from the work of the third sector which illustrate the value of strong communities and preventative approaches. One such example is the Foodtrain ‘shopping plus’ service for older people and their carers. An evaluation of this highlighted that it was “…a well targeted, effective and flexible service that ... generates high value outcomes for customers and fulfils a critical role in supporting them in their desire to retain their independence… Its economic value in delaying the onset of higher-cost packages of care is highly significant…”\(^5\)

---


\(^5\) Co production – What it is and how to do it (Governance International/JIT, 2012)
We urgently need to develop and invest in community infrastructure of this sort to reduce the need for formal services or to facilitate a swift return to the community. Public sector procurement should be supporting and nurturing such initiatives instead of creating a more challenging environment for them.

It is not clear how the provisions in the Bill will, of themselves, accelerate investment in community capacity, prevention, and sustainability or provide a more joined-up approach between health and care services at the front line. This is a major omission which risks seeing effort and critical time being wasted on an institutional reconfiguration with no purpose and no real change of approach or outcome.

Question 2: To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The Bill might perhaps encourage the conditions and possible structures and infrastructures which facilitate a redirection of investment into communities and the provision of seamless services but this is not guaranteed. There is a real sense of complexity emerging in this bill, alongside already complex structures being set up in anticipation of it coming into force. Local statutory partners continue to set up ‘shadow’ partnerships in anticipation of what might be “in scope” for integrated services. We are in danger of replacing a mire of bureaucracy for funding and service arrangements with a newer and more convoluted version of the same.

With the potential to create greater confusion, worry and stress for families and carers, there is a real risk that the policy intention to “support improvement of the quality and consistency of health and social care services”⁶ may not be achieved. In turn this could create further demand on already stretched third sector services such as independent advocacy.

There are no provisions in the Bill which will ensure that resources are used effectively or efficiently - only an assumption that joint working will make this possible. It is also worrying that, as outlined above, the amount and direction of resource shift is not detailed.

A particular concern is that despite the positive contribution of the third sector to Reshaping Care – and its considerable role in health and social care - it will have no say in decisions around those resources and perhaps a limited role in planning service delivery. Ministers have frequently, in recent months, expressed their admiration for the creative and transformative approaches taken by voluntary organisations to meeting the health and wellbeing needs of people and communities. Yet, the Bill does not channel this much needed expertise into the planning process with anywhere near sufficient authority or centrality. We are in danger of being left with a new version of the old planning system built around existing institutional interests, where any positive developments which brought the third sector to the table could potentially be lost.

---

⁶ http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Bill/b32s4-introd-en.pdf
Meeting the demographic challenge and dealing with the increasing number of people with longer term and often complex needs requires a whole suite of changes to policy, practice and service configuration – the Bill could have provided a starting point for this, beginning with a strong understanding of how the Reshaping Care for Older People Change Fund has – or has not – made any difference in terms of moving more towards prevention and capacity building.

Question 3: Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths?

Question 4: Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.

We have provided responses to these questions above.

The question we should be asking ourselves is what cannot be achieved without this legislation? We have to ask whether the legislation in its current state will make any real difference to the quality and consistency of care for people given the points outlined in this response: the lack of recognition of the contribution of the third sector (above); the current state of social care (below); and the increasing sense that services are “done to” and not “with” people.

The Local Government Committee’s recent report on public service reform would certainly back this assertion:

“The best examples of PSR arise when local communities and front-line staff are fully engaged in the process of designing and procuring services. We are sceptical of the value of top-down or centrally driven changes to services.”

The Local Government Committee also highlighted a number of challenges and practices which prevent real reform of public services and which must be considered in the context of health and social care integration, namely:

- Public investment in earlier attempts at partnership working has meant little real improvement in services or prospects for some of our most disadvantaged communities.
- Very deep-seated attitudes and behaviours that will take time to change.
- There is little evidence of significant real progress in PSR being delivered (e.g. through Community Planning Partnerships).
- The need for improvements in communication at all levels – an issue raised consistently by communities and front line staff.

It is clear that the Public Bodies Bill has a lot to do. We need to ask if the Bill in its current form will tackle a culture where resources in one sector or service are ‘protected’ sometimes to the detriment of an individual or family’s wellbeing. Ministerial intention may be strong, but it is not carried through in this draft Bill, and that may not be enough.

---

7 [http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Reports/lgr-13-09w.pdf](http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Reports/lgr-13-09w.pdf)

8 Ibid.
Question 5: What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

The question should be “how do we secure sustainable health and care provision?” We can only do this by reducing demand for formal services through a much greater appreciation of the role of strong communities, self and mutual help and high quality social and housing infrastructure. Integration plans which focus on providing services to people in need and only on traditional views of health social care will not be enough. We must see the wellbeing of people more widely e.g. as cuts to local transport services bite, people will become more isolated.

If the Bill is to achieve its goals, then it is essential that the make-up of local partnerships takes us beyond the planned split between health and local authority representation. This approach sends inauspicious messages about power, responsibility and control which are the very opposite of the intentions behind integration. What matters in the future provision of health and care services is that local, user and carer groups and public interests have much greater involvement and shared ownership of plans and services – and not just at local level.

We are particularly aware of the emergence of an inconsistent narrative surrounding the involvement of the third sector - a full and necessary partner at the top table of Community Planning - yet it is viewed only as a set of interests to be consulted and engaged in the development of local health and care plans in a process which is dominated by statutory interests. The sector and stands ready to do so despite the challenges it faces.

In terms of efficiencies, as things stand, the sector risks having a marginal, yet resource intensive involvement in complex bureaucratic structures. Where health and social care structures do not mesh with community planning structures we will see duplication of time and effort and the diversion of resource from the main purposes of the third sector. With significant improvement - including clarity about the relationship with community planning, full involvement of the third sector at strategic levels and a structural facility and willingness to redirect investment - efficiencies are possible.

Question 6: What effect do you anticipate integration plans will have on outcomes for those receiving services?

This really depends on the quality of the plans and the willingness of local statutory partners to work inclusively and strategically with the third sector and the people affected by these planned changes, and to make determined shifts in how public resources are invested. It will also depend on how involved the third sector and service users and carers are in determining the national health and wellbeing outcomes which will be the goals that partnerships will strive to achieve.

Experiences from the Change Fund and Change Plan processes have been mixed whilst early development of strategic commissioning plans illustrates how far there is to travel in developing sustainable approaches to health and
care provision in the future. But we mustn’t lose any positive achievements within this context.

If the integration plans mean more of the same and a refusal to tackle tightening eligibility criteria, charging and the loss/reduction of services which are essential to enabling people to live independently then we have lost an important opportunity. This is not about delayed discharge or bed blocking – we must remember the assets, ability and contributions of people receiving support through health and social care. That should be the starting point for this legislation.

We need also to consider the potentially strong clash of cultures that could occur in the move towards more integrated services - one service is free at the point of use (NHS) and another has charging inherent to it coming together.

Wider feedback

Business Regulatory Impact Assessment

Read across to other legislation:
The linkages between this and other legislation e.g. Children’s Bill, self-directed support, and welfare reform policy and legislation are not clear or missing.

There is a risk that the focus on structures, finance and process inherent in the Public Bodies Bill could divert attention away from implementing the self-directed support legislation. On the other hand, integration could potentially provide opportunities to consider how self-directed support could operate in a health context e.g. purchase of more ‘personalised’ equipment and adaptations, therapies etc.

Welfare reform:
The impact of welfare reform on the Bill and subsequently on services which will be delivered under new arrangements is largely absent. There is the likely impact of welfare cuts on income from charging, but, more importantly, the effect of recent benefit changes on the health and wellbeing of people and communities – many of who are already vulnerable and face challenges to their own wellbeing.

Guidance issued to health boards via the Scottish Public Health Network (ScotPHN) provides some sense of what this impact could look like.9 The transfer to Personal Independence Payment (PIP) and the potential devolution of the Independent Living Fund are ‘ones to watch’ in terms of increased demand on already stretched services across the third and public sector.

As such, we would suggest that it would be worth revisiting the linked Equality Impact Assessment in light of our understanding of how welfare reform will affect people receiving services and their families. The Deep End report which engaged GP perspectives on austerity and welfare reform10 remains a powerful summary of the impact on health and

---

10 http://www.gla.ac.uk/media/media_232766_en.pdf
social care services – but it also highlighted how demand for support from the third sector is increasing as statutory services struggle. Recent work carried out by SCVO\textsuperscript{11} suggests that almost 90% of respondents in a recent mapping exercise expect demand for support to increase because of the welfare reform programme.

Welfare reform creates a perfect storm for third sector organisations – not only are some being diverted from their core purpose, but the potential changes which the Public Bodies Bill will bring present yet another challenge for the third sector in a difficult operating environment.

\textit{Challenges to engaging in integration:}

Involvement of the third sector in development and scrutiny of strategic and locality plans and delivery is critical to success given the experience, knowledge and skills it brings in the wider field of health and social care. Other responses to the call for evidence e.g. Voluntary Health Scotland, Health and Social Care Alliance will emphasise this important point.

The sector will also need to change how it works, and any changes to commissioning and procurement that result from integration developments could have a substantial and potentially negative impact.

Yet the sector continues to face significant financial challenges. SCVO and CCPS research to examine these will be published soon and some early findings highlight that:

\begin{itemize}
  \item Funding packages rarely make provision for annual inflation.
  \item The overwhelming majority of respondents (83%) said that they did not receive an annual inflationary increase – many report that budgets have been static for many years, with many experiencing often significant budget cuts.
\end{itemize}

In addition, procurement practice in Scotland presents significant challenges to funding and the day to day operation for many organisations across the sector.\textsuperscript{12} The fact that many may face extensive procurement exercises for short term contracts is one specific challenge highlighted by our members in the research outlined above.

Given the context described above, the capacity of third sector organisations to engage effectively in the journey towards more integrated services could be reduced. With less room for manoeuvre, it is therefore worrying that the Financial Memorandum says that:

“Third sector partners will also be expected to consider efficient and effective use of current resources and funding streams to enhance their own capability.”\textsuperscript{13}


\textsuperscript{12} E.g. http://www.ccpscotland.org/assets/files/ccps/publications/FOImainreportCCPS2%20%284%29.pdf

\textsuperscript{13} Para 64, page 34
Whilst the pot of money directed at the sector within the Financial Memorandum to tackle these issues is welcome (£360,000) it’s worth comparing this to the £3 million set aside for clinicians’ involvement in locality planning.

More positively, the bill and the development of integration plans present an important opportunity to realign how we commission and procure a wide range of services and interventions which drive a more preventative approach and focus on wider outcomes and wellbeing - not a narrowly constructed review of health. As CCPS outlines in its response to the call for evidence: “If joint commissioning is effective and successful at a) prioritising more ‘upstream’ and preventative support that helps people to stay well and out of the care ‘system, and b) embracing the (third) sector as a key partner in the achievement of the national outcomes, then we might see a greater involvement in investment and activity” – i.e. the sector could play a significant role in achieving the outcomes.

We need further discussion about how we support that role.

**Conclusion**

A strengthened bill could provide a framework for reshaping how health and social care operate. However, we will also need better investment in preventative support, community interventions and local infrastructure and services which actually make a concrete difference in people’s lives. This means that we need to see health and social care more widely – where do housing, local environment/planning systems, transport and so on play a role in helping people to remain independent and to stay connected to their communities, jobs and each other? This is where the third sector has much to contribute.

Achieving any nationally agreed outcomes relating to health and wellbeing must recognise the wide range of enabling support which can be accessed via self-directed support and non-traditional approaches and interventions – these equally have tangible benefits and outcomes relating to health and wellbeing and must feature strongly in integration planning and delivery.

Activity to bring health and social care together, to improve quality and outcomes of support will fail unless all key partners are around the table. This includes voluntary, charitable and other supports as outlined above.

Real change in the experience of all who use health and social care services will not come from legislation or restructuring alone. Cultural change is needed; we need less risk aversion in service provision and more effective communication across sectors and between professionals, individuals and families. Involving the people who matter most in planning and shaping integrated services – disabled people, older people, unpaid carers, families and local communities – strategically and in delivery and monitoring is key to success. Their own aspirations to live well, to work, to take part in their local communities must be the starting point and main driver of this legislation.
Across the third sector, many of us feel that the Bill’s provisions need to be stronger in order to achieve this shift in focus in policy and in practice. We will work with colleagues across the third sector and the Scottish Government and the Parliament to make this happen.

Scottish Council for Voluntary Organisations, 2 August 2013

About us
The Scottish Council for Voluntary Organisations (SCVO) is the national body representing the third sector. There are over 45,000 voluntary organisations in Scotland involving around 137,000 paid staff and approximately 1.2 million volunteers. The sector manages an income of £4.4 billion. SCVO works in partnership with the third sector in Scotland to advance our shared values and interests. We have over 1300 members who range from individuals and grassroots groups, to Scotland-wide organisations and intermediary bodies.

As the only inclusive representative umbrella organisation for the sector SCVO:
- has the largest Scotland-wide membership from the sector – our 1300 members include charities, community groups, social enterprises and voluntary organisations of all shapes and sizes
- our governance and membership structures are democratic and accountable - with an elected board and policy committee from the sector, we are managed by the sector, for the sector
- brings together organisations and networks connecting across the whole of Scotland

SCVO works to support people to take voluntary action to help themselves and others, and to bring about social change. Our policy is determined by a policy committee elected by our members.14

Further details about SCVO can be found at www.scvo.org.uk.

References
Scottish Voluntary Sector Statistics 2010, SCVO

---

14 SCVO’s Policy Committee has 24 members elected by SCVO’s member organisations who then co-opt up to eight more members primarily to reflect fields of interest which are not otherwise represented. It also includes two ex officio members, the SCVO Convener and Vice Convener.
Public Bodies (Joint Working) (Scotland) Bill: Stage 1

09:45

The Deputy Convener: Under item 2, the committee will take evidence on the Public Bodies (Joint Working) (Scotland) Bill. I welcome our first panel of witnesses. We have with us Dr Allan Gunning, who is the executive director of policy, planning and performance at NHS Ayrshire and Arran; Jeff Ace, who is the chief executive of NHS Dumfries and Galloway; Susan Manion, who is the chair of the Association of Community Health Partnerships; and Alan Gray, who is the director of finance at NHS Grampian. I thank the witnesses for agreeing to go straight to questions from members. Richard Lyle has intimated a desire to ask the first question.

Richard Lyle (Central Scotland) (SNP): Thank you, convener, and good morning, lady and gentlemen. I start the question session by asking you about the models that are suggested in the bill. I understand that there are two such models: the lead agency model and the body corporate model. You might have another suggestion, and I would welcome any direction on that. What is your opinion of the models that have been suggested?

Dr Allan Gunning (NHS Ayrshire and Arran): NHS Ayrshire and Arran and the three councils carried out an options appraisal of the two options that are available to us, and decided that the balance of advantage lay with the body corporate model. In Ayrshire, therefore, we will form three partnerships that cover each of the council areas, and they will all be bodies corporate.

The body corporate model provides the greatest opportunity for close integration. The only advantage that we could see in the lead agency model was that it might make support services more straightforward to provide, but the changes are not about support services; they are about supporting the better and more seamless delivery of front-line services.

Jeff Ace (NHS Dumfries and Galloway): Similarly, NHS Dumfries and Galloway is most likely to go for the body corporate model. That is our current working assumption. Unlike NHS Ayrshire and Arran, we have not progressed to the point of making a formal decision in front of the NHS board and the council, but that is the assumption on which we will base our work going forward. As Allan Gunning said, the body corporate model seems to offer a good degree of flexibility and the ability to influence change locally, on the ground.
Susan Manion (Association of Community Health Partnerships): At the moment, what is coming back from my colleagues across Scotland is that a number of discussions are still taking place about the models. However, it appears that most areas are moving towards the body corporate model for the reasons that have just been described.

That said, the intent and purpose of both models are the same and are around developing integration. Deciding on the best delivery model depends on historical positions and local preferences.

When it comes to alternatives, I am not sure that we are considering any in any significant detail. Many of the alternatives exist under existing legislation, and there is enough flexibility in the bill to allow for local flexibility in the two models that are suggested.

Alan Gray (NHS Grampian): NHS Grampian has adopted the same position as NHS Dumfries and Galloway. We will take a decision to the board in October and we are likely to support the body corporate model. The indications are that local authority partners are likely to follow suit and support that decision in the next few months. However, that is within the remit of the councils.

Richard Lyle: I take it from what you have said that the consensus is that the body corporate model is the one that most organisations will adopt. However, do you share the concerns of some local authorities about governance and accountability in the body corporate model?

Dr Gunning: That is one of the areas that need to be clarified and nailed down. There are some uncertainties that I am sure are still being worked through. The governance and accountability arrangements will be clarified, which is important because 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.

Susan Manion: A significant amount of clarification is required on governance and accountability. Both health boards and councils are concerned to ensure that the issues are clarified. Existing accountability issues cause difficulties between councils and health boards, and it will be absolutely central to get that aspect sorted.

When we deal with issues around service change, when we seek to create change and when we consider performance management, we must be absolutely clear: we must have a single performance management structure, with clarity about what we need to achieve and about accountability, so that we can achieve the organisation’s objectives. At the minute, I am not sure that the bill is clear enough on that.

Alan Gray: Our point regarding the clarity around governance is that it is very important to make a success of the integrated arrangements. The planning arrangements are very important, as is having absolute clarity around how they will work and how they will be approved. We need to set off in the right direction in that regard, and we need to have the support of all the organisations concerned as well as a clear plan, particularly as we have multiple local authorities across the health board area.

Richard Lyle: You said that there needs to be clarity. What further clarity would you suggest? I am sure that you have looked through the bill. Perhaps I am taking away questions from other members, but what other suggestions or concerns do you have?

The Deputy Convener: Before the witnesses start to answer, I should point out that, although we did not take any evidence from you there, Mr Ace, all four of you should not feel obliged to answer the same question if you are going to make the same comments.

Does anyone wish to talk about specific examples regarding more clarity?

Dr Gunning: The issue applies to areas such as the chief officer’s accountability, both to the integrated joint board and to the statutory agencies. There are a number of things that flow from that in relation to the financial governance of the integrated budget.

The bill is not particularly explicit in areas such as clinical and care governance. Staff governance is a statutory responsibility for us in the NHS. That is another area that needs to be thought through in a wee bit more detail.

I hope that those examples are helpful.

Jeff Ace: We have a beautifully simple system in health in Scotland at the moment, and when we look at the new models, there is some nervousness that they are more complex. The key thing is that we should not establish a governance structure that gets in the way of the change that we want to make. I am reasonably confident that, certainly in a simple system such as that in my health board, which is coterminous with the local authority, we can work through a governance structure that does not get in the way of people undertaking the radical service changes that are needed.

Nonetheless, as a chief executive who has signed the accountability letter that singles me out as the accountable officer, it is clear to me that our beautiful simplicity of line, from cabinet secretary
through the board and the chief executive, will become slightly cloudier as we go lower than that if we have a body corporate model or a lead agency model—it does not make a lot of difference which we choose.

We just have to be careful that, in creating this vehicle for more interagency change and perhaps more dispersed decision making than we have at the moment, we do not lose some of the current system’s simplicity and clarity.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I mainly want to ask about the acute side of things but, following up Richard Lyle’s comments, I think that all your submissions agree that structural change in itself is not going to deliver the changes that you want. However, we end up talking about the issue a lot because that is what is in the bill. I find it interesting that most of the questions are about the body corporate model and that that is the model that most people seem to want. As a result, that is the issue about which we will probably ask you and others quite a lot of questions.

Some—albeit not many—people have argued that, in a way, we do not need legislation because a lot of this can be done without it; indeed, a lot of what is proposed is already happening. I know that many of you have already gone down the route of closer working relations, if not integration, with local authorities but, from a health point of view, what changes or further steps will you have to take as a result of the bill that you have not already taken?

Susan Manion: The changes represent a significant step up from the current local arrangements across Scotland. Integrated financial and service planning will be absolutely crucial. The bill gives us the opportunity to take that approach through integration and strategic plans. However, the major issue is how we bring the financial resource together, which will require a system to support operational delivery, and how we plan to deliver significant service change and ensure that resources are shifted around the system to do that effectively. You can do a lot of that with pooled or aligned budgets, but the bill takes things to a whole new level and it is crucial that we have the right infrastructure in place to support that.

Dr Gunning: I highlight some points of principle, the first of which relates to joint and equal responsibility and accountability between the statutory authorities. That is important because targets for health-specific issues such as delayed discharge and emergency admissions to acute hospitals have been very much seen as health targets. Although we have worked very well with local authorities and other partners, statutory provision will help to clarify and strengthen things.

The second point of principle is 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.

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 plan that will spell out the intended changes and a performance regime that will monitor whether those changes are actually being delivered.

10:00

Jeff Ace: To follow up on Allan Gunning’s point, the key advantage for my local system concerns locality planning and the local delivery of change.

In health, we have centralised our decision making a little bit over the past five years or so, and integration gives us 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. Suddenly, in my system, we will get four natural localities across the region and a critical mass of devolved decision making that we are optimistic will be a game changer for us.

Although there has rightly been a lot of focus on the top end of corporate governance and the body corporate model, we need to flip that on its head to see the impact of the bill. It is about localism, and we need a far greater critical mass of decision making at a community level if it is to work. That is the bit about which we can get our clinicians and partners exited in a way that they are not excited by the machinations of the body corporate.

Malcolm Chisholm: That is really interesting. That was the intention of community health partnerships, but it has not happened to the extent that it should have done.

As I said, I will mainly ask about the acute sector. The worry that people have about any integration is that it will reinforce horizontal
integration but weaken vertical integration within the health service. I am interested in how the acute sector relates to that.

One health board has expressed concerns that integration may lead to the separation of the body corporate from the acute sector and almost lead to a purchaser-provider or commissioner-provider relationship between the two. I would be worried about that. How do you see the acute sector relating to the proposed model? The key question is: how do you envisage the financial power of the acute sector relating to it?

**Jeff Ace:** I am in a lucky position because I have one council, which is coterminous with my boundaries, and a relatively small acute service—I have one district general hospital and one large community hospital that provide acute care. My plan is to bring the whole thing into the body corporate model so that we do not lose the integration between primary, community and acute care. We will put the whole £250 million-worth of health services we have into that partnership.

It is a function of luck—the size of my system—that I am able to do that. It is a great solution locally, but I am not sure that it transposes across Scotland, given the far greater complexity and size of organisations in the rest of the country.

**Susan Manion:** My response is linked to the point that Mr Chisholm made about CHPs and localities. The intention of the original CHP legislation was to improve the quality of what was provided locally. It was about engaging with patients and service users as well as communities.

There are significant areas in which CHPs have been successful and I am anxious that the integrated partnerships build on those successes. CHPs were less successful in leading change across the system. Although that is a fair criticism, they perhaps had a lack of leverage to do that. The bill allows us to consider the partnership’s commissioning responsibilities, which will allow us to create change.

The argument—it is sometimes an argument—about what is in and what is out when it comes to acute services has sometimes detracted from the reality of what we are trying to create.

It is essential that we get the links right between acute, community and primary care services, so that we engage clinicians at the local level as well as specialist clinicians. However, the argument about acute services has become a distraction that has impeded progress on many of the issues that we face across the country in the context of organisational change. Some clarity on that might help.

**Dr Gunning:** Mr Chisholm asked an important question. I think that it is useful to clarify the situation. Joint strategic commissioning—the strategic plan—has echoes of a return to the internal market for the NHS. People ask whether we will have the purchaser-provider split and something equivalent to NHS trusts, with all the bureaucracy that goes with them. However, joint strategic commissioning is really designed to bring about improvement by assessing needs, determining the best way to meet them and ensuring that the required services are delivered.

In Ayrshire we have two district hospitals, each of which provides services to residents in all three partnerships areas in Ayrshire. As Jeff Ace said, in some places the Dumfries and Galloway model is not supported. The important issue is the patient’s pathway, which is what binds the partnerships and acute services together. There needs to be a seamless flow for patients, users and carers between the community setting, primary care, hospital—when that is appropriate—and then discharge, re-enablement and rehabilitation.

I think that everyone knows that, but maybe what is missing is a process that binds everything together, which, for me, is about being clear about the changes that we want to make to shift the balance of care. The strategic planning process should make that transparent and spell out what the partners are committed to doing to bring about change, and the resources should follow.

In the context of shifting the balance of care, the change agenda in acute services should not, in principle, be any different from other major service change that has occurred in the NHS over the past 20 years. For example, in mental health services there was a clear policy of no longer having continuing care beds in the NHS for people with a learning disability. Partners then got on with bringing about the changes that would support that policy outcome. Partnerships and acute services will have to work through the same process.

In principle, the relationship between partnerships and acute services should not be any different from the relationship between partnerships and the many major local authority services that are extremely relevant to the partnership agenda but which are unlikely to be managed within it. Education is probably the best example of that.

**The Deputy Convener:** Does Malcolm Chisholm want to come back in at this point?

**Malcolm Chisholm:** No, I think that the responses were helpful. I just wonder whether things will be different in the large health boards. I was quite interested in a comment at the end of NHS Ayrshire and Arran’s submission, where you asked how the arrangements will work if non-executive directors in health boards have to sit on lots of local authority partnerships. That might be a
slight problem for Ayrshire; it will be a much bigger problem for local authorities in the old NHS Argyll and Clyde area. I am interested in how that will work in practice.

The current process is not really analogous with the changes in mental health and learning disability services, because the acute sector cannot be run down in any comparable way, not least because of the demographics. I suppose that is why I am still struggling to understand how the budgets will work. Indeed, one of the witnesses on the next panel will argue that the budget should be centrally determined because there will be such difficulty in deciding, first, how much goes in and, secondly, what services are covered.

**Alan Gray:** That is one thing that we must tackle up front, so that we do not get too focused on the money. How we move resources is clearly an issue that we must resolve. I echo what Allan Gunning and Jeff Ace said about the importance of spending time on getting the planning right. It is about integration of services, not just in the partnerships but between the partnerships and the acute sector.

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.

The most important decision that we will make is about spending time up front in the early years of the partnerships on building confidence in one another and building the strategic plans that will allow us to see how we can move resources over time. It takes time to move resources that are currently invested in staff and services, but we need vision in the strategic plan along with the leadership that will allow us to make the changes that we need to make to build a sustainable healthcare system in Scotland for the foreseeable future.

**Dr Gunning:** I agree with Mr Chisholm that the detail of the analogy does not always hold. The point that I was getting at is that, essentially, we are shifting the balance of care in learning disability and mental health services. One of the policy objectives is to provide seamless services in the home or in as homely a setting as possible. In principle, the same proposition is before us and all the partners will have to be very clear about how that will be delivered. That is really the point that I was trying to make.

Secondly, there is a distinction between total resource and the operational management of budgets. I would certainly not be in favour of splitting up the operational management of budgets within district general hospitals. From my experience, I do not think that that would work; it would become tremendously confusing.

We have to bear in mind the fact that the majority of resources that are consumed by acute services are the consequence of decisions that are made by colleagues in primary care. We have to strengthen the link, and I think that we have the opportunity to do that.

**Rhoda Grant (Highlands and Islands) (Lab):**
In listening to what you are saying, it occurs to me that the body corporate model means setting up a whole new bureaucracy in times of tight restrictions on spending. I can see how savings can be made by better incorporation and sharing at ground level, but setting up a whole new bureaucracy must have a cost associated with it. Is that the case?

**Dr Gunning:** I would not describe it as a whole new bureaucracy but support for a new way of working. We have to look at the bigger picture and find opportunities to share services.

I can show how structural change can support changes without organisational change, and I will step outside the current discussion to talk about procurement as a function within the NHS. All the NHS boards in the west of Scotland have got together to procure things as a single body, so instead of doing something five times we do it once. We have been able to make substantial savings as a consequence, but there has been no structural change in line management reporting. That model can be transported and the body corporate model can support real change and improvement without leading to a big increase in bureaucracy. The bureaucracy does not automatically follow.

Clearly, the setting up of the integration joint boards and the non-executive input will all have to be thought through. My view is that we should keep those things that need to be put in place to the absolute minimum that is required to support the change on the ground. That is where all the things that we have been talking about in relation to locality planning become important.

**Jeff Ace:** The challenge is a powerful one. We need to demonstrate to our local communities that the structures that we put in place do not create a bureaucratic cost. It would be a very hard sell if we had to say to our population that the services that we were providing separately will now be provided together and that that will cost us more in bureaucracy. I would not like to have that conversation, so the onus is on us to make the systems work within our existing financial, management and leadership resources. It is a
strong challenge because, on paper, the set-up is now more complex than it was. We have to find a simple way through the potential complexity that does not cost us more suits on seats.

10:15

Rhoda Grant: That is certainly a concern.

I will move on. We had evidence last week from councils that are concerned about the breadth of the bill, because it does not focus only on health and social care but includes any services that are offered. Is it right for the bill to have that wider scope? Alternatively, do you agree with the councils that it should be amended to focus only on health and social care?

Susan Manion: That is a good point, because you can read quite a lot into the bill in its existing form about the shape of the organisational arrangements and about what is in and what is out.

Briefly, we would seek clarity—it will come either centrally or locally—about what is meant by the proposal on acute services, what is meant by the inclusion of unscheduled care, and whether that is part of a commissioning budget or a provision budget, because the proposals broaden it out.

The discussion about the body corporate model indicates that it is very difficult to draw lines around older people’s services as such. The bill therefore has to be broader because, from an NHS point of view, when it comes to primary care and community services it is very difficult to separate out different chunks of how we deliver. We have to think about how we work together locally around GP practices to link into patient pathways of care. It is a crucial issue.

Dr Gunning: There are some specifics towards the end of the bill on the role of agencies that currently provide services only to the NHS but under the provisions in the bill can provide services to wider stakeholders. The spirit of the bill is to ensure that any potential barriers to integrated working are removed, and its provisions are designed to support integration. The important point is that there is an appropriate balance between providing the necessary statutory framework and allowing enough flexibility for local partnerships to operate in the way that best suits local circumstances. That is always a difficult balance to strike.

As was said previously, when you look at some aspects of the bill in isolation, you see that it contains residual powers that could be quite considerable if enacted. Those are the important issues that are before us.

Rhoda Grant: Do you have concerns about that? Or, from a health perspective, is that okay?

Local government covers a spectrum of services including not just social care but transport, housing and education—the whole lot. In your role, do you have a concern about the breadth of the bill?

Dr Gunning: I do not think that we have such a concern in Ayrshire. We feel that, on the health side, the bill gives enough flexibility for us to organise in a way that we think is appropriate to support service delivery. For example, it is welcome that services beyond services for adults can be included if local partnerships feel that they would benefit.

We would clearly like to see clarification about the services that must be included, those that might be included and those that will not be included. To be fair, some further detail that has still to come out—probably in regulations—will give us more information about the position.

Susan Manion: Active participation from integrated partnerships with local community planning arrangements and strategic community planning arrangements will be absolutely crucial. The bill does not touch enough on health inequalities and how we are going to look at the whole shift towards prevention and dealing with inequalities. There is a real opportunity for partnerships to be key to part of that work.

Through the commissioning arrangements or through the existing planning arrangements, we need to be able to work much more closely with colleagues outside social work and across the council because we need to be able to influence our colleagues in transport, housing and the environment because those issues all impact on inequalities. The fact that the bill has a broader look at where the partnership would sit in relation to its planning partners is crucial.

Nanette Milne (North East Scotland) (Con): I want to follow up what has already been said about stakeholder involvement. Concerns have been expressed to us, particularly by the third and independent sectors, that there is limited detail in the bill about the involvement of stakeholders. What are the panel’s thoughts on that?

Also, last week we had some discussion about the role of GPs. It is crucial that they are involved. I well remember when CHPs were set up because my husband was a GP at the time and there was disillusionment because they had lost their local area. Suddenly, instead of looking after a small area, the whole of Aberdeen as it was became a CHP. The profession is fairly disillusioned, so how will the bill enthuse them and help you to get their involvement? Without that, it is not going to work.

The Deputy Convener: How will the bill motivate GPs? Who wants to come in on that?
Jeff Ace: GPs do disillusion very well. It goes back to an earlier argument about localities and communities, and I think that I can wrap in all stakeholders as well as GPs.

Clinical professionals and a lot of third sector bodies find it difficult to engage with us on a regional basis. Their ability to act and to mobilise resources does not work in that way. They can put different solutions in place in different areas.

The focus of our integration locally is on a decentralising integration in which we achieve critical mass in a locality area that is far smaller than a traditional CHP area. That allows us to bring in GPs—we will have a GP clinical lead for each of the localities—and to bring in the third sector and other organisations that are active in that locality. They might not be the same organisations in other localities. The flexibility to create solutions that are tailored to a relatively small area and a small number of communities is a real strength. That seems to be raising enthusiasm among clinicians and other partners.

Dr Gunning: I support Jeff Ace's comments about locality planning. If we go back far enough to local healthcare co-operatives, there is almost a nostalgic look in the rear-view mirror at how they worked.

I have a practical example that I heard one GP talk about. The agendas need to be locally relevant to practice populations. For example, this particular GP said that they know that there is necessary bureaucracy in the running of public services, and all of that can go 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.

One of the successes in the community health partnerships has been the role of the public partnership forums, not only in CHP-related service change but in the wider landscape of service change. This is another point of clarification, which goes back to the point that Susan Manion made. We want to build on what has worked well in CHPs, through such mechanisms. In Ayrshire, some of the forums that support the CHP committees have wider stakeholder engagement and have worked well.

We have a model for engagement of the third and independent sectors, in the joint strategic commissioning process for services for older people, which seems to have worked well. I think that those sectors want to build on such strategic input. We can build on what is already working.

Susan Manion: The discussion about the whole clinical and care pathway for individual patients is crucial, because GPs and clinicians are most interested in what they can do to make life better for the patients who are in front of them. Much of that is about having some influence over how to change things, whether we are talking about incontinence services or patterns of referral to more specialist services.

That is what GPs are interested in. Links with other clinicians locally, through the models that are starting to emerge, are helpful and will, I hope, help GPs to become more engaged in what we are trying to do.

Nanette Milne: Do the witnesses think that there should be more detail in the bill, particularly about the third and independent sectors? The sectors have provided a significant amount of evidence to argue that they should be in the bill.

Jeff Ace: 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 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.

The Deputy Convener: We will put that point to the third sector in the next part of the meeting.

Dr Gunning: It is important that there is positive engagement with the sector and, as I said, we have a model in that regard. However, the arrangements must follow the governance and accountability arrangements. 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. It is important that we draw that distinction, to be fair to colleagues in the third and independent sectors.

Gil Paterson (Clydebank and Milngavie) (SNP): It is clear that there is a status issue. The bringing together of health boards and local authorities and their budgets gives status to the two big organisations. However, the third sector delivers a lot on the ground. How do we give the third sector status and a voice, so that we get the best out of it?

We will hear from the third sector, as the convener said, so my question might be more appropriately put to those witnesses. I am sure that they will have something to say about the matter.

The Deputy Convener: I think that our next witnesses are in the public seats, just behind the current panel. Their ears are probably burning. [Laughter.]
Alan Gray: Mr Paterson’s question takes us back to the point that Jeff Ace made at the start of the meeting. We are turning the issue on its head by putting locality planning at the forefront, supported by strategic frameworks.

We have to make that approach a success and we need to engage with the third sector. We also need to engage with the public on looking after their own health. We need to empower communities to be involved in decisions that affect them. There are assets dotted all over our health board areas, which could be better used by communities. It is for us, as leaders of the health service, to ensure that we engage meaningfully at locality level.

GPs’ biggest frustrations are about making connections, even within the health system. We must make it easier for them to make connections with the public and ensure that when they want people to be admitted to acute services they have a known point of contact—a face, a person. A range of work has been done around trying to integrate GPs into the whole health system and integrated health and care partnerships.

10:30

The Deputy Convener: With our witnesses’ indulgence, because of time constraints, we will move on to the next question from members.

Mark McDonald (Aberdeen Donside) (SNP): I will be shamelessly parochial, but I think that it will nonetheless be relevant to the bill. Mr Gray possibly knows where I am going to go.

Concerns have been expressed about Aberdeen City Council’s decision to establish an arm’s-length company—a local authority trading company—for the delivery of some of its social care services. The chief executive of NHS Grampian is on the record as saying that, although that does not prevent integration, it could restrict the range and nature of the partnership that is established in the Aberdeen area. Given that things have moved on and the council has established such a company, what discussions have taken place? Are you confident that the partnership will be able to provide the maximum benefit?

Alan Gray: Without going into the details, we have to recognise that the local trading company has been set up. I view it as a service delivery vehicle, as it will deliver services and will be commissioned by the integrated authority. It will not not make things any more difficult. It is different from what we have in the other two local authority areas with which we work but, if we take a sensible approach with the city council, the vehicle will not be an inhibitor to progress on the integration agenda. We just have to understand what the vehicle is there to do. It is there to achieve a range of objectives for the council, but it will not necessarily get in the way of effective partnership working in the city of Aberdeen.

The discussion has moved on from when correspondence was exchanged on the issue, and we now recognise what the vehicle is there to do. There has been positive engagement between health board and council officials. We now have to spend time on strategic plans, and the trading company will be part of that, because it will deliver part of the service that we commission, in the same way that some of our operational services in the community health partnership currently provide services. I do not see the trading company as an inhibitor and I do not think that the bill needs to address the issue specifically. It is for us to work through the detail of that as part of the joint commissioning arrangements.

The Deputy Convener: Mr McDonald, it is valid to follow up on that specific issue, but, if you want to do so, could you be brief, because there is a wider issue about structures?

Mark McDonald: That is the point that I am coming to. Previous legislation has often been found not to capture local authorities’ arm’s length organisations. Is that approach captured by the framework in the bill?

Alan Gray: The governance remains with the integrated authority. That is where the responsibility lies for governance and for the decisions on the planning and provision of services. It will be for that group of individuals, when they come together, to determine how the trading company forms part of that and what services will be commissioned through it. That decision is still to be worked through, but it should not prevent that approach.

Mark McDonald: Obviously, we are focused on the governance and accountability issues in the bill, but the driver behind the bill is to improve service delivery to individuals in receipt of care. I am aware that there are long-standing issues in some areas, in relation to the recruitment of carers, for example. Do you envisage that the closer working and the potential to look at issues such as workforce will have a positive impact on the situation in areas where there is a difficulty in recruiting appropriate care professionals?

The Deputy Convener: I do not think that that is specifically directed at Mr Gray, although he is welcome to answer it. I will come back to the other witnesses.

Alan Gray: That comes back to the point that I made earlier about looking ahead. We now have to design a health system that can be delivered within the constraints of various local markets. Each of us faces different difficulties. It is for us to
design a system that recognises where the challenges are and then to work together to find a way forward. There will be challenges on issues such as recruitment, but we need to find a way of working through them to come up with a system that is sustainable and attractive for people to work in and that recognises the challenges in local areas.

Dr Gunning: From the perspective of carers, one potential advantage of workforce change is fewer handoffs between services, because health and social care staff will be working as part of a single team. People talk about conversations over the kettle, but the fact is that co-locating those teams in a single area enhances teamwork, outcomes and the involvement of carers. There is a big human resources and organisational development strategic agenda here, but we must build on things that have already been successful, such as joint training in child protection, to ensure that we are developing the workforce in a coherent, consistent and appropriate way.

Susan Manion: Dr Gunning has highlighted a point that I think was missed earlier in response to the question about the potential added value of the new legislation. Workforce planning must be linked to the resource change that needs to happen because under the current arrangements we still have different care workers—care home and healthcare workers, for example—going into people’s homes and there are sometimes still gaps and overlaps in provision. Planning and delivering that service more effectively while taking HR issues into account will provide significant added value. Indeed, that is what excites us about the new legislation.

Jeff Ace: Linking back to a previous question, I think that it is important to realise that the bulk of carers come not from the statutory agencies but from families and third sector organisations. That is the sort of area where each system has to demonstrate its effective working with other partners at a very low—say, community or family—level. That quality of engagement with the third sector and other partners is what will determine whether this bill makes any improvement.

Carers provide a really useful example of how not all of the solution lies within the statutory agencies. In fact, most of the solution might not lie with those agencies; it might well be that a lot of our success will be driven by the quality of our engagement with our non-statutory partners.

Dr Gunning: I think that there is a wider strategic agenda that links back to the Christie commission and particularly to the question of how public services reshape their relationships with local communities. That is a central issue for us all; indeed, in East Ayrshire, a vibrant and very structured communities programme has been set up through community councils to address that very matter.

If we in Ayrshire have a concern, it is about some of the links between this bill, the community empowerment and renewal bill and the Children and Young People (Scotland) Bill that is currently going through the Parliament. There is a responsibility to ensure that those specific examples are consistent with each other and lead to the same outcome that we all want. There will be quite legitimate overlaps, but we must ensure that they are positive and that we are not duplicating things or, worse still, pulling things in different directions.

Aileen McLeod (South Scotland) (SNP): The only questions that I had been hoping to ask have been asked and indeed answered, particularly on the issue of encouraging the meaningful involvement of our third and independent sectors or users and carers in the design, development and implementation of our services. However, if you wish to put anything that you have not already said on the record, feel free to do so. For example, I am aware that the community health and social care partnership board in Dumfries and Galloway includes representatives from the third and independent sectors and there is also, of course, the putting you first programme.

My safety net question was going to be about workforce planning and training to build capacity in the community but that, too, has been asked and answered.

The question that I will ask, coming back to the bill, concerns complaints and patients’ rights. I understand that, at present, our health boards and local authorities operate entirely separate complaints procedures. In addition, health boards have to comply with the Patient Rights (Scotland) Act 2011, which sets out the rights and responsibilities of patients who use NHS services.

How do you envisage the complaints systems and the 2011 act working with integrated services that are meant to appear seamless from the perspective of the users?

The Deputy Convener: For the moment, the witnesses thought that they were getting a blank sheet of paper and could say whatever they liked. However, we now have a very focused question. Any takers?

Jeff Ace: For the bulk of the pathways, the means by which a patient’s complaint will be dealt with will be clear. In perhaps four or five years’ time, there will be a blurring in community care at the home level between what is health provision and what is social care provision. At that point, the question of which of the discrete processes we will use will become difficult to answer, and we may
need to come up with some sort of different landscape around complaints management.

**Dr Gunning:** I think that that is right. Already, some complaints cross boundaries between agencies, just because of the nature of things, and the agencies have to work together to address those issues. There may be a need to formalise those arrangements a wee bit more.

I would like to use the question to cover another point that we have not dealt with yet. The issue of complaints leads to the issue of ombudsmen and so on. It is important that the scrutiny agencies go with the grain in terms of the policy objectives of the bill. I know that thought has been given to joint scrutiny arrangements, but the last thing that we want—going back to the earlier point about bureaucracy—is for scrutiny to take place individually and then collectively, because, before we know where we are, the burden of bureaucracy on frontline services will increase, which is the last thing that we would want.

**Aileen McLeod:** At the moment, the 2011 act is primarily aimed at patients using NHS services. Should that be extended to cover social care services also?

**Jeff Ace:** A client in the social care framework and a patient in the NHS framework both have a framework of rights-guaranteeing legislation, so I do not think that there is a gap at the moment. I think that you are asking whether we should blur the line between the two frameworks and make one the dominant structure, as it were. I do not think that there is an urgency around that. At the moment, I think that people understand clearly where the Care Inspectorate’s responsibilities lie and where the responsibilities of Healthcare Improvement Scotland lie. I think that we have clarity at the moment. It might be an issue that needs to be dealt with in the future, but I do not think that there is an urgent problem there.

**Dr Gunning:** The focus of some of the provisions in the current patients’ rights legislation is very much on treatment times in acute services, such as the 12-week treatment time guarantee. Whether there will need to be a statutory underpinning around access times in future is a major policy issue. Certainly, however, I see many of the challenges within the current legislation being to do with the issue of guaranteed access times, which is really important.

10:45

**Gil Paterson:** Most of the questions that I wanted to raise have already been covered. Dr Gunning said that he likes conversations over a kettle. I was born and raised in Springburn where we used to try to have conversations over a barrow. I think that his way is much better than the way I was brought up.

**The Deputy Convener:** Can I just say, as a representative of Springburn, that things have moved on a lot there?

**Gil Paterson:** That is right. I no longer live there.

Ms McLeod raised the idea of two different systems for people to make complaints, which is a serious question. I suspect that you are saying that it should change organically and that in the future they will come together, and that putting in effort and resources now may make it fail. A comment on that point would be fine.

**Jeff Ace:** We will always be able to answer a complaint. Between us and the council we will find a mechanism, as we do now, when an individual crosses our organisations, so there is no urgent necessity for legislation on the complaints mechanism.

**The Deputy Convener:** Do any other witnesses want to comment on that point? Mr Paterson, do you want to comment?

**Gil Paterson:** No thank you. That is fine. I have heard enough.

**The Deputy Convener:** It is not often that members have no comment to make at this stage.

May I take the opportunity to say briefly, because time is starting to get ahead of us, that if other witnesses want to put something on the record that you have not been asked about, now is your opportunity to do so. Is there anything that you would like to add?

**Susan Manion:** Speaking for the CHP association—saying this might seem like turkeys voting for Christmas—we are delighted with the opportunities that integrated partnership presents. When one is called to give evidence one considers the issues that are missing or the bits that we want to emphasise.

We appreciate the thrust of the change. We recognise that it is coming off the requirement for us to be bold and to use the opportunities. Locally, we are keen to be bold and to use the opportunities. We need to make sure that we make some step changes now to build on what has been successful, because there is so much more that we can do together, but we need the legislation to help us to be able to do that, otherwise we would have done a lot of it before now.

**Jeff Ace:** I will pick up on the point about the third sector that was raised earlier. It is important to re-emphasise that every system will need to make its engagement with the local third sector work in a way that is dramatically different from the
way in which it has worked so far. We need to be assessed on the quality of how well that works.

I and some of my health service colleagues are thinking about how to legislate effectively for that engagement in a way that works for Glasgow or for rural Dumfries and Galloway. That is the bit we are thinking about, not the realisation that we will have to change radically the level and quality of our engagement with third sector and other partners.

The Deputy Convener: Thank you Mr Ace. Does Dr Gunning or Mr Gray want to add anything to that comment?

Dr Gunning: I will make two brief points. Although we are talking about structures, governance and accountability, integration is not an end in itself, it is just a mechanism for improving outcomes for the people and the local communities that we serve. Integration cannot be achieved by legislation alone. There are big leadership challenges at all levels, national and local, within and outwith the statutory agencies. We need to be aware of the organisational development and wider change agenda, and the leadership that will be required at all levels to make integration a success.

Alan Gray: It is important to understand the relationships between the strategic plans that the councils and the health boards will undertake and the integrated plans that each of the partnerships produced and how they will work together. Our board serves more than one council area and it must be recognised that a lot of our services are organised across a region, indeed, across the north of Scotland.

It is important to get the right balance between planning decisions at a strategic level across a board area and the strategic planning decisions taken at an integrated authority level. If the legislation can simplify that, as Mr Ace said, in terms of governance and accountability, that would be ever so helpful to ensure that we achieve the right outcomes and deliver what we are required to deliver under the new arrangements.

The Deputy Convener: Thank you very much. I remind witnesses that our scrutiny of this bill will be on-going and if there is anything that you want to add in writing please do so, as the committee continues to take evidence. We would find that helpful and welcome it. All that remains is to thank all four of you for giving us your time.

The meeting will suspend for five minutes while the next set of witnesses comes in.

10:55

Meeting suspended.
third sector representation. We would like to see the third sector represented at all levels in the new structures. If we are going to have the new structures, it is important that the third sector have a seat at the strategic tables because it has a strategic contribution to make to the bill, and not just to its objectives.

If only the statutory agencies are to vote—based on the rather odd reasoning that we have heard so far, which is that they are statutorily responsible for public money—the third sector and other interests should have some power of veto over the plans and how they are developed. It should certainly have a right to contribute to those plans.

I know that Mr Paterson said that it is not a question of money, but there needs to be a modest investment in the third sector’s capacity to engage with all the structures, otherwise you are simply asking hard-pressed volunteers in voluntary organisations to stop doing something else in order that they can engage in statutory planning. There needs to be investment.

Most of all we argue that it is not a question of structures; it is about building stronger communities, which will take the strain and the pressure away from all the focus on delivery of care services to people. If we do not do things that reduce demand on formal services, we are kind of missing the point.

11:00

Ranald Mair (Scottish Care): I was not sure whether the reference to “two big beasts” was a reference to Mr Sime and Mr Henderson. [Laughter] As you know from the written evidence that we have submitted, Scottish Care is clear that it will be a missed opportunity if the third and independent sectors are not fully included in the governance arrangements in the future. That is the position that we have to date enjoyed and discharged responsibly within the work of the change fund and the reshaping care for older people programme. Those are 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.

Rather than capture the progress that has been made, the bill sets us back dangerously to a point where the third and independent sectors become “consultees”, and not full partners in a process. Despite the optimism that was expressed by Dr. Gunning and others, there is a real danger of our losing ground rather than gaining it. The evidence that we submitted makes it clear that the third and independent sectors deliver more social care than the statutory sector delivers. One has only to look at care homes and care at home, in which the bulk of services are delivered by third and independent sector organisations.

How can there be integration of services? In a sense, and in an honest way, the title of the bill states that it concerns the “Joint Working” of statutory bodies. That is it. We have given up on “integration”.

As you know from our written evidence, we would have preferred that this was a public services bill in which everybody who is part of the delivery of public care was brought together, and that the focus was on that level of integration. We feel very strongly that the third and independent sectors have to be represented at all levels of governance and planning in order that we are not just at the commissioned end of service delivery but are wholly part of the process from the outset.

Nigel Henderson (Coalition of Care and Support Providers in Scotland): I echo much of what has been said. It is particularly interesting to note where we are today and the part the third sector has played in achieving that. An awful lot of what is delivered across the country was pioneered, innovated and created by third sector organisations and is now part of the mainstream.

It is also interesting to see the push within the health service now to move to a person-centred way of working; the health service is playing catch-up with the voluntary sector, which has been person-centred for the past 20 years. We have a significant contribution to make—not just as providers, but as equal partners. 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.

I absolutely echo what Mr Sime and Mr Mair have said: we need to be involved at all levels. We can deal with the mechanics and how we sort it out later, but the basic premise has to be involvement. The third sector does not always speak with one voice; it includes a diverse range of organisations. We have diverse interests, but our range of interests crosses the whole community in Scotland, at different levels. It is very important that we do not leave the two big statutory authorities to do this by themselves. They need people like us to help to shape, to create and to innovate for the desired outcomes.

Gil Paterson: I hear what you are saying and how you are delivering your message. Are there any practical items that you can bring to the table that encapsulate what you are trying to achieve, bearing it in mind that you have just said that the range of voluntary and third sector organisations and where and how they deliver is very wide? How
do you bring all that together before you can impart power to act to maybe one individual?

Ranald Mair: I have an example that relates to Nanette Milne’s questions in the earlier evidence session, about the decisions that GPs make and why people end up in hospital. The GP can pick up the phone and get access to a hospital place if they are worried about Mrs Smith, but they cannot get immediate access to an intensive care-at-home package or to a care home place. The purpose of integration is to bring all the options to the fore so that when GPs are making such decisions they have immediate access to all the options.

If we leave the provider sector in a situation in which commissioning must be through the social work department, there is not immediate access, not all the options are brought to bear and the systems are not redesigned. It seems to me that there are practical ways in which the provider sector—private and voluntary—must be part of the planning and the bringing together of options at the front line.

Martin Sime: There is a track record in this. The Government makes a significant investment in what is called the third sector interface—none of us likes the name very much, but the intent is very clear—which consists of local umbrella bodies that are designed to provide a framework through which the third sector can co-operate. In health and care, we have heard examples of the different roles that the third sector can play as a vehicle for user, carer and community groups, as an advocate for special interests and people with disabilities, and as a service provider.

It is clearly quite difficult for any one organisation to represent in a traditional sense all that diversity in statutory planning processes. However, we are working towards that in the community planning world and we are making real progress with the TSIs. The representative role is to enable messages from the diversity of interests in the sector to be represented at the table and reflected in the discussions. However, it is just as important for the messages from the community planning table to come back to the diverse constituency in the community. In other words, the role is not to represent a bloc of interest, but to act as an interlocutor and take messages back and forth from what are really quite diverse sets of interests.

We could undertake that role in health and care, but we cannot do it from a standing start with no resources. That is my message to the committee. Also required is a very clear message to the statutory partners that this is not an optional extra or something that should be left to local decision making. We know what happens when such things are left to local decision making: in large parts of the country, they do not happen.

Nigel Henderson: I think that the question was specifically about how we do integration. I do not have a snappy answer, but I would reflect what Martin Sime said. We already have community planning structures, although getting involvement is sometimes difficult. Certainly, as a service provider, I sometimes find engagement difficult; equally, though, I understand that we have third sector representation.

However, there must be discussion of how integration and community planning link up. We could set up lots of committees, structures and all the rest of it, but I would then worry about how we as a sector would ensure that we were represented. We think that we are entitled to be represented and to be part of things, but as Martin Sime said, the question is about how we would resource that. There are already frameworks in community planning that could feed into health and social care integration so that there is awareness of what is happening from the ground up.

Gil Paterson: So, to make integration happen, must there be a reference to it on the face of the bill, or would it work through guidance?

Nigel Henderson: I think that it is a strongly held principle within the policy memorandum, so I do not see why it should not be on the face of the bill.

Ranald Mair: To strengthen that point, anyone reading the bill as it stands would not know that the third and independent sectors existed or contributed anything. There is a disconnect between the policy memorandum and the bill in that regard. We are already core partners and need to continue to be. Reference to that in the bill would mean that the matter cannot be left to any local opt-out or whatever; our inclusion would become a formal requirement.

There are partnerships in which that would happen anyway, as was reflected by Dr Gunning earlier in the meeting. He said, “In Ayrshire, we would do that.” That is fine, but there might be other parts of the country where the choice would be not to do it, or not to do it well enough. Therefore, it has to be in the bill.

The Deputy Convener: I have a supplementary question, if members will indulge me. Mr Sime, I think that you said to challenge our views that, if it is about equal partners, we have local authorities, health boards and the voluntary sector, which could hold the balance in a strategic board. What should be the balance of influence in voting rights and input for the third sector on a strategic board? More important, if you believe that there should be something on that in the bill, the bill has a great
deal of flexibility on what the body corporate may look like, for example. I do not mean this glibly at
downstream deliverer of public sector priorities. If we do not
table, the tent will become very uncomfortable
institutional arrangement is necessarily limited.
I do not have an answer to the dilemma that the
that third domain above the first domain, we will
have lost the plot.
big lesson an object lesson in 14 public bodies
communities, and the need for all public
locality planning level. We should be involved at all
that allows for consensus to arise and in which we
strategic planning at the earliest phase. That is about meeting outcomes for individuals in
in delivery of health and care services and the promotion of initiatives in the
community, which might obviate the need to use
my colleagues have reiterated, the third
sector’s engagement in delivery of health and care
service infrastructure. If the message is that you
can have all this public sector infrastructure
without the engagement of the third sector, I would
of course have to say, that you cannot.
My argument is that the third sector needs to be
seen as an established partner, not as a
downstream deliverer of public sector priorities. If we are not an established partner and are outside
the tent, the tent will become very uncomfortable
to be in altogether, because the third sector will
make its voices and interests known in other ways.
I do not have an answer to the dilemma that the
committee faces. I understand why local
government and the health service are equally
unwilling to cede a voting seat at the table: it is
because of the power that that would give the third
sector. The third sector would be ill advised to
do a strategic needs assessment in an area, to
develop a locality plan and to appraise the options
for how services can best be delivered without the
inclusion of the third and independent sectors. It is
not beyond us to come up with a governance
model that would allow that strategic inclusion,
while accepting that the statutory agencies have
particular lines of accountability in relation to
public moneys and so on.

11:15

The Deputy Convener: That is helpful.

Nigel Henderson: There are three potential
levels of involvement. One is at the health and
social care board level, one is at the level of the
strategic commissioning process and one is at the
locality planning level. We should be involved at all
levels. Being involved early in any strategic
planning is crucial. We would like the bill to be
changed to reflect that and say that the third and
independent sectors must be involved at those
points.

In an ideal world, it might be useful for us to
have voting rights at board level. However, as
Martin Sime said, hopefully we have a process
that allows for consensus to arise and in which we
do not have to wave votes around because people
share the same vision and agenda on integrating
health and social care.

The Deputy Convener: There are two
supplementary questions on that, from Aileen
McLeod and Richard Lyle.

Aileen McLeod: Martin Sime said earlier that
the issue was not about the structures but about
building stronger communities. In his written
submission, he mentioned the capacity
implications for the third and independent sectors
and the fact that
“the operating environment for the third sector remains challenging”.
A key challenge within that for the way forward is
how we rebuild capacity in communities to deliver
health and social care services effectively. How
should that be done?
Martin Sime: You put that question in an interesting way. I am not sure that the top priority in my book is to build capacity to deliver services. The top priority is to build capacity to reduce the demand for services. The third sector does a range of things, or is a vehicle for them, in communities, such as befriending, lunch clubs, care-and-repair initiatives and the Food Train. There is a raft of third sector interventions that enable people to sustain themselves in communities and be independent. Community transport is a classic example of that.

Those are not commissioned care services; they are voluntary organisations doing things with communities that enable older people to be independent. We need much more of that, but it is precisely those services that are most under threat from the reductions in public expenditure. As budgets tighten, the statutory or formal services retain an element of priority and anything else is seen as marginal. That is exactly the wrong way round. An investment in services that enable older people to sustain their independence and good health in the community would be genuine prevention.

My worry is that we all run after this word “prevention”, but it is interpreted in much the same way as the change fund was interpreted, which is to mean that new ways of intervening in people’s lives and providing services have priority over ways in which people can make decisions for themselves.

I want to open up one area that has not had enough priority. We are having conversations about the bill and the delivery of services without sufficient reference to the Social Care (Self-directed Support) (Scotland) Bill. It seems to me that the two bills are ships passing in the night. Self-directed support ought to enable people to make decisions for themselves about the kind of support and infrastructure that they need to meet their needs. That is fundamental to the canvas of services going forward.

The Deputy Convener: Mr Mair wishes to speak, but I ask him to hold on to his thoughts for a second. If he and Mr Henderson want to answer Aileen McLeod’s question, they can do so, but two members want to ask supplementaries. We will take Richard Lyle’s supplementary now, so that the witnesses can reflect on both questions. That will allow us to get through questions more speedily.

Richard Lyle: In some ways, your submissions are quite critical. I agree when you say:

“This sector provides 85% of the care home places in Scotland and over 50% of care at home. There are more older people in care homes any night of the week than in hospitals, and more … care workers employed in the private and voluntary sectors than in the public sector”.

I love the bit from Ranald Mair that says:

“The mundane title of the Bill might also tend to obscure the fact”

of “its impact”.

A number of critical points are made.

I come from a local authority background and I have been involved with many local organisations and many sectors. In a partnership, who will speak for all those involved? Who will be at the table? If you were included, would you really need a vote?

The Deputy Convener: I think that some committee members have jumped the queue for asking questions. A very patient Rhoda Grant was meant to be next.

Aileen McLeod asked about building capacity; Mr Lyle asked who would represent the third and independent sectors should a vote ever have to be taken.

Ranald Mair: I will try to respond to both points. We have good experience to draw on from the change fund and reshaping care partnerships. We have tested the ground on some of the issues. We have representation—we have worked out how to do that. There are representative bodies. I sit on the Glasgow reshaping care partnership steering group, on which the third sector is represented through the Glasgow Council for the Voluntary Sector and the independent sector is represented through Scottish Care. We have worked out who will represent us, which has been important.

One of my disappointments with the bill is that it does not seem to say what is working. Some of that ground has been painfully gained over the past period; that did not happen automatically. Initially, the involvement of the third and independent sectors in some aspects felt tokenistic, but that has improved as we have demonstrated that we bring something to the table.

On capacity, we have had a dual model to enable our sectors to be full partners. Money has been channelled from the Government to support the sectors and their engagement, and local partnerships have invested money because they recognise that, if we want the third and independent sectors to be full partners and deliver new models of care, they have to put resource into that.

We have good experience that we could draw on, but we are not doing that. We do not have to say how the sectors will be represented, how to create joint structures and how to develop capacity, because we have done that for the past two or three years—we have been on that journey with reshaping care. We should capture and build
on that, rather than start again, but the bill has the danger of pushing us in that direction.

Nigel Henderson: The bill refers to the third sector—the voluntary sector—as well as the for-profit independent sector and the not-for-profit service-providing sector. Those distinctions are important. No one single body will represent the totality of third sector views. Service providers, which I represent, have a view about the contribution that we can make, which might differ from the view of community and volunteering groups. It should not be beyond the imagination of partnerships to look at how such voices are heard and at how to enable them to be heard.

In the past, a lot of change has been miscommunicated. For example, when a hospital is to be closed, we hear only the headline that the hospital is to close, and we do not hear the headline that better services will sometimes be developed in the community. Why are we not communicating and engaging with communities? There might be capacity issues, but there is a willingness, a creativeness and an inventiveness in the sector and we will find ways in which to participate. It will be much better if we are invited to be there as equal partners instead of having to barge the door down.

There needs to be something in the bill that says that the third sector must be involved, although how that happens could be left to local discretion. We already have the model of third sector interfaces in community planning, so it will then become our job to ensure that our views are being represented through those third sector interfaces. I do not think that there is a one-size-fits-all solution whereby we can simply say, “That will be the body.”

Rhoda Grant: Let me reel back the discussion a little to the plea to be involved in governance and commissioning. How would you deal with that, given the rules and regulations about governance and financial interests in the public sector? There is strict guidance about how people can use their influence in decision making. If you were on the board, you would be commissioning services in which your organisations, as contractors, would have a financial interest. That would be a huge conflict of interests that would be difficult to manage because there is no statutory control of your organisations. How would that work?

Nigel Henderson: If we have a conflict of interests, that will be shared by the other partners, as they, too, provide services.

Rhoda Grant: But that is their role—they have been set up as public organisations to provide those services.

Nigel Henderson: In terms of statutory control, the scrutiny to which we are subjected is as intense as, if not more intense than, the scrutiny of some areas of the national health service. We must be registered providers and must go through all sorts of processes. We are inspected regularly and we are held accountable. We are also, in the main, charities and we are held accountable by the Office of the Scottish Charity Regulator. What we can do is very much subject to controls and limits.

Your starting point is to jump to the point at which we might get into arguments about who does what and all the rest of it. If the bill is about fundamentally shifting the landscape of health and social care—if it is about considering the Christie commission principles, moving things upstream and beginning to think about prevention—we need to be involved in the discussion to ensure that we help to shift the agenda. As I said, we have a long history of being creative and innovative and finding different solutions, and all the people who contribute to what happens in health and social care must be involved on an equal basis. The governance issues are important, but we should not lose sight of what we are trying to achieve.

Ranald Mair: It is an important issue that we must address. Scottish Care is not a service delivery organisation; it is a not-for-profit representative body. Therefore, I think that we can represent the potential contribution of the sector as a whole without feeling compromised or having a conflict of interests—possibly better than local authorities, which may want to protect in-house services while supposedly adopting an open options-appraisal process. I do not necessarily agree that the conflict of interests would apply to us and not to the statutory partners.

The important point, which is one that I have made to the committee in previous discussions, concerns the regulation of commissioning processes. We need clear national standards. The process needs to be regulated to ensure transparency and to ensure that our involvement at a strategic level in commissioning focuses on the volume and range of services that we require and how we shape the models of care to deliver what is needed in the future.

11:30

If we are not at the table, time will be wasted. I am in discussion with one health board and local authority at the moment about the development of intermediate care to prevent people from going into hospital. Traditionally, the local authority commissioning staff went into a darkened room and came out with a spec of what they wanted but, when that was presented to providers, it became clear that it could not be delivered in the way that was wanted. In other words, we must be involved...
at an earlier stage to shape the models of care that will deliver what is needed.

I do not think that there is a conflict of interests that cannot be overcome. If we are involved in the commissioning process from the outset, the gains will far outweigh the concerns that we might be partisan in how we go about the process.

Martin Sime: Having read the evidence that was given by local government representatives last week, it is difficult not to conclude that here was the promotion of self-interest on a grand scale, so to be accused of somehow promoting our interests in the commissioning and governance arrangements seems rather rich. For our sins, Ranald Mair and I sit on the national delivery group for health and care, and we have had two special meetings over the summer to consider the bill and its implications. Those discussions—although that is a polite word for them—have been absolutely dominated by the pursuit of the institutional self-interest of health services and local government to the point where the purpose of the bill and the interest of people who might need access to services was almost completely absent.

One thing that the third sector might bring to the top tables is a continual focus on those needs, on the purpose or object of the exercise and on what we are trying to achieve. If one takes a top-down approach to public authorities delivering things to people, either directly or indirectly, one gets into the business of thinking about conflicts of interest.

If the bill was somehow turned on its head and we thought about how to build a system of health and care support from the bottom up, based on the needs and interests of communities and underpinned by the rights of individuals to make choices about the services that they felt were appropriate to their needs, one would come to a completely different set of conclusions whereby health and care institutions are the servants rather than the masters of those processes. The problem is that the bill, in a traditional Scottish public service top-down way, is paternalistic at its heart and is the exact antithesis of the recipe as set out in the report of the Christie commission on the future delivery of public services for building services around communities and their needs. In the bill, we are building structures around institutional interests.

Rhoda Grant: There is nothing to prevent other organisations from being involved in community planning.

None of you has answered my question about how to set up governance structures that are not only fair but seen to be fair, and that ensure that Joe Public does not think that private contractors and third sector organisations who will make a profit are involved in making decisions about how the care is delivered. How do you prove to him that you are not doing it out of self-interest for your organisation and that his interest is at the heart of it?

People in health boards do not have a financial interest and neither does local government. Local government has a democratic interest in serving its public, because its members are elected on and off to do that— they are public representatives. How do you square that circle and ensure that you are seen to be making that decision not only properly but transparently and in a way that fits with standards in public life?

Martin Sime: Voluntary organisations that deliver care are almost universally charitable. They do not distribute profit and there is no personal gain or private advantage. Any resources that they generate go straight back into their cause or mission. They are a public good, so if a charity sits at a top table articulating a view on behalf of the community that it seeks to represent, I am not sure that the public would have much of a problem with that. The public seem to support the idea that charities can play a bigger role in the community and have significant confidence in them.

Of course, charities are subject to adequate and proper regulatory frameworks, thanks to the sterling work of the Parliament to pass Scottish charities legislation for the first time and to establish OSCR to ensure that charities keep to their bona fides. It seems to me, however, that we are kind of missing the point. Not all charities have a service delivery interest; some have a representational interest. The third sector interfaces, for example, do not deliver health and care; they deliver support to the third sector organisations that deliver health and care. It is therefore perfectly reasonable for us to be represented at the top table without any conflict of interest.

We see the problem manifested in adult care services. Local government thinks that the best way of getting the best value—a term that local government does not apply to itself, incidentally—from working with the third sector is through competitive commissioning processes and offering contracts to what is usually the cheapest provider of services. There is lots of evidence, particularly from some pretty innovative work that the Scottish Government health department is doing with the third sector, that that does not get the best out of the third sector, because all that the buyer gets is what is written in the contract. They do not get the third sector using its development expertise or volunteers engaged in the service or a developmental approach that might find other resources to bring to the table. There is none of that if the service is on a commissioned and
contracted basis. That is not the way forward for health and care services being delivered by the third sector. We need to find new ways to generate proper partnerships between the third sector and the state to get the best of both worlds.

The Deputy Convener: Mr Mair, how do you address the conflict that Rhoda Grant suggests?

Ranald Mair: I have a couple of things to add. As has been said by others, I do not necessarily think that we are caught in that trap. We have the evidence base from the reshaping care programme and the change fund that we have discharged that involvement in an even-handed and non-partisan way, but that has to be open to scrutiny. People should have the option to withdraw from certain decisions and they can declare their interest if there is a perceived conflict.

Within commissioning, we can separate off the strategic planning element and the broad options-appraisal element from procurement. I do not expect to be involved in any decisions about how services are procured. The procurement process should be transparent, whether it uses a tendering model or another model. We can separate the planning function and the options-appraisal function from the mechanics that are involved in procuring services. It would be inappropriate for sector representatives to be involved at that level.

Again, I do not think that the one cancels out the other. We need to be clear about the level of involvement and the range of decision making in which we are engaged. Processes need to be clear and transparent so that there is no conflict of interest when it comes to the procurement of services. However, as I said, I would equally apply that rigour to local authorities. They should not be able to allocate contracts to in-house public bodies while insisting on tendering and retendering processes for the third and independent sectors. Let us have one set of rules for everybody, as well as transparency for everyone.

The Deputy Convener: Would you like to add anything, Mr Henderson?

Nigel Henderson: I just reiterate that we are a not-for-profit sector. We are charities, so there is no profit motive and, as Martin Sime said, everything goes back into the work that we do. Within CCPS there are about 73 organisations, which are all social care providers. About 75 per cent of our income comes from public bodies through contracts, service-level agreements and grants, and we generate the other 25 per cent ourselves from individuals, charitable trusts and other pots of money. That money goes back into the public good as well, so we already add considerable benefit. We are not in it to build empires and deliver simply for the organisations; we are there because we believe passionately in delivering better outcomes for people in the community. As Martin Sime said, the public can have confidence in charities through some of the structures that already exist.

I echo the point about commissioning and contracting. Local authorities now put out tenders in which they cap the rate at about £14 or £15 and say that no one will get more than that. However, we know that their in-house services cost at least £10 an hour more than that. It is therefore not a level playing field. There is already a lot of self-interest evident in the public sector. We need to be able to get to grips with that. If we simply move the structure but have the same behaviour, we will not achieve the bill’s goal.

The Deputy Convener: Would you like to add anything, Rhoda?

Rhoda Grant: No. I have not really had an answer to my question, but I do not think that I will get one, so I will just leave it there.

Mark McDonald: I understand entirely the need for the third sector to be confident that the bill will not exclude some of the good work that is currently being done. However, do the witnesses believe that the issue of third sector engagement needs to be on the face of the bill? Could guidance be developed to ensure that the role of the third sector is taken into consideration, which might give some comfort to you?

Martin Sime: We seem to be going over the same ground. Let us see whether we can look at the issue in a slightly different way. I am a bit of a sceptic about whether the bill will achieve its intended purposes. I am not sure that all the discussions that we are having about the role of the third sector should be solely in relation to the bill; they ought to be more in relation to how the third sector engages with public authorities more generally and how the third sector engages locally.

I believe that the third sector’s engagement in the delivery of health and care services and the support of communities is critical for the future, because there is no plan B that involves not using or working with the third sector, or not building strong communities. It therefore seems incredibly unfortunate to have a bill such as this that completely marginalises the third sector to some kind of downstream deliverer of public sector priorities—that simply does not work.

I think that a lot of the bill is totemic anyway, so let us have the totemic engagement of the third sector recognised on the front page of the bill to send a very clear message to public authorities. The previous panel of witnesses reflected the view that they did not need the third sector at the strategic level but just needed it for delivery. That sort of message is incredibly damaging in the long
run to the interests of people who use health and care services. We need more third sector engagement at the strategic level, but the bill does not get there in its current form.

**The Deputy Convener:** Mr Henderson, do you want to add anything?

**Nigel Henderson:** It feels like we are going over this issue in great detail. 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. That is a principled argument, to some extent. Martin Sime is right to say that there are some areas of tokenism, but it is an important token to ensure that we are an accepted and credible part of what happens in the public service world in Scotland.

11:45

**The Deputy Convener:** I assume that Mr Mair agrees with that.

**Ranald Mair:** No, I am going to disagree wildly. [Laughter.]

I listened to the cabinet secretary last week as he emphasised once more that the move towards integration was not about structures but about culture and vision. I agree with that in one sense, but the structures that we develop must reflect the culture and vision that we want to have, and if that is about partnership, the structures must embody that partnership.

The text of the bill does 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. The detail can be in the guidance, and it will be for local partners to work out some of the mechanics that we have discussed this morning and come up with the working answers. If we have not managed to provide those answers now, we can—I hope—find them at local level as we try to move things forward.

The issue is the absence of any reference to us. We do not need a lot of comfort built into the text of the bill, but some acknowledgement that we exist would be marginally helpful.

**Mark McDonald:** That comes back to a particular difficulty with the sector. In a local authority or a health board, it is easy to define who is responsible or accountable. However, it is difficult to define who is accountable or responsible in the third sector, given that it ranges from prominent national organisations to local organisations that are often much less prominent. How do you ensure that, rather than having 100 different voices at the table, you have one voice that will represent adequately that range of interests?

**Martin Sime:** In a sense, we have covered that. In reshaping care for older people, it was agreed at national level that the third sector interfaces would take on the responsibility of enabling the third sector to be represented. Those third sector interfaces had, written into their funding agreement with the Scottish Government, a responsibility to engage with all parts of the third sector and to enable the sector to represent itself to public authorities.

You will not get a corporate view, because we do not have a single view on these matters—you will get a lot of different views, and that diversity is a critical strength of the third sector. We therefore need an enabling mechanism, which must be the interfaces, as there is no other mechanism. It is their core business, and they must reconcile the needs of small local and community organisations with the needs of big national care providers, housing associations and many other interests in the third sector, including those organisations—on which we do not seem to be spending enough time—that give voice to particular needs and interests in communities. Carers groups, for example, must be represented and have a role to play in integration. Where will the voice of people with disabilities be heard amid all these structures and infrastructures?

The third sector interfaces are the starting point for that consideration. The interfaces receive modest central funding to enable them to be independent from local government, the health service and other public authorities. The third sector already plays that role in community planning in every part of the country and there is no reason why, with a modest investment, it cannot play that role in the arrangements in future, as it has done with the change fund for older people. My preference would be for that to be recognised in the bill.

**The Deputy Convener:** Mr Mair, I am not sure whether you want to answer that but, because of time constraints, if you could let it pass, I would be grateful.

**Ranald Mair:** I am happy to leave it. The focus should be on what has worked within the change fund arrangements, because we are already doing that, so we do not need to reinvent it.

**The Deputy Convener:** I have three colleagues who still wish to ask questions.

**Mark McDonald:** I have one further question, convener, if you will allow me.

**The Deputy Convener:** Of course, but it will be brief, I hope.
Mark McDonald: It was on Mr Mair’s response to Rhoda Grant. I do not want the panel to think that I am in any way trying to downplay the importance of third sector partners, but we have to look carefully at how the interaction will work under the bill. Mr Mair suggested that there could be third sector involvement in things such as strategic planning but that the involvement would be removed at the point of commissioning and procurement. Could the system be disaggregated to that level, given that strategic planning will by definition inform the commissioning and procurement approach?

Ranald Mair: I see it all as part of strategic joint commissioning, the principles of which are being shaped. Within an overarching commissioning approach, one could separate off the strategic planning and options appraisal aspect from the procurement aspect. I am saying that third sector representatives would not need to be—and arguably should not be—involved at the procurement end. I would not want to be involved in evaluating tender bids that come in from provider organisations, as that would be wholly inappropriate. However, as a sector representative, I should be involved in the design stage, the strategic planning stage and the weighing up of how we best secure the provision going forward. In all those areas, we can add value to the discussions. Indeed, we can make the procurement exercise more productive when it happens and ensure that it achieves its purpose.

If we use the principles of strategic joint commissioning and allow third and independent sector representatives to be involved at that level but leave the procurement to the statutory agencies, there will be separation and an avoidance of conflict.

Nigel Henderson: Again, the issue goes back to the diversity of the sector. I hope that people who use services and people who care for those who use services will be heavily involved in the decisions about what services are procured. They have their own structures and representative groups and bodies. Are we talking about third sector representatives or third sector advocates? It might be a clearer role if people are given a voice at local level to contribute not just to the big picture but to the local picture. It will be different horses for different courses within what is a diverse sector.

Mark McDonald: Could the issue be dealt with through, for example, a requirement to have meaningful consultation with the third sector, rather than the third sector being involved? The issues of lines of accountability and conflicts of interest that have been raised would thereby perhaps be removed.

Martin Sime: Personally, I would not recommend that way forward. It seems to me that we are talking about a paradigm in which the public sector does things such as procurement to us in the third sector. That is already a move away from the policy intention of the bill, which is to create partnerships to enable us all to play to our strengths. With the bill as it stands and the intentions as you describe them, as well as the discussion about conflicts of interest applying solely to the third sector rather than equally across the public sector, we are already in a hierarchical relationship in which the third sector is seen as the deliverer of public sector priorities. That is not the way to get the best out of us, and it is certainly not the way to create a partnership. It would not go down well among organisations working at the front line if public authorities told us what to do. Why is procurement a process that is applied only externally and not something that is applied to public authority delivery of services, too? We need to move on from that.

The Deputy Convener: I hate to say this, Mr Mair, but please be brief, as we have two further questions to ask before we close.

Ranald Mair: Okay. The model that we are advocating is the one that Audit Scotland advocated last year in its report on social care commissioning, which said that providers need to be involved at a much earlier stage in the process and not just at the procurement end, because that leads to poorer results. The argument is not about some sort of empire building on our part but about how we get better outcomes for people. The drive on self-directed support will mean that individuals are increasingly empowered to make choices about the services that they get, so we will have to change the emphasis on local authorities controlling the commissioning process.

The Deputy Convener: Thank you. We have to move on. I call Nanette Milne, who has been very patient.

Nanette Milne: I am pleased that Mr Sime mentioned the SDS bill, which is now the Social Care (Self-directed Support) (Scotland) Act 2013. I have long felt—and I think that I am on the record as saying—that it will not work properly until we achieve the cultural shift that the integration of adult health and social care should bring us. Do you believe that the bill will facilitate the implementation of SDS in the integrated arrangements? How could it best do that?

Martin Sime: I would like to say that it will but, unfortunately, my view is that there is not strong enough evidence that the bill will lead to the changes that we need in order to make self-directed support the norm. We need a bit of history. We need to look back over the past 10 years to successive failures to drive integration...
and join up services, budgets and processes, and we need to ask ourselves whether the bill will somehow overcome all those difficulties. I have not seen the evidence, so I am not convinced.

The best example that I can give on the potential for self-directed support and the work of the third sector to change people’s lives for the better is around Alzheimer’s. The Government has made a welcome commitment that individuals who are diagnosed with Alzheimer’s have a right—that word is important—to a year of post-diagnostic support. That is a huge advance, and people around Europe are looking at how it could be implemented elsewhere. It is a great credit to the Parliament and the Government that that is being instituted.

I understand that there are voluntary organisations that feel that, at the end of that year, they will be able to go in and work with people and their families to deliver a package of care that is based on what they want, using the right to self-directed support. Over the next few years, we are going to see a huge change in the quality of services and their relevance to individuals, and all the evidence suggests that that will reduce demand on formal public services in the long term, that it will be cost effective and that it will deliver for families.

Those changes are possible because of the self-directed support legislation, but they have nothing to do with the bill that we are discussing. The bill is irrelevant to those changes. We are able to change things on the ground because of self-directed support and the work of the third sector in a way that was unimaginable in the past. We need to pause and reflect on that experience and think about how we can get more of the benefits of the self-directed support and the work of the third sector in a way that is closer to what we are trying to achieve with self-directed support. It is to be hoped that there is a point at which the two have to come together—on the ground, if not in terms of legislation. However, I do not think that the bill does enough to capture the connectedness between the different strands.

Nigel Henderson: There are a number of issues. The bill does not capture the self-directed support stuff at all. Also, the Social Care (Self-directed Support) (Scotland) Act 2013 is largely about local authority spend, not about health spend. Our concern about the new integrated budgets is that, if money loses its identity—if there is no longer a health pound or a social care pound, just a pound for health and social care—what are the implications for charging and eligibility? How does the health authority view the money being used for social care purposes? A lot of things need to be bottomed out there.

The culture that we want at the core of this is reflected in the self-directed support act. It is a culture in which citizens are empowered, in which they have choice and control and are no longer simply passive recipients but active participants in their care pathway or in their care journey. It would be interesting to see much more about how SDS can help to shape the future of health and social care integration rather than it simply being seen as a subset of what already exists.

Nanette Milne: I find that very interesting. I was concerned during the evidence taking for the self-directed support bill that there seemed to be a sort of disconnect between the statutory bodies. How to get the culture change—to properly bring them together, hearts as well as minds—concerned me and that is why I thought that the 2013 SDS act would not really work properly unless what we are discussing now was effective in bringing about that culture change. That is why I was interested to hear what you said.

The Deputy Convener: We want answers to this question, of course we do, but we have one further question and time is almost upon us, so brevity would be good. I know that it is an important question.

Nigel Henderson: I will just throw in a word: trust. Part of it is about trust. We have talked a lot about whether the third sector can be trusted as partners. That has been a major theme of the discussion this morning.

Do we trust citizens to make the right choices and decisions for themselves? It seems to me that
the secret of the SDS act will be whether we actually trust and empower people to make choices and take control. At the moment, I have to say that there is a bit of foot dragging on some of that. The SDS act becomes law next April. I think that it will take a few years to bed in, but trust is at the heart of a lot of what we are talking about here.

Ronald Mair: There is a parallel bit within the bill that I think is relevant—there is some emphasis on locality and local planning and there is a similar point to make about what we are prepared to devolve to localities. Will we give them control of budgets? Will we empower localities in the same way as we are talking about empowering people in relation to self-directed support? Will we trust individuals? Will we trust local communities? That, for me, would be the strongest potential connection—if we get the locality planning aspect of things right in the bill.

Martin Sime: I will simply add that this is a debate about institutions and I am not convinced that rearranging the institutional furniture will get us to the point that we need to be at. We should be having a debate about how to face the demographics. If we do not have that debate—if it is postponed because we are all busy shuffling the deckchairs—the ship will sink.

The Deputy Convener: I will move to our last question shortly. If I did not make a brief comment on self-directed support, carers and adults with learning disabilities in Glasgow would think that I was not adequately representing them. I think that there is a feeling that in Glasgow self-directed support has been used—this may link in to other decisions—to mask budget decisions by a local authority rather than in the spirit of the Social Care (Self-directed Support) (Scotland) Act 2013 and that it has been used to pursue a local authority agenda rather than to ask individuals what they really want.

I will leave that comment sitting there. Constituents have written to me and asked why I did not mention that when self-directed support was mentioned, so I felt that I had an obligation to do so.

Martin Sime: I will respond briefly, because we are having a debate in the third sector about our attitude to self-directed support being influenced by its inappropriate application as a means of rationing by local government. We stand by the principle of self-directed support and the empowerment and user choice that it offers, but it asks a much more fundamental question of us all: why is the application or delivery of self-directed support a responsibility of local government and therefore subject to variability? Why can the Parliament not just say, “Everybody has a right to this,” and establish what that right involves in terms of resources. After all, we are talking about a population of only 5 million people.

It seems to me that we could cut the resources a different way and that to have 32 separate discussions about what self-directed supported means for people with Alzheimer’s does not do justice to the interests of those people.

The Deputy Convener: We will have to leave both my comment and Mr Sime’s comment sitting on the public record. Malcolm Chisholm has the final question.

Malcolm Chisholm: I will try to move us on to one final new area, although I have enjoyed the discussion and we could say a lot more about connecting the bill with other areas of policy. I agree with what you have said about the gap that there is, in several ways, between the policy memorandum and the bill—the third sector is one of those issues; quality is another that some of you mentioned in your submissions. We do not have time to talk about that, but clearly it is also very important.

I will talk about budgets—the issue is not unrelated to Martin Sime’s comments about demography. Nigel Henderson’s comment about budgets in his submission was extremely interesting. Although I have not read all the submissions, I think that it was quite an unusual comment. A lot of the direction of travel is towards more local flexibility but, as I understand it, Nigel Henderson’s group is saying, “Look, particularly around the acute budgets, you will have so much trouble working out how much money will come in, how much will come from health in general and how much will come from local authorities.” In a sense, that organisation’s view is that budgets should be centrally set. Given that budgets are such a key aspect of all this, it is important to ask Nigel Henderson what the thinking behind that suggestion is, but it would obviously also be interesting to hear the views of the other witnesses.

Since I am asking only one question, my final comment is that, although I am quite attracted to Nigel Henderson’s idea, it probably means that there would be a greater degree of prescription around the services that are attached to that budget.

Nigel Henderson: Absolutely. Martin Sime has described this as a very institution-focused discussion. One of our concerns after the bill was launched was that we already sensed that local authorities and health boards were looking to minimise what they might have to put into the integrated pot. We worry that we could create this whole new infrastructure and it might have very little control over very little money. We think that there needs to be more prescription about what
money should be allocated to the joint health and social care partnership fund.

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.

Ranald Mair: I agree with Nigel Henderson that, interestingly, in the past months there has been a retreat from the enthusiasm for pooled budgets. Both local authorities and health boards seem to be looking to hold on to more resource within each of their separate areas rather than put money into a shared pot. There are some issues about what is put into the budget and what decisions are made about it.

Two other difficulties should also be touched on. We talk a lot about the shift in the balance of care, but through the three years of the change fund to date we have seen very limited shift in the balance of resource. Keeping Mrs Smith out of hospital saves money on paper, but there is no corresponding shift of resource—the money does not follow Mrs Smith. That creates a difficulty because there is an increased spending requirement to maintain Mrs Smith in the community, while the spend within the hospital sector is also maintained. We have not actually seen the big shift that was to be one of the things that would create sustainability going forward. I think that we have yet to come up with a workable model on that.

A final budgeting issue is that the overall requirement for a realistic budget for delivering older people’s care continues to be, as the delivery group suggested, the elephant in the room. There will be a shortfall. Between now and 2020, we will run into difficulties. As a society, we will need to find ways of spending more money on that. We need to spend the existing pot better and more effectively and, yes, we need to seek to control and reduce demand, but even if we do all that and become more efficient, there will still be a shortfall.

Martin Sime: Welfare changes, demography and public expenditure cuts are all heading us down a really difficult route. There was an expectation that integrating health and care would help us to get all our ducks in a row so that we could create efficiencies. For those of us who have been engaged in this process for many years, it is a huge disappointment to discover right at the last minute that there is no prospect of significant agreement between health and local government on how much money goes into the pot. Without that agreement, the purpose of the bill simply defeats me.

We are at a critical point. It could be that a whole lot of backstairs arm twisting will get some level of agreement. As I understand it, the latest is that the stand-off position that is acceptable for health is that how much health money goes into the budget should be a matter for local agreement. That could mean a lot or it could mean a little. It could mean that local variation wins out—so the Convention of Scottish Local Authorities will be happy—but it will not drive any of the changes that are necessary in order for us to meet these challenges.

I think that we need to ask ourselves some pretty uncomfortable questions. Is the current standard of anonymous 15-minute hurried care visits the kind of future that we want for our care services? Is having a voluntary sector workforce on minimum-wage zero-hours contracts and without pensions the kind of future that we want for our care workers? What is the case against national rates for care and self-directed support?

If any of those things were done and if the centre said, “This is how much money is going into our future health”, that would take a lot of the heat out of the institutional battles about power and responsibility. The third sector has no interest in taking sides in that institutional battle. It is a very unedifying sight that is not getting us to the point that we need to get to, where we are all perfectly aligned so that we can use our limited resources to meet what are quite substantial and growing demands in our communities.

The Deputy Convener: Does Malcolm Chisholm want to pick up on any of those points?

Malcolm Chisholm: No.

The Deputy Convener: Due to time constraints, I will not ask, as I did with the first panel, whether you wish to make any additional comments, but I am sure that you are vocal enough that you will write to us and follow up matters very closely, as you have done already. Please do that, as it helps us to form an opinion as we continue to scrutinise the bill.
I thank the three witnesses who have appeared before us in this second evidence session as well as those who appeared in the first panel. As previously agreed, we will now move into private session.
Public Bodies (Joint Working) (Scotland) Bill

The Coalition of Carers in Scotland

Do you agree with the general principles of the Bill and its provisions?

Last year we held a series of consultation events with carers and staff from local carer support organisations to ascertain their views on the Integration of Health and Social Care and the likely impact this would have for unpaid carers. (The full report has also been submitted)

Carers cautiously welcomed the integration and increased joint working between different sectors. 33% indicated that it would result in ‘a bit of an improvement’ in the recognition and support of unpaid carers. However, 52% of respondents indicated they felt ‘Things will stay the same’ and 14% felt ‘Things will get worse’

Carers identified many positive outcomes from increased integration/joint working, including:

- More resources directed towards preventative community services
- People able to live independently at home with support for longer
- Better recognition and services for unpaid carers
- Better communication and shared outcomes between health and social care
- Increased role for the voluntary sector
- Potential for better engagement with carers in relation to decision making
- A better experience for service users and carers at critical times, such as hospital discharge.

However, they also identified the following concerns, which they felt had the potential to lead to a negative impact on carers

- Shifting the balance of care leading to a greater burden on carers.
- Less investment in acute services leading to problems at times of crisis.
- A step back in terms of carer engagement with a failure to recognise carers as equal partners in care and a failure to include carers at the highest level of decision making within the new structures.
- Reorganisation taking the focus away from frontline services, resulting in carers needs being left behind
- The new structures being equally bureaucratic, with resources being wasted in setting them up thereby widening the gap between policy and the reality of carers’ lives

In general carers agreed with the principle of integration/joint working, provided:
a) The central premise is to improve outcomes for service users and carers

b) Carers are able to participate in the new structures as equal partners in care.

At the moment we feel that these key principles are not sufficiently represented in the Bill.

**To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**

We understand that the Bill is mainly focused on the underlying structures and processes which are required to facilitate joint working and that much of the detail will be provided through secondary legislation.

However, we feel it is essential to establish the role of carers as equal partners at the outset and ensure the mechanisms for carer engagement are embedded within the emerging structures.

The role of the third sector is highlighted in the explanatory notes accompanying the Bill

62. **It is intended, through secondary legislation, that integration authorities will be required to fully involve the third sector as key partners in strategic commissioning, locality planning and service delivery activity. The Scottish Government recognise the key role non-statutory, not-for profit providers of health and social care services play in the provision of care, working in partnership with statutory partners. It is expected that there will be a degree of overlap between these activities and those currently required for third sector participation in community planning and in developing change fund commissioning plans.**

63. However, initial scoping work with third sector partners has identified a number of levels at which additional resources might be required to ensure sufficient knowledge and capacity to enable third sector partners to fully participate.

There is no corresponding commitment outlined in relation to fully involving carers as equal partners in strategic commissioning, locality planning and service delivery activity. Yet as service providers, unpaid carers are the greatest contributors to health and social care provision in Scotland and these reforms will have a significant impact on the provision of services which support them in their caring role.
In addition, while there has been a commitment to provide additional resources to the third sector to ensure they have the capacity to fully participate in the new structures, there has been no such commitment to providing resources to enable carers to participate. For carers to be fully engaged they require structures to enable them to come together and share their views, either through local forums or social networking. It is also necessary to provide training and support for carer representatives on planning groups. Local carer organisations have the expertise to undertake this role, but they require resources to enable them to do so.

The Coalition undertook a project in the Highlands in 2011/2013 looking at carer engagement in the emerging integrated structures. It found that the community planning structures were confusing and cluttered and that integration had only added to their complexity. While there was a willingness to engage with carers, this stopped short of including them at governance level and giving them a place on the new health and social care partnership. It also recognised that further investment was required to support carer engagement in community planning.

It is important that we learn from the experience of carers in the Highlands and ensure that the new joint structures involve carers as equal partners at all levels of decision making and that carers are supported to have a voice in a meaningful way. If the new structures merely replace one bureaucracy with another, with the emphasis on the contribution of statutory agencies, they cannot hope to achieve their primary objective of improving outcomes for service users and carers. This view was reflected strongly in our consultation with carers and other stakeholders with 100% of participants indicating that they believed carers should have a guaranteed place around the table in the new integrated structures, with one carer commenting:

‘For carer involvement to work at all in an integrated structure there has to be a basis of supported, informed carers contributing to local support organisations, which in turn feed into higher level governance and decision making bodies. This is undermined when funding is withdrawn from carer organisations.’

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

We welcome the adoption of an outcomes approach to joint working/integration and support the government’s intention to consult carers on the proposed outcomes.

As previously mentioned, we welcome the objective of improving outcomes for service users and carers, involving carers in the design and delivery of services and improving the transition between health and social care provision.
Please provide details of any areas in which you feel the Bill's provisions could be strengthened

We are disappointed that the name of the Bill has changed from Integration to Joint Working. We feel that this conveys a weakening of the Bill’s intentions and the impression of organisations retaining their separate identities, rather than working as a partnership.

As previously outlined, we feel the Bill needs to be strengthened in relation to carer engagement and the recognition of carers as equal partners in care. We hope that this will be clarified in secondary legislation with carers being recognised as equal partners with a guaranteed place on partnership boards. We seek reassurance about this and ask that carers are recognised in the way the third sector has been in accompanying explanatory notes, with a commitment, not just to include carers, but also to adequately resource them to fully participate.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

Integration has the potential to result in significant benefits to our member organisations, who provide local support to carers across Scotland.

With a greater focus on shifting the balance of care to supporting people at home and in the community, we would anticipate more resources being directed towards carers through carer support organisations.

If this is not achieved, then there can be no doubt that integration will result in an increased strain on carers and the organisations that support them.

What effect do you anticipate integration plans will have on outcomes for those receiving services?

We refer back to the messages from our consultation sessions outlined in question one. In this carers identified both positive and negative outcomes arising from integration, which could significantly impact on their lives.

If integration is successfully implemented it has the potential to greatly improve people’s experience of using health and social care services, particularly at times of transition. It also provides the foundation for more personalised preventative services and improved carer engagement leading to better planning and use of resources.

However, this is dependent on strong leadership at a local level and partnerships embracing a new more open way of working which is inclusive of other
stakeholders such as carers, service users and the third sector. One respondent to our consultation pointed out that what is needed is:

‘Trust, openness and mutual respect for other people’s issues. But beware that integration sets up new barriers somewhere else.’

The Coalition of Carers in Scotland
August 2013
Consultation on The Integration of Health and Social Care Messages from Carers - Summary Paper

Background to our Consultation Process

In partnership with Carers Scotland, the Coalition produced a briefing paper on the Government’s proposals, which was circulated to carers and local carer organisations through our membership. In addition, we facilitated several consultation events with carers and stakeholders at both a national and local level.

At each of these consultation meetings the proposals were outlined and views from participants were sought on the implications of the proposals for carers.

These events included:
- A national meeting of our members on the 29th of February
- A joint meeting on the 26th of June with the Scottish Health Council and Highland Community Care Forum. This event brought together health and local authority practitioners and carers from across Scotland
- A local meeting of carers in Edinburgh on the 13th of August
- A local meeting of carers in Renfrewshire on the 24th of August
- A discussion group with our members on the 29th of August

At each of the meetings a series of questions were posed, both through open discussion, workshops and also through carers writing their views on message boards. The responses are detailed below:

1. Do you think the greater integration of health and social care services will lead to an improvement in the recognition and support of unpaid carers?

   Yes a big improvement: 0%
   A bit of an improvement: 33%
   Things will stay the same: 52%
   Things will get worse: 14%

2. How will integrating health and social care change things for the better, or for the worse for unpaid carers?

   - Great need to stop layer after layer of bureaucracy / ladder to climb when wanting help.
   - Simplify processes, communication with carers to take part.
   - Be open about what councils do with their budget.
   - Changes are finance based and have little or nothing to do with quality provision for carers. The service user is left behind in all of this.
   - If it is done properly it could make a huge difference – with a focus on early intervention rather than crisis management. However, partnerships
must not be allowed to create new bloated management structures in order to save their own jobs.

- If integration embraces carers it should get better but it won’t if it is an afterthought.
- It will only make things better if they listen to and implement carers issues whether integrated or separate health and social care.
- If you live in Glasgow I feel we will be left behind because of politics.
- Should be one door approach – one assessment.
- At the beginning I doubt the two bodies will be capable of integrating working practice. However, new staff brought up in the new ways might.
- If the powers that be listen to service users and carers and process the information this could lead to better services.
- Integrated services will lead to more people supported in their own homes which will require greater input from unpaid carers. They must be properly supported!
- Things should change for the better
- Hopefully for the better, by working with one another and alleviating stress on carers Working together towards the same outcomes should improve services, no doubling up
- It must not result in higher charging for services. Carers should not be charged for any services as they are providing a service. If charges increase, people will stop using services’

3. Should carers have a guaranteed place around the table in the new integrated structures?

**YES** 100%

**NO** 0%

- YES, YES, YES, YES, YES.
- YES, YES, YES.
- Yes and be recognised and treated as an expert.
- Consult before legislation.
- Good to talk but more important to be listened to.
- Decisions made behind closed door are no use or telling carers what is to be, after decisions are made.
- Edinburgh had a Strategic development Group for Carers which included carers, it has now disbanded. The new group is the Scottish Planning Group for Carers which has no seats for carers.
- Unpaid carers are saving the government millions why aren’t they recognised for this.
- Listening to carers who are supposed to be ‘equal’ providing the care. Often they know the most practical solutions
- When carers sit on panels it tends to always be the same ones who may be confidant speakers but don’t always have the best things to say.
Should consider use of advocacy services to give the views of other carers.

- Carers should have a guaranteed place but only if it a fully supported place so that it can be meaningful.
- Different types of carers (rural/mental health/learning disability/dementia/young carers etc) all have different experiences/needs specific to them. A balance of ‘types’ of carers is needed on all consultation groups/committees.
- Carers are key partners in care!
- Carers are indispensable. I know – I am one.
- Use of independent advocates for carers to express the views of several ‘types’ of carer at one meeting.
- Yes supported by Secondary legislation (Guidance, directions etc to NHS Boards and councils) The omission of carers in membership of Health and Social Care Partnerships etc – if explained in terms of ‘not having caught up with CEL6’ – would demonstrate carers are not really being valued. Behavior reflects beliefs!
- This does happen in my region but some officers treat you as an individual and not as a representative.
- Carers being on commissioning and planning (strategic) groups either ‘on their own account’ or ‘as a representative’ is a key issue, but so too is the process of identifying and selecting a carer to fulfill the role. To often its simply down to who is ‘willing and able’ and this is often the ‘well kent face’.
- Carers should have a voting right at board level
- Carers often know more than the professionals and should be treated as such
- Carers need to be recognised, valued + heard
- Carers should have a guaranteed place around the table in the new integrated structure
- Must be carer rep in committee national as well as local

4. What are the barriers to integration working well and producing improvements in health and social care?

- Ignorance, bad attitudes, carers experiences being disregarded.
- Not taking carers seriously – Tokenism.
- The independent sector often provides what the NHS and local authorities don’t want. Usually it’s the staff that cost ‘too much’ It’s not a level playing field. Often it’s the independent provide that can provide integrated health and social care.
- Lack of training, loss of identity, loss of specialism, lack of knowledge as NHS takes a lead and stamps over social work, paranoia over stats, rather than qualifying quality service provision for carers.
- I think that there is a danger that as the paid workers jostle for recognition of their role, the role of carers may be overlooked.
• Ignorance of the consequences of caring for someone leads to carers becoming service users – anxiety, stress, depression, lack of resources.
• Workers are bogged down with change and recent loss of specialist identity and carers needs are left behind.
• It is people not systems which will make or break integration.
• An attitude of mind.
• Communication pathways between health and social care must be clear and simple, especially between departments and specialist areas within both.
• Thoughtlessness on the part of statutory bodies.
• Too many patients/people are ‘defaulting’ to NHS continuing care eg/spinal injury and head injury. Patients who have completed specialist rehab and are medically stable, simply because statutory authorities can’t fund care packages.
• Budgets – Managers not wanting to share in delegation of responsibility.
• Providers of services – talking down, not listening.
• Health and Social Work still looking after their own corners and no one looking after the cross over areas and grey areas in the middle.
• Neither one taking a holistic view of an individual
• Budgets are the barriers. Each organisation wanting to hold in to their own budget and not wishing to share.
• The detail of services needs to be regarded with the highest importance. The outcome for carers support has to include the efficiency and effectiveness of services from a carers perspective
• Too much bureaucracy
• Aimed at older people, lack of focus on learning disabilities etc – others could lose out
• If Social Work and Health are joined; will it lead to more bureaucracy, fighting amongst each other?
• Will this result in job losses at a time when we need more?
• Could be conflict due to resistance to change information, communication must be bottom-up

5. What contributes to services working better together?

• Constructive dialogue, lack of suspicion.
• Carers must have rights. The right to be listened to, the right for good services, the right for help.
• A genuine understanding of each others roles and responsibilities, including carers. To work this needs to be invested in.
• Communication.
• Willingness of doctors/nurses to engage fully with families/carers of patients and work on collaboration with carer’s groups.
• The right people in the right jobs should not be lost – keep what is already good.
Trust, openness and mutual respect for other people’s issues. But beware that integration sets up new barriers somewhere else.

There is frustration about over/underspend of NHS/LA budgets and how these are distributed as a result. Underspend doesn’t necessarily mean lack of need for services, often lack of awareness.

Please find a way to get G.P.’s involved directly, not Practice Managers who don’t pass things on.

Need consultations to be done locally and specific carer consultation events

Open and honest dialogue.

Outcomes for carers are: To be recognised as an important component to after/long-term care. To be able to get services when needed.

Money – budgets for carers must be ring fenced. Monitoring is a must for any new developments to social care.

It would (lead to improvement) if service managers support it and make it happen.

If important carer pathways are identified early within new structures.

There should be a better understanding of needs of carers, more equality of funding

Listening, communicating and taking on board the needs of care in the community and providing a good service

Carers must be respected as equal partners – legality and parity

Improve G.P /Community nurse focus on carers

Both NHS and social work services need major culture shifts to make integration work

Needs to be a joined up I.T system inclusive of all services to improve information sharing

Making and strengthening - outcomes all carers being involved

6. The government is asking ‘How can you help us make it work?’ What can carers and local carer organisations do to help achieve better integration between the different sectors?

Help to facilitate carer awareness training for all professionals who come into contact with carers.

Why do we always look to creating incentives for GPs within their contracts to endure their participation? We could instead impose financial penalties if they fail to demonstrate participation.

For it to be make clear to professionals that carers are equal partners.

On the closure of hospitals or wards – the staff released must be fully trained for local community work. I believe that hospital and community nurses are on different wavelengths.

As a unpaid carer I provide over 138 hours of free care a week. What else am I expected to do.
Basically the movement of carer from hospital to the community means that information from the hospital and G.P must be perfect and complete.

For carer involvement to work at all in an integrated structure there has to be a basis of supported, informed carers contributing to local support organisations, which in turn feed into higher level governance and decision making bodies. This is undermined when funding is withdrawn from carer organisations.

GP practices have to be on board. GPs are the first port of call, or should be, for carers. They must be pulled into the system.

Monitoring of services is key.

Carer representatives should be limited to 4 years, to ensure other views are heard.

Everyone on planning and commissioning groups need to be empowered to take decisions. It is not just carers who currently lack decision-making authority. Often the real decision makers sit behind the scenes where the real decisions are taken.

Day care centres play a vital part for carers, respite care and well run agency care services.

It is vital that 24hour a day carers have a voice in helping to make change.

Looking better at the circumstances of individuals.

Communication with various groups. Important that they all reach the same conclusions.
1 Introduction

1.1 Inclusion Scotland is a network of disabled peoples' organisations and individual disabled people. Our main aim is to draw attention to the physical, social, economic, cultural and attitudinal barriers that affect disabled people's everyday lives and to encourage a wider understanding of those issues throughout Scotland.

1.2 The Independent Living in Scotland project aims to support disabled people in Scotland to have their voices heard and to build the disabled people's Independent Living Movement. It is funded by the Scottish Government Equality Unit to make the strategic interventions that will help to make independent living the reality for disabled people in Scotland.

1.3 We welcome the opportunity to submit written evidence to the Health & Sport Committee on the Public Bodies (Joint Working) Scotland Bill.

2 Health and Social Care Integration

2.1 Inclusion Scotland and the Scottish Disabled Equality Forum (SDEF) held a series of workshops earlier this year to consult with disabled people in Scotland to have their voices heard and to build the disabled people's Independent Living Movement. It is funded by the Scottish Government Equality Unit to make the strategic interventions that will help to make independent living the reality for disabled people in Scotland.

2.2 This evidence draws on the responses received from disabled people at these workshops. It also builds on 'It's our world too: 5 asks for a better Public Services (Joint Working) Bill' produced by Independent Living Movement, which can be found at www.ilis.co.uk.

3 Do you agree with the general principles of the Bill and its provisions?

3.1 We believe that the principles and outcomes of health and social care integration should include; independent living, co-production, equality and human rights. These principles should apply to all sections of the Bill, including the development and revision of integration and strategic plans and local planning and delivery of services, as much as they apply to the end product of integration itself.

3.2 Whilst we recognise the policy intentions, the Bill as presently worded fails to meet this aspiration, and may facilitate a move back towards the medical model of care rather than the development of a human rights based social model of care.
3.3 We are concerned that the “policy ambition for integrating health and social care” (Policy Memorandum, paragraph 2) is too focussed on the provision of care services for people in their homes – i.e. how and where care is provided, rather than on promoting independent living – i.e. the outcome of care.

3.4 We would like to see the Bill amended to;
• include a general principle that integration of health and social care services will follow a human rights approach, similar to the amendment to the Social Care (Self-directed Support) (Scotland) Act (s2), and
• to use the definition of 'independent living', developed by the Disabled People’s Independent Living Movement, in the Bill (the first ask):

Independent living means; “disabled people of all ages having the same freedom, choice, dignity and control as other citizens at home, at work, and in the community. It does not mean living by yourself, or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life”

3.5 We endorse the principle of integration of health and social care. It has the potential to create better joined-up services and bring positive benefits to those requiring support. In particular we welcome the planning and delivery principles where they emphasise the importance of wellbeing and that services should be integrated from the point of view of “recipients”. However we question the use of the term “recipients”, which implies passive receivers of services rather than active partners with providers.

3.6 It is unclear why these principles are stated separately (at s4 and again at s25) rather than as a single set of principles at the start of the Bill.

3.7 The principles, as stated, are too needs-focussed. Services should be delivered in a way that takes into account people’s aspirations in line with a social model of care. The principles should be strengthened by a clear statement of what is meant by wellbeing, to make clear that this goes beyond health and physical wellbeing to include independent living, social life and participation in the community.

4 To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

4.1 We believe that it is essential that disabled people are fully engaged in all aspects of the integration of health and social care services: national outcomes; integration plans; strategic plans; and local planning and delivery of services. This can best be achieved through co-production, an approach that recognises the value of partnership between disabled people and public authorities in developing services, policies and strategies (the second ask). We suggest that reference be made to ‘All Together Now – a guide to co-production with disabled people’(
http://www.ilis.co.uk/get-active/publications/co-production-toolkit) as a means to support this way of working.

4.2 We are concerned that the proposals in the Bill are too focussed on the health and organisational outcomes rather than those of the end user. The change of the title of the Bill, from Health and Social Care Integration to Public Bodies (Joint Working) may reflect this apparent focus on process rather than outcomes.

4.3 There is a risk that the Integration Plan and the Strategic Plan will become ends in themselves rather than as means for real change in service delivery. As one workshop participant said: “It’s not structural change that’s needed, it’s cultural change”.

5 Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

5.1 It is important that disabled people, other service users and the third sector are involved in leading not just on the principles of integration but on how money within it is spent, including eligibility criteria, assessment, and principles for its use (the third ask).

5.2 Whilst the Bill and Policy Memorandum expresses a policy intention to involve representatives of users and carers of users, other than in respect of the power to prescribe national outcomes (s5), this is not specified and left to secondary legislation. Inclusion Scotland believes that the involvement of disabled people and their directly accountable organisations, is central to ensuring that integration supports independent living. The Bill should place a direct requirement on Scottish Ministers to include disabled people as “persons or groups of persons appearing to the Scottish Ministers to have an interest”.

5.3 A common concern raised at our workshops was that past experience suggested that when disabled people respond to consultations or invitations to events, no-one listens and nothing changes. Effective engagement requires disabled people to be involved before the process starts to help design how engagement will be conducted. Integration authorities should be required to provide robust evidence that they have engaged meaningfully with disabled people and other service users, including how they have addressed access and inclusion.

5.4 The Bill would be further strengthened by including the principles of independent living, equality, human rights and co-production in the development and revision of integration and strategic plans, and the local planning and delivery of services.

5.5 There should be more clarity on the membership of integration joint boards or joint monitoring committees. Inclusion Scotland remains of the view that disabled people should have representation and full voting rights on these committees. Statutory authorities would retain a voting
majority and Scottish Ministers the right to intervene in the event of a failure of an integration authority to fulfil its statutory duties.

5.6 The Social Care (Self-directed Support) Scotland Act and the Public Bodies (Joint Working) (Scotland) Bill must work together to promote seamless care provision. Health and social care systems should support and promote self-directed support in the community for the service user when they exit hospital based services (the fourth ask).

5.7 It is important that the principles of independent living and the social model are applied equally to health care as social care. On admission to hospital, social care packages, including self-directed support and employment of personal assistants, can be terminated requiring these to be re-established from scratch before discharge. Disabled people are not allowed to use their personal assistant when in hospital. This leads to discontinuity of care not integration.

5.8 We do not believe that disabled people should be charged for services they require for independent living, whether these are defined as health or social care. Full integration of health and social care is unlikely to be achieved whilst different charging regimes apply to health and social care services. Integration of budgets and delegation of functions makes the existing arbitrary distinctions of what is a free health service and what is a chargeable social care service untenable.

5.9 Participants at the Inclusion Scotland workshops highlighted concerns about whether and to what extent mental health services will be included in the bill. The Policy Memorandum indicates that regulations will set out functions that may not be delegated, including certain mental health social work functions, but gives no further details.

5.10 Workshop participants pointed out that there is an increased likelihood of mental health problems amongst disabled people and their carers when there is inadequate provision and barriers to independent living. It is of concern to us that mental health service users may not benefit fully from the benefits of integration if mental health services are excluded. The Committee may wish to seek clarification on this issue.

5.11 Further clarity is needed on the transition from children’s services to adult services. This transition can already be difficult, with children and families having to fight to secure the continuation of support as they move from one service to the other.

5.12 There also needs to be clarity on the portability of support as different integration authorities, even within the same health authority area, may have different delegated functions. We believe that disabled people should be able to ‘port’ their package of support when they move, in order that they can enjoy the same freedom of movement as other people.
5.13 We know there are currently significant levels of unmet need within the social care system in Scotland, and we know disabled people are subject to significant health inequalities. We think an integrated system of health and social care should set out clearly the minimum level of entitlement for all users, that integration authorities should record all unmet need that falls below this, as well as the level of unmet need that is set against outcomes of equality and human rights (the fifth ask).

5.14 There may be some confusion between the Integration Plan, which establishes the structure for integration, and the Strategic Plan which sets out how integration will be delivered. Perhaps the first could be called the Integration Scheme and the second the Integration Delivery Plan?

6 What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

6.1 If disabled people and Disabled People’s Organisations (DPOs) are to be able to play a full part in developing health and social care integration, then they will require resources to enable them to do so. One key issue is the provision of advocacy services to support disabled people, if and when required, to participate meaningfully in the process.

7 What effect do you anticipate integration plans will have on outcomes for those receiving services?

7.1 It is essential that integration of health and social care is developed in a way that is person centred and promotes independent living. Performance should be measured in terms of the extent to which disabled people are supported to participate in society and lead an ordinary life. It should be based on outcomes that are co-produced and driven by disabled people’s own choices.

7.2 The concern is that the Bill concentrates on structures and procedures which could lead to a top-down approach that is target driven rather than outcome driven. This could lead to a professional/institutional led approach to integration rather than one that is driven locally by users, professionals and the wider community. This could see a reverse of the progress towards the social model of care and the re-emergence of the domination of the medical model, as has been the experience in other areas such as Northern Ireland.

7.3 Legislation and structural change alone will not deliver the change that is needed, but if done well can help contribute to the cultural change that disabled people want to see.

Inclusion Scotland
Independent Living in Scotland
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Health and Social Care Alliance Scotland

Do you agree with the general principles of the Bill and its provisions?

The ALLIANCE welcomes the Scottish Government’s commitment to integrating health and social care to improve outcomes. The third sector has long argued for – and delivered – integrated, high quality support that enables people to access their right to good health and independent living. We would, however, question whether the provisions go far enough to achieving the radical and transformational change advocated in the Christie Commission’s report on the future of public services1.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The Bill has the potential to improve the quality and consistency of health and social care services, however if integration is to succeed then strategic commissioning – and the involvement of service users, unpaid carers and the third sector within this – must be made more effective.

It is a well-established principle that people – at an individual and strategic level – should be active and equal partners alongside the providers of support and services. Audit Scotland2 recommends that local authorities and the NHS work effectively with the third sector to analyse local needs and plan, develop and deliver services to meet this need. Such principles are also acknowledged within Scottish Government guidance on procurement for social care and support3.

The third sector can play a number of roles in ensuring the policy objectives of the Bill are achieved; as a key strategic partner in its own right, helping to reshape support and services; a major provider of support and services (including over a third of registered social care); and an essential mechanism through which people who use support and services can be involved and their voices heard. The sector can play a key function in providing insight and intelligence in the joint commissioning process, and in enabling the direct involvement of people who use support and services.

Without a strong, effective role for the third sector and for people who use support and services, the ALLIANCE fears that the Bill is in danger of focussing too strongly on structural change, rather than acting as a driver of the radical culture shift required across health and social care. There is a risk that the focus on outcomes for people is lost as local partnerships grapple with the complexities of structural, budgetary and cultural aspects of the move to integration. The ALLIANCE believes Section 4, Subsection 1 (b) (iv) should be amended to “is planned and led locally in a way which is

2 Audit Scotland, Commissioning Social Care, (2012)
engaged with the community and local professionals from across different sectors”.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

The legislative duty placed on local authorities and health boards to integrate their services is welcome alongside the emphasis of integration as a major plank of the Scottish Government’s Public Service Reform programme. The Bill as presented, however, risks missing a significant opportunity to deliver support and services differently unless a partnership approach with users, carers and the third sector is taken to policy, design and delivery in the future. The Bill currently reflects a desire to improve services but to do so within broadly the existing paradigm.

The ALLIANCE also supports the emphasis on an outcomes approach, as integration should not only be about trying to ‘fix problems’ within a system, it should be about ensuring people have the support they need to lead fulfilling lives.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

A stronger voice for people who use health and social care support and services is required. Part 1 Section 6 (Consultation) is not sufficiently robust to ensure effective partnership between the third sector and statutory services in developing integration plans. We are particularly concerned that the third sector may not have a role in signing off the local strategic plans. The Bill suggests that Integration Plans are signed off by only the two statutory partners. We presume that the third sector will be among those that Scottish Ministers will be required to consult; however this is a far weaker provision than requiring joint sign off.

Evidence gathered from the Change Fund: Enhancing the Role of the Third Sector Programme suggests a barrier to effective partnership working experienced by some Reshaping Care for Older People partnerships, stemming from the lack of a shared understanding of the role and remit of each of the different partners. The four-way sign-off of local Change Plans has enabled local partnerships to push this agenda forward and provided a framework allowing partnerships to get through some of tensions of working in partnership.

The ALLIANCE is concerned that voting rights will not be afforded to third sector representatives on joint boards, or to representatives of people who use services. The Scottish Government has concerns that such a right would enable the third sector to prevent health boards and local authorities from discharging the duties they’re legally obliged to discharge, i.e. providing services. We believe such risks could be mitigated by the provision of clear responsibilities and terms of reference for board members, including the need to adhere to statutory requirements. The sector, and people who use services,
may lack the same accountability mechanisms as statutory partners, however robust mechanisms exist, and can be built upon, to enable them to play a legitimate role. If the third sector and users of services have little power or influence within partnerships it is unlikely that we will see the kind of transformational change that is widely advocated.

Initial research by the ALLIANCE has found that the composition of shadow integration boards across Scotland contain an alarming lack of third sector involvement and the representation of the third sector in the future remains unclear. Some shadow boards, for instance in Fife and Edinburgh, appear to have taken a clearer approach to public involvement. We are concerned that this variable approach may set a marker for future involvement in joint boards.

As proposed, Health and Social Care Partnerships will only be accountable to health boards and local authorities. There is a risk that the proposals for integration, particularly with the third sector as a non-voting member of the HSCP Committees, will represent a backwards step. The third sector and people who use support/services should be included within membership of Integration Boards at section 12 and strategic plan consultation groups at section 26 of the Bill

We welcome the reference made in the Policy Memorandum to Public Participation Forums (PPFs) as an example of “a successful means of engaging with the public and building the views of unpaid carers and services users” (Page 8, Para 40). PPFs play a significant role in enabling Community Health Partnerships; to engage with local communities; support wider public involvement in planning and making decisions about the health service; discuss how to improve services and support the vision of co-production, as embedded in the National Person Centred Health and Care Programme. There is, however, a real lack of clarity in the Bill and the Policy Memorandum as to what will happen to PPFs in an integrated landscape.

The ALLIANCE welcomes the inclusion of integration planning and delivery principles on the face of the Bill. As they are drafted, however, we are concerned that they do not sufficiently reflect a human rights based approach or wider Scottish Government policy on stronger engagement between the statutory and third sectors, and co-production between those designing/providing and those receiving services.

We would strongly advocate 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. In their content and language the principles reflect the traditional ‘deficit/needs’ based paradigm with professionals framed as holding the balance of expertise and power. This seems at odds with the Christie agenda and wider drives for personalisation, person-centred care and

---

5 [http://goo.gl/F1lJa](http://goo.gl/F1lJa)
the desire to ‘shift the balance of power’\textsuperscript{6}. It also risks undermining the drive for prevention by focusing narrowly on current needs, rather than emerging needs and aspirations of local populations. It is also unclear that the principles encompass unpaid carers and future users of services.

The National Health and Wellbeing Outcomes, Section 5 of the Bill, and requirement for Scottish Ministers to consult on these outcomes are welcomed, with some third sector organisations implicitly included within ‘non-commercial providers of health/social care’. To be an effective consultation process, it will be essential to include strategic third sector organisations, particularly national strategic intermediaries and the local Third Sector Interfaces. It will also be critical to include organisations that may not consider themselves as ‘providers of health/social care’ but who contribute considerably to health and wellbeing through community-based activity. An additional category should be added in Part 1, Section 5, subsection 4 to read: ‘(k) third sector organisations contributing to health and wellbeing’.

Engagement between the Joint Improvement Team and shadow partnerships, facilitated through the Bill’s Advisory Group, has established that a significant number of partnerships intend to include children’s and criminal justice services, or at least some aspects of each, within their integrated arrangements\textsuperscript{7}. There is, however, little emphasis placed on these elements in either the Bill or the Policy memorandum. Clarification is required on how these elements will connect with the community planning partnership process.

The ALLIANCE is concerned integration could lead to an increased complexity in complaints handling arrangements, however, the Bill makes no reference to the complaints process. Integrated partnerships should be required to align their complaints processes to allow for a single point of initial contact.

The Bill does not specify the grounds on which Scottish Ministers would not approve an integration plan. Plans should only be approved if developed with the involvement of the third sector and people who use support and services. There may be some scope in adopting a similar Quality Assurance procedure to the Single Outcome Agreements (SOAs) as set out in a joint letter to community planning partners from COSLA and the Scottish Government\textsuperscript{8}. This approach to quality assurance allows for feedback and constructive challenge to help a CPP develop, improve and agree an SOA.

In the light of the Scottish Government’s review of Continuing Health Care, the ALLIANCE also believes that the Health and Sport Committee should consider the implications of charging for services and the wider relevance this has in the context of integration. Whilst NHS Continuing

\textsuperscript{6} NHS Scotland, A Route Map to the 2020 Vision for Health and Social Care, 2013  
\textsuperscript{7} “Four partnerships are definitely intending to include, at least some aspects of, children’s services and a further six are still actively considering their inclusion… Four partnerships intend to include criminal justice in their integrated arrangements…”  
\textsuperscript{8} SOA Assurance Process – General Letter to CE’s, http://tinyurl.com/l6mlksq
Health Care affects relatively small numbers of people with very complex care needs, it appears that – over time – many families may have been charged for care that ought to have been provided free by the NHS. The ALLIANCE would echo concerns raised by Parkinson’s UK that people with progressive neurological conditions like 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.

The ALLIANCE also echoes the concerns of the independent living movement that a health/medical model may be allowed to dominate where the NHS becomes responsible for social care, potentially undermining the moves towards personalisation and self-directed support. Northern Ireland is often cited as an example where this fear has been realised.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

As the national third sector intermediary for a range of health and social care organisations with over 300 members including large, national support providers as well as small, local volunteer-led groups, the ALLIANCE believes that, integration should have the effect of improving engagement between third sector organisations and statutory bodies.

The Policy Memorandum (Page 2, Para 7) describes two disconnects within the health service, between primary and secondary care, and between health and social care. The ALLIANCE would argue, however, that the crucial disconnect within this agenda is between statutory and non-statutory support and services. This must be addressed and recognised if the needs of Scotland’s population are to be met effectively. There is a substantial risk that without such recognition the integration agenda becomes centred on trying to improve partnership working between health boards and local authorities, rather than being about truly integrated health and social care.

What effect do you anticipate integration plans will have on outcomes for those receiving services?

Integrated health and social care has the potential of promoting good health and facilitating independent living for people who use support and services. Integration plans have the potential to significantly improve outcomes for people if this is used as an opportunity to help drive the transformational change advocated by the Christie Commission, but there are big risks that threaten to undermine the difference it will make e.g. focus on structures, an exercise only involving the statutory partners, a health model dominating, people not being involved effectively as partners.

Health and Social Care Alliance Scotland
2 August 2013
About the ALLIANCE

The ALLIANCE’s vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

The ALLIANCE has three core aims; we seek to:

- Ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.
- Support transformational change, towards approaches that work with individual and community assets, helping people to stay well, supporting human rights, self management, co-production and independent living.
- Champion and support the third sector as a vital strategic and delivery partner and foster better cross-sector understanding and partnership.
Scottish Borders Partnership

Scottish Borders Council and NHS Borders welcome the opportunity to comment on the Public bodies (Joint Working) (Scotland) Bill.

- The partnership fully supports the integration of Health & Social Care and we agree that this should form a cornerstone of the public service reform agenda and we welcome the linkages being made to community planning.

- The focus on the importance of delivering positive outcomes for people using services is supported along with the principles of outcome-based service planning.

- Areas of the Bill are covered in detail (e.g., the process for completion of the integration plan) and may be seen to be overly prescriptive when considered in conjunction with the principles of localised planning.

- The partnership supports the move towards whole-system commissioning: one key area for debate is clarity around acute services and it is hoped this will be clarified in the regulations and guidance that is due to be issued.

Specific Questions:

1. **Do you agree with the general principles the Bill and its provisions?**

   The partnership supports the principle of improving outcomes based on individual needs, and of locality planning focusing on engaging with the community and local professionals.

   We note a general theme around the potential conflict between central accountability and local democratic control.

2. **To what extent do you believe the approach being proposed in the Bill will achieve its stated policy objectives?**

   Overall we believe the approach being proposed will achieve its stated policy objective, particularly in relation to the following:

   We support the broader focus on health improvement and public health in the Bill and the recognition of working with housing as being important.

   The focus on outcomes for recipients is welcome and the need to make best use of resources is an important principle for both the Council and for NHS Borders in terms of best value.

   The requirement to consult with users is welcome but detail of what level or type of consultation or the definition of users is limited.
We note the emphasis on investing in Strategic Commissioning and Voluntary Sector capacity and skills.

3. **Strengths of the Bill**

There are many strengths identified in the Bill. As a partnership we very much support the focus on outcomes and the approach to strategic planning and focus on locality planning. There is a strong commitment to consultation with local communities and professionals which is fully endorsed.

The ability to legally delegate functions from the Council to the NHS and from the NHS to the Council will provide greater flexibility to work together and thereby improve outcomes. However we will be keen to comment on the detail of this when published in the regulations.

The Bill allows the development of potential opportunities for shared services linked to NSS. The extension of the CNORIS supports integrated working.

4. **Please provide details of any areas in which you feel the Bill’s provisions could be strengthened**?

It is recognised that much of the detail is to be left to guidance / regulations and the detail of this will be important so it is difficult to comment on all issues. This includes the make up of the Integration Board, however a number of issues have been highlighted which could strengthen or clarify the Bill.

Chief Officer responsibilities – these are laid out in the Bill and it proposes that the responsibilities subject to the agreement of the Scottish Ministers but it needs to be recognised that local flexibility will be required to reflect local circumstances.

It would be useful to have further clarity on the services within the acute sector that should be included in the partnership.

The powers offered in the Bill to ministers are wide ranging and may be seen to cut across the principles of local democratic control in particular the power to intervene and determine functions that could be delegated into the partnership. The wording of the Bill will need to ensure it does not conflict with relevant local government legislation.

The title of the Bill does not reflect the main content relating to integration albeit Part 2 does cover other functions.

We note the requirement for separate individual locality plans that reflect the needs of local communities. However these will need to be set within a clear strategic context to ensure there is a degree of consistency and a strategic approach across localities.
It would be helpful if the section regarding consultations was more robust with more clarity to include linkages to community planning partnership organisations and community councils as key stakeholders.

5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

Integration plans will provide transparency about the expectations of the partnership. By working together we would expect a reduction in duplication and closer joint working.

A clear single assessment process – will be of benefit for staff and recipients of service.

Clarity around joint accountability and governance will assist partnerships to move forward in an, open transparent culture.

6. What effect do you anticipate integration plans will have on outcomes for those receiving services?

Joint integration plans which have clear agreed joint outcomes for those receiving services and their carers will ensure that all organisations are working together to this end. The arrangements should provide greater ease for people to access services and avoid potential duplication. Performance management which focuses on qualitative feedback from those receiving services as well as effective joint performance data will enable the partnership to take effective robust remedial action should improvements require to be made.

Scottish Borders Partnership
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill
Royal College of Nursing Scotland

Key points

1. The RCN supports the general principle of a Bill intended to improve provision of swift, seamless access to safe, quality care.

2. However, for the Public Bodies (Joint Working) (Scotland) Bill to meet its aims as set out in the policy memorandum, the RCN believes a key amendment is required to embed the quality and safety of care clearly in the core principles of both planning and delivering integrated services. In the wake of the Francis Report, the Scottish Government and Parliament now have the opportunity to take a clear lead in embedding a legacy of effective, safe, dignified care in the heart of this legislative reform.

3. The current absence of this key principle has resulted in the assurance of quality and safety being excluded from core planning, governance and reporting functions on the face of the Bill. The RCN believes this is a serious omission.

4. We had expected to see the co-production of future care services written more clearly into the Bill. We anticipated minimum requirements to involve and engage named professionals, staff representatives, non-statutory partners, patients/service users and carers in primary legislation, with additional flexibility available through regulation. However, this is not reflected in the published Bill.

5. We would note a general concern that, throughout, 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.

6. We welcome this Bill opening the door to a wider range of ages and services than were proposed in the original consultation. However, we question whether frontline staff will be well supported to integrate services across families and communities when two different planning processes are proposed in this Bill and in the Children and Young People (Scotland) Bill.

The RCN represents around 400,000 nurses, nursing students and health care assistants across the UK, as both a professional body and trade union. Over 39,000 of these members are in Scotland. We are delighted to have the opportunity to provide written evidence on the Public Bodies (Joint Working) (Scotland) Bill. The RCN is a member of the Scottish Government’s Bill Advisory Group, as well as a number of key working groups, and we continue to use these fora to raise issues and constructive solutions to this agenda. We do not underestimate the scale of reform focused through this Bill.

As noted above, the RCN supports the general principle of legislation intended to improve provision of swift, seamless access to safe, quality care. With this in mind, we have focused our short initial response to this complex legislation on two of the committee’s areas of interest:
• To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
• Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.

Assurance of safe and high-quality integrated care
The RCN has been clear in its support for integrating care where, within a clear shared vision, processes are designed to promote respectful relationships; local plans are designed in partnership to improve outcomes; the quality and safety of integrated care is secured; and national bodies set coherent foundations for reform¹. The Public Bodies (Joint Working) (Scotland) Bill is now our chance to get the core legislative framework right for a wide-scale programme of health and care reform.

Clearly, the public should expect to be able navigate care services seamlessly when they need them. No-one should have to face the stress, frustration and poor, inefficient care that can arise from fragmented service design between, and within, agencies. The RCN agrees that reforms to our health and care sector must address these issues. However, ensuring that an individual’s journey through services is smooth should be only part of our aspiration for the future of care.

When anyone is in need of formal care they, and their family and friends, should also be assured that they are easily accessing high quality services offering safe and appropriate care, delivered by people with the right expertise, with compassion, dignity and genuine involvement. The more our population changes, particularly with more people ageing with multiple needs and complex clinical conditions, the more important it is that we focus on both parts of the equation: swift, seamless access on the one hand; safe, quality care on the other.

The Scottish Government opens the Bill’s policy memorandum by reflecting this balance:

*The policy ambition for integrating health and social care services is to improve the quality and consistency of services for patients, carers, services users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to delivery services that meet the increasing number of people with longer term and often complex needs, many of whom are older.*

Nevertheless the RCN is concerned that, despite this welcomed emphasis in the accompanying narrative, the actual Bill itself is focused too heavily towards resolving difficulties in delivering seamless care, and too lightly towards ensuring robust assurances of care quality and safety in this new landscape. Primary legislation should set the core foundations of reform,

¹ See: The RCN in Scotland: Principles for Delivering the Integration of Care at [www.rcn.org.uk/scotlandintegration](http://www.rcn.org.uk/scotlandintegration)
which secondary legislation, guidance and practice can build upon. **However, quality in care services is not included in the key principles of integration in the published Bill.**

The RCN believes that this omission may well set the Bill, and future integrated partnerships, off on the wrong track. The Bill provides us all with the opportunity to ensure that we focus firmly on improving services and dealing coherently with the instances of poor care that have hit the headlines repeatedly in recent times. In the wake of the Francis Report, the Scottish Government and Parliament now have the opportunity to take a clear lead in embedding a legacy of effective, safe, dignified care in the heart of this legislative reform.

Including a commitment to service quality and safety within the core principles of integrated service planning and delivery would, for example:

- Ensure that the primary policy intention and aspirations of the Scottish Government and - if the Bill is passed – the Scottish Parliament, are totally clear to the public, service users, carers, staff and to the partnerships responsible for planning, delivering and overseeing services. 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.
- Provide an essential benchmark to ensure that governance structures and decision-making processes established through the Bill focus as much on the robust assurance of safe, high quality care as they do, for example, on strong financial management.
- Support those with responsibility for the governance of service planning and delivery – which we understand is likely to be local councillors and non-executive NHS board directors in the ‘body corporate’ model, for example – with clear authority to take expert advice on issues of care quality and safety. This will help them to make difficult decisions with regard to service provision or plans where quality and safety cannot be robustly assured - even when those decisions may be unpopular.
- Emphasise the importance of establishing clear lines of professional accountability to support frontline practitioners to speak up when concerns arise, giving them confidence that the delivery of safe, high quality services has been prioritised by those in power, locally and nationally.
- Provide a safeguard for the third and independent sectors - given the likelihood of increased procurement of services from these sectors - by supporting non-statutory agencies to negotiate terms which contract care on quality and not just on price. Quality care should be guaranteed to the public, whoever is commissioned to deliver it.

We acknowledge that the draft integrated health and wellbeing outcomes, which will be set through secondary legislation, do include an outcome around
safety. However, these outcomes have rightly been designed to be flexible and easily amended as integration matures. Quality should be a constant at the heart of care and on the face of the Bill.

We also note that the draft outcomes were developed with partners before the integration principles were set out in the published Bill. This has led to some inconsistency. Whilst the safety outcome is not mirrored in a core principle of quality, the draft outcome on effective resource use, for example, is reflected in a “best use” principle. Now that the Government has taken the welcome step to set core principles for integration in the draft Bill, it may be necessary to undertake a wider review of the relationship between these and the improvement outcomes.

For the Bill to meet its aims as set out in the policy memorandum, the RCN believes an amendment should be tabled at Stage 2 to embed quality of care as a core principle of both planning and delivering integrated services. There is legislative precedent for this in Scotland. For example, the general principles at section 59 of the Regulation of Care (Scotland) Act 2001 include the “safety and welfare” of persons using services being “protected and enhanced”.

In light of such an amendment being agreed, we believe that other additions to the primary legislation may be necessary for quality assurance to be a core function of the planning, decision-making, commissioning and reporting undertaken by future partnerships. The RCN is currently discussing how this could be framed within primary legislation with partners and we would be happy to share our early thinking in this area with members of the Health and Sport Committee.

The co-production of plans and services

The RCN supports the Scottish Government’s commitment to ensuring that care services are co-produced in genuine partnership between service users, carers and staff, bringing together the assets of both traditional services and the wider community to improve wellbeing.

Locality planning has been explained to us as one of the key ways for staff and the public to get involved in setting the agenda of local integration. We accept that the finer details of locality planning will be contained in secondary legislation and guidance, but far too little is set out in the primary legislation for such a central facet of the actual delivery of integrated care. Detail is limited to: a) the establishment of localities and their delivery arrangements in the preparation of strategic plans (section 23); and b) a high-threshold consultation and involvement trigger for changes which “might significantly affect the provision in a locality…”(section 32). We are also concerned that the minimum membership of those to be involved in locality processes is also not set out in primary legislation. Furthermore, we would expect local people and professionals to be engaged fully and proactively in the development and delivery of the strategic plan and any amendments to that plan. We note that section 5(4) does set precedent for including reference to key groups on the
face of the Bill and we are unclear why this is not replicated throughout where advice, consultation and involvement is required by integration authorities.

We had anticipated that the Bill would set out far more clearly how locality planning will dovetail with the development of the all-important strategic commissioning process for the entire integration authority. It is essential that there is a clear line of sight in service planning decisions, and the assurance of those decisions, from the very frontline to the governance bodies within an integration authority area. We believe amendments could usefully be brought forward at stage 2 to address these issues.

Within the NHS, the right of staff to be involved in key decision-making is long-established in both statute and clear guidance to NHS boards. This was recently evaluated as “the most ambitious and important contemporary innovation in British public sector industrial relations”\(^2\). Scotland has much to be proud of in its approach to partnership working between employers, employees and the Scottish Government in the health service. However, this is not clearly reflected in the legislation at this time. Indeed, section 11 of the Bill risks undermining current arrangements by permitting Integration Joint Boards to employ staff directly, through future secondary legislation, on varying terms and conditions. This addition was a surprise to the RCN, despite our membership of key groups involved in developing the Bill and our membership of the Scottish Partnership Forum. There is a far greater, open discussion required to understand the consequences of this section on the sustainability and the principles of the NHS in Scotland.

The risks of fragmented planning across families and communities

Quite rightly, we all expect frontline practitioners to ensure that those using public services experience seamless, quality care and support - whatever their age, wherever they live and however complex their needs. We should, therefore, expect that the laws and systems staff must work within to plan and deliver those services are joined-up too. Anything else sets up nurses, social workers, doctors and care staff to fail the people they serve.

Audit Scotland recently noted the “clutter” of partnership arrangements in Scotland\(^3\). With this in mind, the RCN continues to question why two Bills going through Parliament at the same time set out two parallel, but different, systems of planning services for adults and children who live in the same families and communities. We ask the Convenors of all the Parliamentary Committees considering the Children and Young People and the Public Bodies (Joint Working) Bills to consider together whether Scotland will indeed be best served by separate legislation on the planning of joint services.

Royal College of Nursing Scotland
2 August 2013


The stated policy objective of the Bill is:

“to improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.”

Introduction

The Scottish Association of Social Work represents social workers, many offering frontline services throughout Scotland for people adjusting to change in their lives that not only impact on themselves individually but on their families, friends and communities. We have to assess and meet the need, we have to assess and help manage risk and we have to do this in the context of often competing human rights. We work in both rural and urban communities, local government, private and voluntary sector services. We are often are the gateway to local government and third sector services. SASW members are daily involved in the direct decision making process with people about concerns about their well-being and finding solutions. Assessing such situations is a highly complex task and. Critical to the work is the trust that can be established between all parties to ensure positive outcomes.

Do you agree with the general principles of the Bill and its provisions?

SASW fully supports any reform that will help people find a simple path through the complexity of health and social care services. Our members have three overall concerns about this particular proposed legislation.

Structural change rarely produces the anticipated improvement that policy makers and managers seek. It is often expensive and reduces morale at the front line. One of the observations from the Changing Lives Review (2006) was that community capacity building is essential to meet the needs of our communities. The Christie Report stated that need to empower front line staff. These are cultural changes rather than structural and are more likely to achieve the desired outcome of better access to appropriate services that meet people’s needs. Both these recommendations speak to the importance of locally developed and locally based services that meet the needs of our diverse communities. We suggest that resourcing and supporting that cultural change would be as important as legislative change in achieving the objectives.

SASW has already, in giving evidence to the Committee about the Social Care Self Directed Support (Scotland) Act 2013, stated that there is a potential contradiction in direction of these two pieces of legislation in defining
who is in the driving seat to identifying how needs may best be met. The mechanisms of moving budgets from acute health services into supporting complex chronic health and social care will be key to achieving the objectives of this legislation. SASW members are very clear that the people who are experts in what is happening to them are the people who use services, the rest of us are there to help them find resolution to some complex issues. We also believe that people should have choice about what works for them and that any change in the systems must enhance people’s control over their own lives.

The third concern is in ensuring that there are no unintentional consequences on other services, particularly in social work services. We have already seen carefully worked out regulation that provided checks and balances in the jigsaw of mental health legislation to people’s rights when their liberty is at stake amended through statutory instrument to accommodate the changes needed in Highland Council when they moved staff between health and the council. This expediency is in contrast to the developments since 1968 in building up one of the most sophisticated social work services in the world that take account of meeting complex needs and ensuring rights.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The difficulty in answering this question is that the detail of implementation will address whether the stated policy objectives will be achieved and this is not in the primary legislation. Specifically we are concerned about how decision making will take place at the point where health and social work services meet in terms of the allocation of resources and how priorities will be set. How will these affect the decisions people who use services will want to make in terms of self-directed support? How will their opportunities be protected?

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

In answering the previous question about the allocation of resources and the setting of priorities lies the answer to this question. If there can be changes in the long established practice of investing in acute health services and diverting monies into complex chronic health and social care services then there could be a key strength in this bill.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

One of the key issues for social workers is continuous support for professional practice. The Practice Governance Framework developed after the Changing Lives Review that covers the role of the Chief Social Work Officer and the role of the social worker in carrying out their statutory responsibilities is the structure in which we carry out daily recommendations and decision making that often affect such human rights as people’s right to be at liberty in the community and where they live. In this legislation it is critical that this
framework is respected and that practitioners continue to operate within this framework to ensure that those making these decisions do so with the appropriate level of support and responsibility. There are concerns that in new line management hierarchies professional supervision and consultation could be diluted or ignored and that this would not provide the necessary checks and balances in complex decisions making that could affect people with whom we are working.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

A major issue is establishing a cultural and practical change in the use of A&E services as we approach the weekend. This comes in part from people not seeking help until a crisis has arisen, ‘I didn’t want to bother anyone’. In part it comes from a lack of focus in identifying issues much earlier in the process and working in more proactive, preventative practices. This needs public education about how we can make our own plans earlier in our lives by making appropriate changes in our homes and talking with our family and friends about our plans for how we would want to live as we get older. It will also challenge traditional 9-5 working practices for some public services and these will need to be addressed with the workforce. However caring can be challenging, for example as a relative or person being looked after progresses through stages of dementia, so work life balance has to be respected. This should lead to important investment in services like respite care.

For the practising social worker the important factors will be that they can continue to listen to how people want to make the changes that they are faced with in their lives and then to work with them to find out how best to achieve that change. Sometimes these changes may be relatively small but sometimes they mean major change like where and with whom they live. People need time to make and adjust to major life change. Whilst one driver may be to free up a hospital bed people need to be treated with respect with dignity and respect in making adjustments in their lives. The structure needs to support them in this process.

What effect do you anticipate integration plans will have on outcomes for those receiving services?

The delivery of integrated services lies in good practice at local level. It can be achieved in the current structures when people understand the skills, knowledge and expertise of the people coming together to find solutions to complex issues, including the person and their family and community, then turn them into a workable plan of action. This needs good coordination, often a role taken by the social worker. The issue for the legislation is making sure that resources are available in the right places to enable creative solutions to improving quality of life.

There are many challenges in this proposed legislation, there needs to be care in making sure there are no unintended adverse consequences, there
are opportunities to address how public monies are spent but the outcomes will mainly be achieved through cultural change in working practices. Any changes made in this legislation must strengthen the concepts and practices of Self Directed Support so that the people in the driving seat are the people using the various health and social work services that this bill seeks to improve.

British Association of Social Workers
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill
NHS Ayrshire and Arran

Do you agree with the general principles of the Bill and its provision?

Yes. The general principles and provision are welcomed and follow on from the previous consultation on the Scottish Government’s proposals, responses made, and the Scottish Government’s subsequent response to these.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The Bill sets out a coherent framework within which integration can be progressed but leaves room for local partnerships to develop “best fit” solutions within statutory boundaries. It is felt that this strikes a good balance and it is believed will help to achieve the stated policy objectives.

The extent to which the stated policy objectives will be achieved will be largely determined by two factors: (1) moving from a focus on outcomes at a high strategic level to personal outcomes for individuals to ensure seamlessness at point of service delivery (2) effective locality plans which link to, and heavily influence the Integration Authority strategic plans.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths.

The coherence of the policy objectives is a key strength. They will have to be followed through at a personal and locality level supported by an approach which values enablement and coproduction.

Aspects of the policy memorandum are welcome reminders:

- “Integration is not an end in itself – it will only improve the experience of people using services when partner organisations work together to ensure that services are being integrated as an effective means for achieving better outcomes”;
- “legislation alone will not achieve the scale or improvement that is required . . . Leadership is key, locally and nationally . . .”

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.

It may be that the following will be picked up in regulations etc but as it stands, the Bill could be strengthened in the following areas:

a) public accountability arrangements – section 33 mentions a performance report. It may be helpful to link this to a focus on outcomes for avoidance of doubt;
b) statutory public engagement responsibilities – for instance it would be helpful to clarify the position of Public Partnership Forums (PPFs). In Ayrshire, the PPFs have proven to be very effective support to public engagement arrangements across the totality of health provision;

c) consultation arrangements – various references are made to issues such as the preparation of the integration plan but there is a substantive issue to be addressed concerning any implications for consultation arrangements in relation to proposals for service change made by the Integration Authority;

d) following on from this, it may be helpful to clarify approval processes in instances where a strategic plan proposes major service change. In particular whether the Cabinet Secretary will continue to hold what would effectively be veto powers over the Integration Authority’s plans;

e) whilst it is helpful that the Bill makes consistent reference to integration planning principles these are silent on the need to ensure effective clinical / care governance;

f) staff governance is a statutory requirement of NHS Boards and the Bill is fairly silent on what arrangements (if any) Integration Authorities will be required to put in place.

g) there is a need to be more explicit about how the Integration Authority will be scrutinised jointly, by external scrutiny agencies;

h) in terms of analytical review of the Bill as a whole, there may be a case for considering whether the balance between what is on the face of the Bill and what will be in regulations could be improved. For instance while regulations will define the scope of integration, it is on the face of the Bill that the responsibilities of a Chief Officer are subject to the agreement of Scottish Ministers.

What are the efficiencies and benefits that you anticipate will arise from your organisation from the delivery of integration plans?

Efficiencies and benefits are anticipated to arise as follows:

a) the focus on outcomes (providing this is reflected in performance regimes);

b) the introduction of locality planning – this should streamline community engagement across the four sectors and maximise the opportunities for an assets based approach while engaging local users, carers and professionals in an agenda which is real for them. It should also bring a sharper focus on tackling health inequalities;

c) the principle of joint and equal responsibility – this should help reduce “hand offs” between the statutory agencies;
d) the engagement of the third and independent sectors as strategic partners – this is already helping to shape effective plans in services for older people;

e) a logical framework reflected in the flow of the Bill from the model of integration to the integration plan to the strategic plan with consistent integration planning principles throughout – this will bring a much higher level of consistency and focus to joint endeavours;

f) an improved approach to making investment and disinvestment decisions based on a clear process and evidence base and best use of integrated resources;

g) greater potential for a joint strategic commissioning process which is based on improving outcomes at both a strategic and individual level, supports effective service change and views issues from a user’s perspective.

What effect do you anticipate integration plans will have on outcomes for those receiving services?

Integration plans will bring a rigour to setting out what the Partnership is responsible for and how it will be funded. Coupled with the strategic plan setting out how the Partnership will deliver its responsibilities it will give greater transparency to how all of this directly relates to improving outcomes. Crucially, however, it must also link to effective locality plans which should capture how refreshed relationships between the statutory, third and independent sectors and local communities can also improve outcomes.

Other Comments
There will be a need to ensure that there is sufficient Non-Executive Director capacity within NHS Boards to support the effective running of the Integration Authorities. This may be a particular challenge for NHS Boards with several Local Authorities within their Board area.

NHS Ayrshire and Arran
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

UNISON Scotland

Introduction
UNISON Scotland welcomes the opportunity to respond to the call for evidence from the Health & Sport Committee regarding the Public Bodies (Joint Working) (Scotland) Bill. UNISON Scotland has almost 160,000 members, over 90,000 of whom work in local government and 50,000 in the health service. We represent community health staff as well as social workers and social care staff who are all part of the adult health and social care workforce, most of whom will be affected by this Bill.

General Comments
UNISON members in Scotland have been involved in various proposals to improve joint working between health and social care workers over many years and we accept that joint working has not worked well in all parts of the country. This is despite improvements that have been achieved during this time with reductions in the number of elderly people kept in hospital due to lack of care plans which would allow them to return home. We also accept the current emphasis on the potential increase in the number of elderly people which will drive up demand for care services in the future. We are aware of the excellent initiatives that have arisen from the Change Fund programme which have introduced preventative and personalised services in community settings, rather than in acute hospitals and we supported its inclusion of housing and leisure services.

When we responded to the consultation on Health & Social Care Integration in September 2012 we expressed several concerns about the Scottish Government’s proposals and we are pleased that some of our concerns have been addressed in the Bill. In particular we welcome the intention to focus on local implementation of joint outcomes for care integration, rather than top down structural reorganisation, which studies have shown, does not achieve the required aims of service improvement.

For these reasons we were quite clear that we did not favour models that involved the wholesale transfer of staff across councils and health boards, as in the Highland Model. Our members in Highland have experienced many difficulties with terms and conditions of staff, pension arrangements, etc., and we believe that major issues, such as the status and situation of Mental Health Officers, still remain to be resolved.


We remain concerned at the transfer of local authority democratically controlled services to the NHS as well as at the potential for privatisation of health service functions as outlined in Part 3 of the Bill. This will allow health boards to form companies and to act on behalf of other health boards to allow, for example the management and disposal of property and assets and
to form other “corporate structures” under the Joint Ventures initiatives, led by the Scottish Futures Trust.

Questions:
UNISON does support several of the general principles of the Bill as it is set out so far. However, we believe there is still more detail needed on the nationally agreed outcomes which will be set out by the Scottish Government and the scope and arrangements for local implementation of the outcomes. However, the Bill will only achieve its desired objectives if it allows genuine involvement of all parties, including staff and service users in locality planning and implementation of the strategic plans.

The Bill is being introduced at a time of reduced resources being allocated to local authorities in particular, leading to reduced staffing levels, which is affecting social care services. In addition, the Self Directed Support (Scotland) Act recently passed in the Scottish Parliament will be coming on-stream at the same time as it is proposed to implement this Bill, both of which could have an adverse effect on how well integration can be progressed. Joint budgets will need to be sufficient to deliver the services that are needed, despite these restrictions.

Lack of resources is currently causing fragmentation of care, where many care staff are being employed on zero hours contracts. This causes problems for the care worker, who does not know from one week to the next whether or where they will be working. However, it also makes it more difficult for the service user to receive a continuous service they can rely on with the same carer that they get to know. It can be confusing for many to have different staff arriving to care for them at different times. We also believe that the 15 minute visit appears to be becoming the norm which is a totally insufficient amount of time for a carer to perform the tasks that are needed for vulnerable people, often with complex needs, before they rush off to their next client, often not being paid for the travelling time between visits. This practice does not deliver a proper service to people who need to be cared for at home and should be addressed further in the Bill’s progress through Parliament.

Staffing Issues
In our response to the September 2012 consultation, we expressed our disappointment that workplace issues had been given scant consideration in the proposals. 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.

Some of the following issues were highlighted in our response to the initial consultation and still need to be addressed:
Staff transfer: There is an urgent need for a legislative framework for staff transfer. Statutory reorganisations are not treated in a consistent manner in legislation. Local reorganisations operate without consistent guidance leaving management and unions to reinvent best practice in a complex legal context. A legislative framework should include a standard staff transfer order that covers the essential TUPE+ issues. In the model proposed for Health and Social Care Partnerships the employment relationships are unclear and this could lead to complex legal issues including defining the employer.

Pensions: While the public sector transfer club operates for individuals, large scale staff transfer requires regulations for block transfers. The NHS and LGPS pension schemes in Scotland have many different elements and while service is protected on a year for year basis other factors may be important to individual staff. Again a consistent approach is required.

Secondment: Not all options in the Bill require the permanent transfer of staff. A short term transfer may be a more flexible option. This approach has also been used in circumstances involving a non public sector provider. A secondment framework for temporary or short term transfers would again ensure some consistency and guidance.

Staff employed by different employers: The Joint Future initiative introduced working arrangements where staff from different employers work together. In addition a worker can be managed by someone from a separate employer on different terms and conditions and with different professional codes of conduct. For example, a nurse being line-managed by a social worker, or vice versa, where the person from the other discipline may not understand the other's professional codes can cause misunderstandings and friction. There have been problems with different procedures such as discipline, grievance, training and development review. Professional boundaries, ethics and codes of conduct can also be an issue. Recent legal decisions (Weeks) have highlighted employer responsibilities in these circumstances. Some agreed national protocols to cover these issues would be helpful.

Procurement: There is little consistency in approaches to public service reform that involve procurement. The Two-Tier workforce provisions including the PPP Protocol and s52 have been under review for years with no real progress. Existing provisions are not well understood and certainly not consistently applied. A common procurement framework agreement would assist everyone involved in organisational change.

Equality duties: Organisational change almost always requires an equality impact assessment. Our experience is that this process is often not understood and inadequately implemented.

Governance: Different governance arrangements can be complex and confusing. This also applies to the governance of workforce issues. Christie therefore recommended the development of "an appropriate set of common powers and duties". We believe there should be a single statutory staff
governance framework. There are also different approaches to, for example, health and safety, asset management between health and local authorities, and we believe a staff governance framework that offers a system of industrial democracy ensuring the opportunity for staff and their trade unions to be fully involved, from an early stage, will assist with the formulation and implementation of change between the different groups of staff. The perceived problems of the different systems of industrial relations currently in place cannot be over-emphasised.

Statutory Roles: We are pleased that the Bill confirms that the status of statutory roles, such as the Chief Social Work Officer, Chief Financial Officer, Chief Public Health Officer, etc. will remain but their position alongside that of the new Board Chief Officers needs to be clarified. In addition, the status of Mental Health Officers needs to be recognised, as the need for impartiality is of paramount importance.

Conclusion
UNISON accepts that care services face major challenges and we believe strongly that service users must be able to easily access services which will enhance their lives and enable them to live safely in their own homes and we believe the some of the principles of this Bill will assist this aim.

Our members have participated in many instances of organisational change over the years and many may be sceptical about the merits of any further major structural change. The body corporate model may lessen some of the difficulties experienced through structural reorganisations; nevertheless, significant questions still remain over how this will operate in practice.

The 15 minute visit by home carers and the practice of zero hour contracts for low paid staff must be addressed to ensure that high quality care is available to vulnerable people who rely on these services.

We have emphasised our concerns at the questions that also remain over the workforce issues outlined above which we believe are crucial to ensuring that the aims of the Bill are able to be implemented satisfactorily to the benefit of both service users and the staff involved.

UNISON Scotland
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill: Stage 1

09:49

The Convener: Agenda item 2 is continuation of our evidence taking for stage 1 of the Public Bodies (Joint Working) (Scotland) Bill. I warmly welcome our first panel: Claire Cairns, network co-ordinator, the Coalition of Carers in Scotland; Pam Duncan, policy officer, Independent Living in Scotland; Ian Welsh, chief executive of the Health and Social Care Alliance Scotland; and Karen Hamilton from the Borders public partnership forum.

In the interests of time, we will go directly to Rhoda Grant for the first question.

Rhoda Grant (Highlands and Islands) (Lab): One of the criticisms of the bill is that it concentrates on bureaucracy instead of principles and outcomes. Is the bill sufficiently well drafted to allow the meaningful involvement of carers and service users and, if not, what could be added to make that happen?

Pam Duncan (Independent Living in Scotland): First of all, thank you for the invitation to give evidence—we very much appreciate it. I also want to say at the top of this evidence session that disabled people welcome the integration of social care and health services, in the hope that it will result in seamless service provision.

The bill’s principles are good but could be strengthened to make a clear statement that integration is about the delivery of services for people and those people’s experiences. As a result, we suggest the inclusion of something akin to the independent living principles that were added earlier this year to the Social Care (Self-directed Support) (Scotland) Act 2013. Health and social care are absolutely essential material supports for disabled people to participate in society and lead an ordinary life, as without them many disabled people simply cannot participate in society. I could not have got out of bed this morning, never mind come here to give evidence, without good social care that is accessible and which I can control. Equally, the health services that I access as a disabled person are essential for me to live and cope with my condition.

In short, given that these matters need to be considered in the context of equality and human rights, and given our fundamental belief that health and social care infrastructure is essential to the delivery of equality and human rights for disabled people, we think that the Scottish Government could really put its head above the parapet and lead the way in Europe by including in the bill a provision that specifically related health and social care to disabled people’s right to participate in society and lead an ordinary life.

Ian Welsh (Health and Social Care Alliance Scotland): As the committee knows, the bill will be a piece of enabling legislation, which means that there is much that is not in it. One thing that ought to be in it, however, is the determination to apply human rights principles, and we and our partners will certainly bring forward an amendment to that effect. The legislation setting up the Scottish Parliament enshrines human rights legislation, but we believe that our proposal will embed that even more in the Scottish context.

The commitment to health and social care integration as described in the bill is absolutely the right thing, and the Cabinet Secretary for Health and Wellbeing has shown exemplary commitment to it. In saying that, I should add that we are not members of the same party. However, to come back to Rhoda Grant’s question, I think that the challenge will emerge back in the places where action is going to take place—in other words, the health boards and the nascent health and social care partnerships.

There will be a default position in which structures and budgets take prominence, but the jury is out on whether the new health and social care partnerships will get to the point of putting in place the vast array of supporting guidelines that pay significant attention to the rights of carers, disabled people, people with long-term conditions and the principles of co-production, putting people at the centre of services and indeed fundamentally redesigning services in the context of public service reform. The bill’s strength is that it offers the local partnerships the flexibility to get on with integration but, in my view, its weakness is that the health and social care partnerships might simply default to a bureaucratic transition.

Pam Duncan talked about seamless transition. When I was in local government, we always used to talk about seamless transitions. The danger is that we get a seamless transition and do not get a fully thought-out approach to the philosophy of delivering services locally in a new way—not just a cheaper way, but a much more inclusive way. In my view, that opportunity will be lost if the new health and social care partnerships do not go beyond the words in the bill and are not encouraged by the supporting guidelines to make the third sector, in particular, and the individual full partners in the process.

Does that help to answer your question?

Rhoda Grant: We will have to amend the bill to make it work properly. You say that the guidelines and, I suppose, the sentiment behind the bill are
moving in the right direction. How can we amend the bill to make it focus on the things that you say are important? That is the challenge for us.

**The Convener:** It would be helpful if witnesses could go through the chair, because Claire Cairns and Karen Hamilton may wish to respond to the first question. I do not know whether you do—do not feel any pressure to do so if that is not the case—but it would be helpful for the committee if you could respond to Rhoda Grant's first question.

**Claire Cairns (Coalition of Carers in Scotland):** That is great—thanks.

We, too, welcome the bill’s focus on outcomes and the principle of strengthening the involvement of carers, but we think that it could be strengthened in various ways. When the first proposals on integration came out, we held quite a lot of consultation with carers. They felt that, for integration to be successful, it was absolutely essential to have not just carer engagement but meaningful carer engagement, and a move beyond involvement towards co-production. There are several ways in which that could be strengthened, perhaps not through changes to the bill but in the development of the guidance and regulations.

One suggestion that carers made was that carers should be recognised as equal partners. They are recognised as equal partners in the carers strategy and as partners in care in the Community Care and Health (Scotland) Act 2002. It is important that reference is made to that in legislation, or certainly in guidance and regulations. It is important to realise that carers are recognised as equal partners.

One comment that was made in our consultation was:

“If integration embraces carers it should get better but it won’t if it is an afterthought.”

It is all about ensuring that carers are involved in all the structures from the top down. At the moment, there is a question mark over whether carers will be represented on partnership boards and whether they will have voting rights. I know that that has been discussed. Carers overwhelmingly want that, but it requires to be resourced. There is a lot of talk about resourcing the third sector to get involved, but there is little mention of resourcing the involvement of carers and service users, which is essential if engagement is to be meaningful, as carers keep saying that it needs to be.

When we talk about carers, we are talking about a wide community of people. A carer could be a young person or an older person who is looking after a partner, and they could be dealing with a range of illnesses, disabilities or other conditions. It is quite difficult to capture their views and to feed that information into the process, and that needs to be resourced. We have put together best practice engagement standards. Our way forward would be to use the expertise that already exists in carer centres and to have a network of forums that representatives can go back to as a community of carers and feed their views through. However, as I said, that will need to be resourced.

There are other ways to strengthen things. Ian Welsh mentioned co-production rather than consultation. 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 and not just as an afterthought. We also recommend that they should have a role in signing off the plans, for example through a local carer organisation. There has been talk of interface organisations signing off the plans, but we also see carer organisations having that role.

Another quote from our consultation was:

“Good to talk but more important to be listened to.”

We heard that a lot. I know that, as integration goes through in the bill, a lot of the process will be about looking at the guidance and regulations, but I think that it is important to have this discussion and to give thought to such matters from the beginning.

**The Convener:** I ask Karen Hamilton whether she wishes to respond.

10:00

**Karen Hamilton (Borders Public Partnership Forum):** I do not think that I have anything to add to what my colleagues have said.

Rhoda Grant mentioned bureaucracy in her first question. I can appreciate that a bureaucratic framework is part of the process. I do not want to support that, but if we do not put the relevant structures in place and people do not know, for example, who they are responsible to, who they are accountable to and how the chain of command works, I do not think that the process will succeed. One of the issues with previous attempts has been that issues such as who holds the resources and how funds are transferred have been a bit muddy. It is bureaucratic, but up to a point it probably needs to be to make the system work.

**Ian Welsh:** We will all bring forward a range of amendments. We would suggest, for example, that insufficient engagement should be grounds for ministers not to approve the integration plan. That would be a mechanistic way for ministers to
ensure that the local partnerships—many of which have first-class engagement plans—are held to account for lack of engagement. We will bring forward an amendment on that issue as well as on others.

The Convener: I ask Pam Duncan whether she wishes to comment.

Pam Duncan: Thank you for giving me a second opportunity on the same question. As members can probably imagine, we have a few suggestions on how the bill could be amended. One is specifically to lift text from the United Nations Convention on the Rights of Persons with Disabilities and include it in the considerations in preparing integration plans in section 3 of the bill. We have given a bit of thought to how that could fit in nicely. As I said, that would be a good step for Scotland to take to show that it takes human rights seriously and puts people rather than bureaucracy at the front of health and social care.

I will make two other points. The first is on portability and the principles of the bill. If the bill is about the individual, it would seem odd if there were any barriers to people moving around between local authority areas, particularly given that, in the new integrated systems, we could have 32 different systems with, for example, one health board covering two or three different social care areas or local authorities. There is an opportunity to iron out some concerns that disabled people have quite frequently raised about the impact of moving from one local authority to another. Unless we take the opportunity to address the issue, there is the potential for quite a lot of confusion. We have ideas about how we could strengthen the bill in that area.

We have recently published a toolkit called “All together now”, which is about working in co-production with disabled people and which has been endorsed by the Cabinet Secretary for Health and Wellbeing as a useful tool to have in the box to make the integration plans work. As Ian Welsh said, we want that to become an integral part of whether the plans are signed off. We think that the toolkit could help people to get it right and to engage with the process.

The Convener: We are familiar with many of those themes, but the hard question for us is: what is there in the bill that will deliver on the recurring themes that we have heard from you in the past? How will the bill deliver the outcomes that you want? How will it bring about a shift in power from local government and health boards?

Ian Welsh: That is a big question. I speak as a seasoned campaigner who has worked locally—I sit on the health board and, as you may know, I used to lead a local council. Some of you sitting round the table will have seen successive initiatives over the past 14 years from local health care co-operatives onwards. As Karen Hamilton said, the difference is that there will be a consolidated budget. There will be a real pool of money—it will not be kid-on money—and there will be a statutory responsibility.

The words in this enabling bill reflect the Christie principles. They reflect the requirement for public service reform, they insist on personal outcomes for people and they insist on co-productive techniques.

The challenge is that, when we move from the centre to the periphery—although that is not the periphery but the centre to those who serve such communities—there is an overwhelming requirement for culture change, which can happen only through action. For example, health boards and local authorities are briding 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.

I have referred to the supporting guidelines. I take Karen Hamilton’s point that we need a bureaucratic structure. The problem with structural reorganisation is that, although it provides a chance for a year or perhaps two years to change how we operate, if we seamlessly continue to do what was done before, we never get the engagement with change. However, there is loads of good practice across the country in different pockets. East Renfrewshire provides a good example, as it already has inclusive working and co-productive working, with carers at the table and disabled people discussing their services. East Renfrewshire is also looking at moving from downstream investment to upstream preventative action.

I am sure that there will be loads of amendments to the bill to produce a good piece of legislation, but the challenge for all of us will be to ensure that the local partnerships do not become enmeshed in simply meeting the budget. If that happens, we will not get the transformative change that is required.

Claire Cairns: As I said, we consulted carers on integration. It was interesting to get their views about integration in general and whether it would improve their lives or have a negative impact on them. There were positive and negative views about the impact of integration. About 52 per cent thought that things would stay the same; 33 per cent thought that there would be an improvement;
and 14 per cent thought that things would get worse, for a variety of reasons.

When we looked at what carers thought would make integration successful, a few key points emerged. We have said that engaging carers in the new structures was the number 1 point. Another issue was co-producing plans and ensuring that people have ownership of any decisions that are made. As Ian Welsh said, another point was ensuring that people are at the table for signing off plans.

A very big issue was ensuring that resources are directed towards carer support. A lot of the policy integration—in reshaping care for older people and so on—is looking at shifting the balance of care, shifting resources from acute services to the community and having people stay at home longer, living independently. That really requires the involvement of carers. If we do not provide resources for carer support, that will have a hugely negative impact on carers’ health and wellbeing. If we are saying that more care needs to happen at home, in the community, it makes sense to direct resources towards that.

As Ian Welsh said, there have been really good examples through the change fund. As members probably know, 20 per cent of the change fund had to go towards carer support. That acted as an excellent catalyst for developing new services and ensuring that carers were integrated into the process and that developments took their needs into account. We would like something similar to happen with integration, to ensure that carer support remains a priority.

The big one that a lot of carers mentioned was culture change and leadership. A lot of people said that whether integration would work would be down to not processes but individuals. That is about all the partners working together and being committed not only to the process but to making the engagement and co-production meaningful. That means embracing people coming into what some might see as their territory and being prepared to listen to and involve those people.

Karen Hamilton: We have talked about third sector involvement. I will highlight a risk that might exist. A few weeks back, I attended a third sector involvement session down in Melrose. It was well attended, with people from probably 60 or 70 organisations coming together. The feedback from that was that it is difficult to integrate the third sector and have people speak with one voice. People articulated that themselves. There are sometimes commercial conflicts and different principles.

Although I welcome the fact that we are involving the third sector in the process, I note that there is a risk—it is a watch point for the committee—in that we should not assume that the sector has a single voice or is a single body. There are a lot of people with conflicting views and we should not gloss over that.

The Convener: They have all been here to give evidence as well.

Pam Duncan: I will make a similar point. Disabled people sometimes suffer from what we call majoritism. It is difficult for seldom-heard voices to make their point through things such as the third sector interface, because it attempts to represent a large group of local people. Throughout our engagement exercises, disabled people told us that they and their directly accountable organisations must play a key part in looking not just at the outcomes but at how money is spent and how policies are developed from the start of integration right through to monitoring and evaluation.

Many disabled people’s organisations are operating at below a critical mass. We are saying that we really need to be engaged, and disabled people are innovative because they have to be. When I get out of bed in the morning, I need to think of solutions to a lot of problems. Health boards, local authorities and others in our society could draw on that. However, that needs to be resourced and supported, and many disabled people’s organisations are struggling with that.

Section 26 of the bill contains a commitment to reimburse expenses for people’s involvement, which is important, but it should also be recognised that something extra is needed in the resourcing of community-based organisations, and not just the wider third sector, for them to become accountable and give input on plans. We go further and suggest that ministers should recognise disabled people’s organisations. The bill states that ministers will recognise organisations that they think are representative. We argue that DPOs, as directly accountable organisations of disabled people, should be considered throughout the bill in that respect.

Richard Lyle (Central Scotland) (SNP): Good morning. It is nice to see you again, Pam. Sorry—I am not singling you out.

I return to the point that Claire Cairns made about the percentages. It was interesting to read all the submissions, and the issue that I will raise runs through all of them. The Coalition of Carers in Scotland’s survey asked:

“Should carers have a guaranteed place around the table in the new integrated structures?”

and 100 per cent of respondents said yes. In fact, there are eight yeses in the response—it sounds like “The Vicar of Dibley”.

Ian Welsh stated:
"As proposed, Health and Social Care Partnerships will only be accountable to health boards and local authorities. There is a risk that the proposals for integration will represent a backwards step. The third sector and people who use support/services should be included within membership of Integration Boards”.

Do you feel that you should all have a seat at the table and be involved under the bill to ensure that you have what Pam Duncan called for earlier—a voice?

**Ian Welsh:** Absolutely. To take Karen Hamilton’s point, I note that, as a collective, the third sector in Scotland is massive. It is fair to say that it is hugely misunderstood. When you all go back to your constituencies, I bet that you find a different third sector organisation every week. The sector has a massive reach.

The sector is not unorganised. In the evidence that the committee took from the Scottish Council for Voluntary Organisations and the Coalition of Care and Support Providers in Scotland last week and in the evidence that it will take from other strategic intermediaries, such as us, it will find a significant common thread on the requirements for giving a voice to carers, disabled people and third sector organisations that aim to put people at the centre of services. In that regard, I disagree with Karen Hamilton.

10:15

Emerging from the chaos or the maelstrom of activity that sometimes happens in Scottish public life is a requirement for every local partnership to have a third sector interface that is tasked with providing some kind of voice. There is a mechanism locally and nationally to give a much more unified voice to the third sector and carers.

Integrated boards are required to take care of business such as the transfer of staff and the structures quite quickly. However, when we move beyond Christmas and head towards April, local healthcare and social care partnerships will be required to walk the walk. It would be a poor thing if they did not.

There should be a disabled person presence and a carer presence. The concerns about that in statutory terms—in sign-off terms—are vastly overstated. I do not recall many occasions, even in my local authority life, when we have been divided significantly over budgets in health and social care. It would be a huge signal of inclusiveness for health and social care partnerships if those people were given a voice. Having one representative of the care in the community sector, one representative of the disabled population and one third sector representative against maybe eight statutory sector representatives seems reasonable to me.

**The Convener:** What is more important to securing an improved outcome for individuals—having those individuals on boards or having a human rights focus to every decision that is made? Is one option exclusive of the other?

**Ian Welsh:** Pam Duncan can answer first.

**Pam Duncan:** Thank you for deferring to me—I appreciate that, as I was eager to get in.

I do not think that the two aspects are mutually exclusive; I think that one is needed to guarantee the other. Under the Scottish Human Rights Commission’s approach to human rights principles—the PANEL approach—the first word is “participation”. We cannot have one without the other. It is really important to include the representatives whom Ian Welsh described as key partners in order to deliver on the human rights aspirations.

**Rhoda Grant:** Are you saying that, rather than have someone from the third sector interface on a board, you want carers, service users and service providers separated out, so that each can express their voice individually on behalf of the group that they represent?

**Claire Cairns:** Yes.

**Karen Hamilton:** Yes.

**Pam Duncan:** Yes.

**Nanette Milne (North East Scotland) (Con):** I will touch on the Social Care (Self-directed Support) (Scotland) Act 2013. People who have spoken to us have wondered how self-directed support will work once the services have been integrated and budgets have been pooled. The SCVO has said that self-directed support is probably vital to the working of integration. What effect will the proposed new arrangements have on self-directed support? Will they help it or hinder it?

**Pam Duncan:** We have asked similar questions, because we are not 100 per cent clear—I am not sure that the bill is 100 per cent clear—about how those things will work. We have always said that people should be able to apply the principles and practices of self-directed support when they exit hospital to access services in the community, and that should continue throughout.

We are integrating two systems. One is based on eligibility and is free at the point of delivery—the national health service—and one is based on eligibility criteria that are broadly outlined nationally but are, in effect, determined locally. Most cash-strapped local authorities are delivering according to high-level criteria, so that is literally life-and-limb provision. That, too, will have a huge
impact on the provision of more care in the community.

If there is to be more care in the community— which we support—the situation needs to be looked at, because we do not want to unblock a bed in hospital and allow someone to go into the community if they are only going to get up in the morning, get fed, have their bum wiped and go to bed at night. We want social care that is much more than that. There are many questions about how SDS will work with that and, more broadly, how social care will be delivered in the future, given the funding crisis that local authorities and social care services are experiencing.

Throughout the engagement events that we held, we heard from disabled people that there is a large amount of unmet local need for social care. One way to make SDS work well as part of an integrated system—there is a vision and we can see that it can work—would be to start recording unmet need so that we know what is missing. Until we do that, I do not think that the local partnerships that come together will be able to determine how much money is needed for social care or for healthcare. To get to that point, we need to start recording unmet need.

That was a slight diversion from Nanette Milne’s question, but there are a number of questions about how SDS will work.

Ian Welsh: I agree with everything that Pam Duncan said. However, there is no indication that the situation will worsen; the question is how quickly SDS needs to be accelerated. That is partly down to resources, but it is also partly about answering a larger question. SDS is focused almost exclusively on social care, but there is a developing argument about applying SDS in health settings as well.

Some good work is being done in Scotland, and my organisation has an officer who is looking at self-directed support in health settings. I nearly said that the challenge is to take the fell hand of accountants off health budgets, but I do not quite mean that. At the moment, health budgets are locked in a particular paradigm, but come the day, come the hour, maybe a third of a health board’s budget will be located in health and social care partnerships. In that setting, there will be the opportunity to look at SDS in a different way.

I hark back to my original point. Health and social care partnerships and the statutory agencies need to look at integration as an opportunity to refresh and reform the way in which they think about things. They are locked into crisis management of budgets and timetables for delivery, and they need a bit of space to do fresh thinking about what policy and practice mean in the 21st century. If they do not get that, we will not see an acceleration in SDS for social care or any innovative approaches to SDS in health settings. My plea is for the new health and social care partnerships to look at health and social care services through a new prism.

Nanette Milne: Both those responses are helpful. Since care in the community was introduced, it has been recognised that it is not a cheap option and that, to work properly, it requires resources. I agree with Ian Welsh’s point about the need for a culture change in how things are looked at. That is perhaps the only way in which SDS will work. It is helpful to have that on the record.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): The discussion has probably moved on a bit since I first indicated that I wanted to come in, because I was interested in the mechanisms for embodying the bill’s principles. I completely agree that the principle of co-production should be in the bill, but I was wondering about the mechanism for ensuring that that happens. In that respect, Ian Welsh’s comments about who should be on the board were helpful.

I was also wondering about the current mechanisms, one of which is the public partnership forum, which has not been asked about. You want the principles in the bill and people on the board—which is fine—but will those other mechanisms still exist? I presume that the third sector interfaces will remain, but do you still find the public partnership forum, which I note has been commended in two of the submissions, to be useful? How will all that fit together? Do we simply need a multiplicity of forums and mechanisms to ensure that this happens?

Karen Hamilton: At the moment, PPFs are a bit at sea because there is some confusion about where they fit in and, indeed, about how representative of the public’s views they are. As they tend to be made up of people with vested interests, one might argue that their views are skewed. The PPF that I represent really does not know what the situation will be and has not been able to identify in the legislation as drafted any guidance or information on where it will fit into the new health and social care partnerships.

Moreover, although the PPF has various subgroups such as patient reference groups, we are concerned that we do not have reasonable representation from the carer population or particularly good representation from young people. There is an opportunity to look again at the formulation of PPFs and the role that they might play in the new partnership set-up.

Claire Cairns: We undertook a project in the Highland pilot area, when it was moving towards integration, on how carer engagement and structures for such engagement worked there.
What we found—and I think that this is typical of most areas—is that the environment can often be confusing and cluttered. As well as public partnership forums, there are often quite a lot of specialist forums or groups and it is difficult to discern where decisions are made, where information is going, where the flow is and whether discussions on particular subjects make it to meetings at which decisions are made about budgets or service development.

Whatever the new structures are, they must be meaningful and we must not ask too many carers to be involved in too many groups. Carers want to be involved in meaningful groups that make the decisions; they want to be listened to; and they want to be resourced so that they can attend not only those meetings but meetings of their carer forum or group to allow them to bring forward information from that reference body of carers.

Those are the lessons from the Highland experience. They kept a lot of structures and just added new ones on top of them, which put quite a lot of strain on people’s involvement. People want to be involved in the decision-making process but, as I have said, they want to ensure that their time is well used.

Ian Welsh: We talk about moving to new structures but the fact is that the world is messy. Going back for a moment to the archaeology of all of this, I note that the Scottish health council was tasked with setting up public partnership forums for the health service and did so diligently; it is also responsible for monitoring how well health boards deliver that mechanism. Although Karen Hamilton’s points about representation on the forums are properly made, I have to say that the NHS still has an active participation network that serves its purpose relatively well and which in some areas is excellent—although in others perhaps less excellent. Moving to a new structure that brings another tranche of services to the fore and which contains a different participation network will be a challenge.

10:30

To answer Malcolm Chisholm’s question, I think that what will happen, practically, is that the existing structures will be mapped on to the new partnerships for a while and something will emerge. I know that the Scottish health council has designed an inclusive new model, but I think that, in the first instance, the public partnership forums will be mapped on to the new health and social care partnerships.

I go back to my first point—there will be a requirement on the new health boards to look at engagement. There are engagement guidelines; Pam Duncan referred to them. The Scottish Community Development Centre has developed national standards on community engagement, which are applicable here, but it is not a tidy world. Over the next year and a half, work will have to be done to build new participation methods. As I said earlier, in the first two years there will be a focus on building something new and much more inclusive.

Pam Duncan: In the same way that we would not ask a men’s organisation to represent women, we believe that it is fundamental that disabled people’s organisations can represent disabled people. On that basis, we think that it is extremely important that their ability to engage with the structures that you have described or the third sector interface is strengthened because, in times such as these, it is difficult for organisations to grow their capacity to do that.

We believe that, by taking a social model approach to health and social care—as we do—disabled people’s organisations will be able to offer a broad view of the real impact that health and social care can have on people’s lives, the difference that it can make to their participation and the crucial role that it plays in relation to their human rights and their being equal in society. It is important that such a broad view is taken, particularly when we are looking at the preventative agenda, which, as well as being about treating conditions and providing care and support, is about enabling disabled people and other service users in health and social care to lead an ordinary life and to play their full part in the community. I think that DPOs have a unique lens through which to provide key invaluable information and engagement.

Malcolm Chisholm: Thank you—that is helpful.

I have one more question, which I think goes to the heart of the matter in a slightly different way. Ian Welsh said that one third of the health board budget would go into the health and social care integration arrangements, but he also said that there was a significant common thread between his evidence and that of the organisations that we heard from last week.

I do not know whether you followed last week’s proceedings, but I think that at least two out of the three organisations on the panel to which you refer were very concerned that minimal amounts of money would be put in by health and, possibly, local government, and they suggested that there should be more national direction on that. In fact, I think that at least one of them, if not two of them, suggested that budgets for the bodies should be set nationally. What do you think of that suggestion? If you do not support it, how can you ensure that the appropriate sum is put in, given that some people are concerned that the acute sector in health, for example, will put in very little?
Ian Welsh: I do not always agree with SCVO or CCPS. Sometimes, that is partly because I am still involved locally. The approach that is taken will vary. There is a tension between central direction and local control. MSPs will be more aware of that than any of us. My view is that health and social care budgets should be decided locally. As a former elected member, perhaps I would say that. There is also a tension to do with the extent to which acute care money is allocated to the budgets; the approach to that will vary across the board, too.

To put that in context, the bill is enabling legislation; it is a piece of partnership legislation. Therefore, the budgets that go in will depend on how good and trusting the local partnerships are. Already, the approaches vary. For example, at least one of the local authorities in Ayrshire is putting in some of its children’s services, while other authorities are not. I do not agree with my colleagues that it is all about packing in additional resources. It is about maximising the best outcomes for the local population.

Pam Duncan talked about unmet need. Sometimes, scant regard has been given to trying to meet population need in the localities. To me, that is an important part of the process. My son is disabled and I am a carer but, to be honest, my interaction with the health and social care systems is minimal. My son is 30 years old and he kind of strolls through without making an impact. For Ian Welsh, putting in some of its children’s services, while other authorities are not, I do not always agree with SCVO or CCPS. Sometimes, that is partly because I am still involved locally. The approach that is taken will vary. There is a tension between central direction and local control. MSPs will be more aware of that than any of us. My view is that health and social care budgets should be decided locally. As a former elected member, perhaps I would say that. There is also a tension to do with the extent to which acute care money is allocated to the budgets; the approach to that will vary across the board, too.

To put that in context, the bill is enabling legislation; it is a piece of partnership legislation. Therefore, the budgets that go in will depend on how good and trusting the local partnerships are. Already, the approaches vary. For example, at least one of the local authorities in Ayrshire is putting in some of its children’s services, while other authorities are not. I do not agree with my colleagues that it is all about packing in additional resources. It is about maximising the best outcomes for the local population.

Pam Duncan talked about unmet need. Sometimes, scant regard has been given to trying to meet population need in the localities. To me, that is an important part of the process. My son is disabled and I am a carer but, to be honest, my interaction with the health and social care systems is minimal. My son is 30 years old and he kind of strolls through without making an impact or getting any significant support in any shape or form. So a local response to circumstances is needed.

It is not all about resources, but it is about partnership. Another dimension that we have not even talked about is the issue of locality planning and how general practitioners face their communities. I see that John Gillies, who is on the next panel, is sitting behind me in the public gallery. Fantastic work is being done in localities to link the community to GP practices in a much more significant way, and that needs to be part of the landscape. My view is that it ain’t all about money, but it is all about how people work in partnership locally.

Pam Duncan: I agree that it is about using resources differently as well as how we address some of the unmet need. That might involve new resource, or it might be solely about how we use the existing resource differently. Ian Welsh’s point about variability in local partnerships’ approach takes me back to my earlier point about having the principle of portability in the bill. Although variability and local decision making are important—I could not possibly sit here today and advocate, as I have done, that disabled people need to be so deeply involved without recognising that decisions need to be made at community level—that should never come face to face with someone’s human rights.

For example, the system should not make it almost impossible for someone to move from one area to another or, as could end up being the case, from one street to another. That is why I again make the point strongly that the bill should include a provision on portability so that end users do not experience significant disadvantage if they choose to move around for education or employment or just because they fancy a different area. It is important to put that in the bill, particularly given the issues that Ian Welsh has described.

Claire Cairns: When we look at the issue, it is useful to look at the initiative on reshaping care for older people—obviously, it is a front-runner on integration—and some of the lessons that we can learn from the change fund and the move towards joint strategic commissioning. In some ways, decisions were a bit easier with the change fund, because it was additional money and it was all about pilots to start to deliver some of the principles behind integration and preventative services. However, when we start joint strategic commissioning, we are asking people to be incredibly brave, because we are asking them to look at money in a different way and to start to consider where to disinvest in services. Currently, partnerships really struggle with that.

I was involved with a joint improvement team in a review of joint strategic commissioning plans to see where carers fitted in. Across the board, the review found that the plans could have been braver on disinvestment. There was little mention of that and very few solutions had been suggested on shifting money from acute services into the community. That is where areas will struggle. Decisions will have to be made on how directive to be and on whether to say how much money needs to go into the pot or whether decisions can be made locally. From the experience of the reshaping care for older people initiative, it seems that there will definitely need to be encouragement for partnerships to be brave. It is difficult for them, because the decisions have to go through local authority decision-making processes that involve accountability to councillors and so on. Those things quite often hold people back from making brave decisions.

Karen Hamilton: I was going to talk about the different structures and accountability processes, but I will go back briefly to where PPFs fit in. Ian Welsh mentioned that, for a couple of years or so, they would be mapped into the new system. A watch point is that we do not lose that golden opportunity to improve them, make changes, make them more effective and broader, and so on. If we
do not do that in the early days, there is a danger that they will get lost and wither on the vine.

Some of the submissions mention guidelines, which are missing at the moment, as are overarching principles. Many things that we have talked about today could be fed into overall guidelines and principles, and I make a plea not to forget that as a principle in terms of public representation in the new bill.

Mark McDonald (Aberdeen Donside) (SNP): I note the comments about who should be around the table. The more people who come to the committee and say that they want a seat at the table, the more I think that some of those integration joint boards will need pretty big tables. However, I take on board the points that have been raised.

At our previous committee meeting, the representatives from the third sector were quite clear that they saw their role as being part of the strategic planning side of things and that they would take a step back when it came to the commissioning of services. Where do you see the organisations that are relevant to your interests fitting into their role if a seat around the table was to be afforded to them? Would they fit with the strategic planning, the commissioning, or both? How do you see that working?

Ian Welsh: I am not sure that Annie Gunner Logan would agree that CCPS, for example, would simply be involved in the strategic dimension and that it would then step back. A significant piece of work is being done by the joint strategic commissioning committee and I am sure that the evidence from that will be fed into the guidelines.

Beyond that, there is a tension between the definition of commissioning and the definition of procurement. For those of us who have been around quite a while, the move in the early 1990s—I cannot remember the date—to compulsory competitive tendering led to a public procurement regime. What happened then, certainly in social care, meant that much of the social value of procuring a service lost out to cost. I cannot speak for Pam Duncan but I speak for myself when I say that we ended up with the obscenity of e-auctions for domiciliary care, for example. Local authorities were constrained by that regime.

A much more sympathetic response to commissioning would be to design a service with service users and private sector and third sector organisations that have developed expertise in the work against a background of the public health requirements for a locality. A much more nuanced approach is coming. If we go back to local authorities or health boards now, we see people who procure services rather than people who commission services. Reshaping culture and values when we design services will involve bringing organisations in, rather than having them compete across a table.

Mark McDonald: I would be interested in hearing any other views before I ask the follow-up questions that arise from that.

10:45

Pam Duncan: We need to be clear that it is not just about saying, “We would like to have a seat around the table, too.” It is about understanding the value of listening and engaging with different people in order to get it right, which is really important. That is probably why everybody is saying that they want to be at the table. There is also a nervousness about who will represent people at the table and put their views across. It is not so much about the size of the table as about how representative the table is. We need to get the representation on the table right and convince local people—I mean communities as well as communities of interest such as the LGBT community and so on—that the mechanisms for engagement with that table are strong. It is less about the size of the table than about how we resource the representation around it.

Karen Hamilton: A third element, in addition to the planning and commissioning of care, is scrutiny. I think that that is what we are talking about. The people around the table do not need to be the planners or commissioners, but they certainly need to be the scrutineers who ensure that the services are being delivered effectively and economically. It is important that we recognise the scrutiny role of those around the table.

Mark McDonald: I come to this from a similar perspective to Ian Welsh’s in that I, too, am a parent carer and understand the interactions that take place. I have two follow-up questions. First, does the role that you envisage necessarily require a seat at the table? Is there another way in which the function that you seek can be carried out without there needing to be something in the bill about it? Reference has been made to having something enshrined in the guidance and the regulations.

Secondly, how would you ensure that, as you put it, the right organisation represents people? In my constituency, a range of organisations provide similar services in different localities. How can we ensure that we have the right voice at the table, so that people do not feel that they have been unnecessarily excluded?

Ian Welsh: In every health and social care partnership, there is a third sector interface that is charged, in part, with signing off the change fund,
for example. That would be the logical third sector representative.

A secondary issue that is implicit in your question concerns the cluster organisations that are out there. In my view—I am speaking from a practical point of view—every health and social care partnership should fund an engagement officer who sits within the third sector interface and is tasked with working with the partnership’s officers to ensure that there is coherent and consistent representation through the various working groups that are set up to look at services. The cost of that person’s salary and the on-costs would be, say, £50,000 out of a potential health and social care partnership budget of about £150 million. That would be one way of getting coherent and consistent activity. Pam Duncan and Claire Cairns may have another view, from a carer’s perspective.

Pam Duncan: At all the consultation events that we held, our members said consistently that they feel that they need to be represented around the table. That is partly a response to the historical oppression that disabled people have faced in society and a fear that—to use a phrase that I heard recently—if you are not at the table, you are on the menu. That may sound controversial and antagonistic, but I do not mean it to be.

It is important that disabled people who use the services on a daily basis are able to bring the unmitigated voice of that experience to the table. That is why I would advocate strongly for having disabled people’s organisations around the table. They are directly accountable to their members locally and can bring the unmitigated voice of experience to the table.

The fact that they are disabled people means that they have to navigate barriers and problems in society and find solutions on a daily basis. Health and social care partnerships should want to bring those factors on board, but not just to tick a box and say that they are including disabled people; they should embrace them so that they do exactly what the bill’s policy memorandum suggests in terms of health and social care integration.

Mark McDonald: On the second point that I raised, I am interested—

The Convener: Does Claire Cairns want to come in?

Claire Cairns: Yes. My point is similar to Pam Duncan’s. We have already referred to the focus groups and the consultation that we did with carers, so members will know that 100 per cent of carers felt that they should have a guaranteed place around the table. Richard Lyle referred to the number of yeses, and I want to clarify that on our carers message board we directly quoted their responses, and one person wrote eight yeses.

Carers felt that one of the potential negative impacts of integration was that they would lose some of what they have already gained in having a place around the table. Members might know that in 2011 carers were given a guaranteed place around the table with community health partnerships. If that does not happen when we move to integration, carers will see that as a massive step backwards.

The point about how to get the right person at the table is a good one. I have already said that carers cover so many different age groups and conditions that it is quite difficult to get one person to represent that range. There is already a very strong network of local care organisations, which I see as being very much the experts. It would not be too difficult for partnerships to go to their local care organisation and devolve that representative function to it. In terms of supporting representation, provided that they were resourced to do it, local care organisations would do that work very well.

Mark McDonald: I think that that deals with my second point.

I have a final question. We have had evidence from the Convention of Scottish Local Authorities on the bill’s scope and the potential for widening it in future. COSLA wants it to be very narrow and to deal with adult services only. That would mean that further legislation would be required if, for example, we wanted to roll out integration to children’s services. Obviously, most of your organisations deal not only with adults but with a range of individuals who come into contact with social care and health services. What are your views about the ability of ministers to widen the scope of the bill, should the approach prove successful? My view is that if we simply say that widening the scope to children’s services can be done locally but that we will not have a wider roll-out, we will end up in the same situation. In other words, we have a couple of areas that serve as pioneers and just crack on, but there are other areas for which legislation is absolutely necessary to get the change that we want to see. I am interested in your views on future widening of the bill’s scope.

Ian Welsh: Our organisation has not taken a view on that. Personall y, I do not support COSLA’s view on the issue, but that would not surprise COSLA. I think that when the 32 health and social care partnerships shape up, there will be an interesting mix, and not all of them will opt simply to have older people’s services. There will be other services in the mix, such as community health and mental health teams. In fact, there will be the full panoply of services. The notion that in
the near future we would return to produce additional legislation would be mind blowing for us.

We are much more interested in seeing the health and social care partnerships as a conduit for change locally. There is a very significant agenda for change to be delivered. The legislative context will allow the proposal for integration to be delivered, and I think that that is enough to be going on with.

Claire Cairns talked about the change fund being new money, but health boards would say that it was not new money but their money. However, it was money directed at the point of change, and my understanding is that at the end of the change fund there will be a similar, potentially enhanced, sum of money that can be utilised for health and social care innovation. I commend that approach. For health and social care partnerships that would be an opportunity to do things differently. You do not need a lot of discretionary money to do things differently at the local level, but you do need some money. To tie that into your question, it would also provide an opportunity to test new approaches and new client groups within health and social care partnerships. I disagree with COSLA on the issue.

Karen Hamilton: We have to allow for the legislation covering all age groups, not least because of the point of transition for younger people—certainly younger people with disabilities—moving through services. The system is already complicated enough; if someone had to transfer from one structure to another, it would become even more so. That is an absolutely critical point.

The local authorities and the health boards need to be able to make those decisions themselves. I know that some already have. I believe that Highland has gone down that route, with the lead agency model. We are already there in some ways so I think that we need to stick with that.

Aileen McLeod (South Scotland) (SNP): I want to pick up on some of the points that Ian Welsh made around locality planning. This comes from an issue that arose at last week’s evidence session with a number of organisations, including SCVO, when we discussed the capacity implications for the third and independent sectors for which the operating environment remains quite challenging. How do we build capacity in communities when more acute care is coming back into our communities? Obviously, there is a key role to be played by our GPs, who are central to much of the roll-out of integration. I am conscious that we will take evidence from Dr John Gillies, from the Royal College of General Practitioners, in the next panel.

What do you think is the best way for us to build that capacity in communities? Proposals came from the general practitioners at the deep end group in March, which talked about health hubs built around GP services involving, integrating and innovating in relation to progressive health and social care initiatives and approaches to the health and social care partnerships.

Ian Welsh: That is a great question. My organisation and the RCGP—I am sure that John Gillies will say more about this—are working on a good project called improving links in primary care, which involves working with GPs to build greater cohesion and provide more information in localities. My organisation is about to work with the deep end group on a related Scottish Government-funded project that will try to establish the efficacy of link workers in deprived areas working around a series of deep end practices. The long-term objective is to prevent people from requiring medical services. If the evidence shapes up after a couple of years, I believe that that will be a practical model that could be implemented in all deep end practice areas.

The wider question of building capacity is challenging. There is already a programme of building capacity through the joint improvement team. I do not know whether the committee will take evidence from the joint improvement team, which is a Scottish Government vehicle that delivers fantastic work in localities, building capacity around co-production, for which it has a very good toolkit. The programme will build an improvement network in the third sector interfaces. In effect, such capacity building is a skill-up exercise. However, in my view the third sector interfaces, which have a change fund sign-off function, really require a bit of additional human resource investment to allow them to step up to the plate.

11:00

As a national resource, the change fund support team, which, as Aileen McLeod will know, is currently hosted by the alliance, will be given a bit of additional resource so that it can become a health and social care support team. That team, which is governed by the third sector but involves the Scottish Government and the joint improvement team, will also help to skill up the third sector interfaces. Therefore, there will be a bit of national support and a bit of other support—although a bit more is certainly needed—for the third sector interfaces.

However, there is a larger question about the extent to which DPOs and carer organisations are resourced to deal with the change. Claire Cairns represents a whole coalition of carers, but she is
only one person so she will not be able to attend
every health and social care partnership. There is
a requirement there, but that requirement is
quantifiable and realisable.

If I was speaking from a sectarian interest point
of view, I would say that the amount of money
required is infinitesimal compared with the £12
billion that sits in the statutory health board
budget. Now, I do not have the political capital or
authority to be able to cull resource from that, but I
suggest that such practical requirements need to
be addressed. The financial memorandum to the
bill provides some scope to build a bit of support
there. For example, the alliance will start to build a
small—but we hope influential—initiative called the
health and social care academy, and SCVO will be
undertaking some pathfinder projects along with
Voluntary Action Scotland. However, we could do
with more money to tool up the interfaces so that
they are prepared for health and social care
integration locally.

Claire Cairns: The change fund already
provides some good examples of capacity
building. In a few areas in Scotland, it has funded
the development of carer forums and the training
and support of carer representatives. That has
been very successful in improving carer
engagement and making that more meaningful,
so that carers feel supported and that they are being
listened to. Those developments have made the
experience a lot more valuable for carers and
have ensured that carers are connected to other
carers in the local area. That could easily be
replicated across Scotland.

The change fund has also funded some really
good examples of increasing the capacity of carer
organisations to provide support to carers. Over
the years, with more older people and more
carers, more people are coming forward who need
support—that has been an issue for quite a long
time. For example, in Stirling funding has been
provided for two hospital discharge workers. They
are based in the hospital setting and identify
carers at an early stage and help them with the
transition back into the home to ensure that the
carer’s needs are considered alongside those of
the person being cared for. There is good
evidence to demonstrate that such interventions,
as a good example of joint working, help to avoid
future crises for carers and future readmission to
hospital.

Another example is in West Lothian, where
there is an older carers worker who works closely
with the local authority’s reablement team.
Whenever a reablement package is being
arranged for someone, the older carers worker
ensures that the carer is trained alongside that.
Reablement is excellent—as I am sure you will
know, it can help people to regain their
independence—but if the carer is not also trained
and supported, it is very easy for people to go
back to their old ways of having things done for
them.

Such things increase the capacity both of carers
to engage and of local carer organisations to
provide the support that is needed to assist
integration.

Aileen McLeod: Thank you. That is very useful.

The Convener: There are a few issues that we
have not covered yet. One is charging and the
concern that has been expressed about cost
creep. We know from previous evidence how
emotive that issue can be. Perhaps we can roll
that up with the broader outcomes, the inspection
and complaints procedures and how people will be
able to exercise the rights that we spoke about
earlier. I ask for some brief responses on those
issues, as we have written evidence from you as
well.

Pam Duncan: I have said this to the committee
in the past, so it will come as no surprise to you to
hear me say that disabled people and their
organisations believe that to charge people for a
service such as community care, which is so
crucial to their independence and their human
rights, is unfair and unparalleled. We do not
charge anyone else for the privilege of enjoying
their human rights in the same sense.

We state in our written submission that 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.

We have done some work on the matter and we
believe that the cost is approximately £50 million
across Scotland. That is the amount that is
collected in charges for social care. In the grand
scheme of things, that is not a huge amount of
money, but the charges can represent up to 100
per cent of a disabled person’s income. When we
look at it from that point of view and consider that
many of the people who pay the charges live in
poverty, it seems unfair. I believe that we need to
address that as a society.

On complaints and reviews, we were surprised
to see that the bill is quite silent on complaints
processes, particularly given that there are
different processes for health complaints and
social care complaints. We note that the duties in
the bill follow the delegated function. In a situation
where a health board delegates a function to a local authority, where would someone complain to and which process would they use? We accept the Scottish Public Services Ombudsman’s recommendation that the processes be aligned as closely as possible, but we would go slightly further—this might not surprise you—and suggest that there probably needs to be an independent mechanism for people to make complaints.

We have raised some concerns about the complexity of the system. This is not a slight on the ombudsman in any way, but the issues are so detailed that it will be extremely difficult to deal with them at a national level in the depth that is required. We recommend that there should be locally independent mechanisms, perhaps in the form of tribunals.

The Convener: Does anyone else want to comment?

Ian Welsh: That was a comprehensive response on the costs.

The Convener: I thought that it was pretty comprehensive, I must say.

Ian Welsh: Maybe I could just say a bit about the outcomes. Again, I congratulate the cabinet secretary and his team, as there has been a comprehensive and inclusive consultative process. There was a working group on outcomes, and I am pleased to see outcomes enshrined in the bill.

However, there is a larger issue. There is a shift towards trying to focus on personal outcomes for individuals—again, that is part of the culture change. My son will be quite different from another young man who has cerebral palsy, and that young man will be different from another young man who has Down’s syndrome, so personal outcomes are really important. We have a series of reports coming out called “We’ve got to talk about outcomes”, which I think will be informative for the committee, and I will be happy to furnish you with them.

Finally, Pam Duncan talked about human rights, and we have a document called “Being Human”, which will give the committee some more background on the issues. It describes the rights-based approach to health and social care integration.

The Convener: Thanks, Ian. We look forward to receiving that additional information.

We appreciate both your written evidence and your oral evidence today. Thank you all very much for your attendance.

I suspend the meeting to allow us to set up for the round table.
panellists’ contributions will take priority over those of politicians. We will try to listen.

Bob Doris: Listening is not something that politicians are always good at doing. I will try to keep my question as brief as possible. The round-table introduction is probably a good starting point, because the question is about stakeholder involvement and which stakeholders—all the witnesses are stakeholders—should be specified in the bill.

We would have to build a new, larger committee table if we were to involve all the stakeholders who would wish to have a formal input into health and social care integration. How do we ensure that all relevant stakeholders have an input into that integration? To what degree does that have to be specified in the bill?

I am aware that there is a nervousness around the fact that, as soon as we start to specify stakeholders in the bill, if an organisation is not represented, we get a two-tier system in stakeholders. I am also aware of how unwieldy it could be, depending on the strategic implementation.

What are the witnesses’ views—not only those of their organisations—on stakeholder involvement? What should be in the bill? How do we ensure that it is dynamic and focused but not unwieldy? How do we ensure that it is important?

Rachel Cackett: One of the important points that we must take into account to begin with is what the involvement is for. Many people have a justifiable desire and need to be around the table in different ways.

One issue for us—which will not surprise you, given the RCN’s submission—is that, although the policy memorandum to the bill is very clear on what the bill is trying to achieve, that is not always translated into the wording of what is on the face of the bill. I know that our organisation is not alone in saying that.

One of the key issues for us is the fact that the bill does not address what we think should be fundamental to any care service: the issues of quality and safety. With those issues missing from the principles of the bill, other issues that follow on from them are also therefore missing. Those issues include the really important issue of how we give assurance—to you as MSPs, to the governance committees of the different organisations, to local councillors and to the general public—that the services that we are commissioning and the services that are being delivered in an integrated way are genuinely safe.

I was very interested in the discussions in your first evidence session this morning because of the issue around the acute sector that came up. I have been working on these issues for the past 18 months to two years, and I have noticed how often the issue of the acute sector becomes about acute sector moneys rather than the quality of care that is delivered—care that may now be in the community rather than in the acute sector.

On the basis of that, it will probably not surprise you that, speaking from the point of view of nurses as part of the clinician community, I think that we have a fundamental role in ensuring and giving assurance that the quality and safety of care that is delivered is absolutely top notch.

It strikes me as somewhat surprising, given that we are debating the bill post the Francis report, that that point is not clearer on the face of the bill. There should be ways of writing it in. I think that there are many ways that we can do it, but there should be ways of ensuring that the primary legislation makes that quality and safety of care a key point and that those who are responsible for assuring it at a local level—whether that is the director of social work or the director of nursing—have a clear route to give that assurance to those who are governing.

Dave Watson: Bob Doris’s question raises the issue of governance of the joint bodies, and I think that there is some confusion, in particular with regard to the body corporate option.

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 employers. The staff governance arrangements around that seem to be somewhat muddled and confused.

An example of the issue would be the mess that we got into with the Police and Fire Reform (Scotland) Bill. We pointed out when the bill was going through the Parliament that staffing governance was not clear, and the Justice Committee spent six months dragging in the players to try to sort it out afterwards, so there is a lesson to be learned there.

The risk of leaving staffing governance muddled is that, as the Convention of Scottish Local Authorities and others have rightly pointed out, the bill has a massive barrage of powers for ministers. Reserved powers are fine—you would expect that in the bill—but the powers of direction are immense. In my experience, they are the most immense that I have seen at any time.
The risk is that, if the bill does not deliver the outcomes that ministers want, the approach might lead to top-down integration models. As we have seen from the work that the Scottish Parliament information centre has done and the work that the Association of Directors of Social Work has done on the international studies, top-down integration simply does not work.

Gabrielle Stewart: The Allied Health Professions Federation Scotland represents 12 professional groups and we are about the same size as the number of medics within Scotland. The previous witnesses talked about inclusion within the bill team when the bill was being created—we have not been included, but we definitely want a seat at the table. We are involved at the rock face, getting people home or helping them to remain in the community, and we think that, if we are not included within the decision-making joint boards, there will be a real loss of experience and of the positive contributions that allied health professionals can make.

Dr Gillies: The issue of stakeholders is difficult, but I tend to agree with Rachel Cackett that being a stakeholder depends on what you bring to the table.

What we do not want to do is embark on considerable legislation with all the costs and upheaval that that will entail and end up with something not very different from what we have at the moment. Many of us are concerned about that and, in my view and the RCGP’s view, we need to ensure that by April 2015 we have a system that has the capacity to innovate, do things differently, and release the talents and capabilities of all the professionals and service users who are stakeholders.

We feel that there should be general practice representation on the partnership boards because we are responsible for making often crucial decisions on whether someone stays at home or in a homely setting or goes into hospital. Given that we make such high-impact decisions with regard to the system’s operation, we should be able to bring our views to the table.

I hope that I will have an opportunity to talk about how locality planning will function in the new system because I think that it is a really crucial element of the bill. The bill needs to make a difference to what happens to individuals, whether one calls them clients, patients or service users. In that respect, what happens at locality level is probably as important as what happens at partnership level, and general practitioners—and, indeed, social workers, AHPs and community nurses—could play a major role in shaping local services.

I will have more to say on that matter, but I think that that will do for now.

Dr McAlpine: As an acute clinician, I think that I have a reasonable awareness of the issues on the acute side of things. I was therefore slightly concerned about one or two comments in the previous evidence session.

It was suggested, for example, that the acute sector could be a source of money that could be moved into the community. We must be aware that older people in particular are very big users of acute care, and in this discussion we should remember that an unplanned admission is not necessarily a bad thing. The term “avoidable” needs to come in somewhere. There is a lot of discussion about the cost of unplanned admissions, but many of the people involved have had acute strokes, heart attacks or pneumonia. Those things will continue to happen and are expensive, because hospital care itself is expensive.

I think that geriatricians welcome integration, but we need to look at smoother pathways. Older people are concerned about the extent to which they have to hang about for treatment and the fact that they do not know how to get things, and we should look at how systems can be made better. The role of AHPs is absolutely key to that.

As for stakeholders, if you asking about who should be at the table and why they are there, I have to say that health and social care are both a bit bedevilled by lobbying groups, who are, of course, there for a purpose. We need to examine how we make the care of older people and indeed all patient groups most efficient and effective, because that is what consumers are looking for.

Ruth Stark: I want to approach the question by considering the actual interface between health and social care. For the social worker getting involved in integration, it is all about working with people who are facing change in their lives, and that should be our starting point when we are trying to measure where we are going with this legislation.

Social workers are interested in three issues—three Ps. The first is preventing people from going into acute services. We are also interested in social protection, which is, after all, a key part of our role, and I have consistently made it clear that one of the bill’s unintended consequences might be its effect on our responsibilities in that respect. I am thinking, for example, of child protection, of children whose parents are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, of human rights issues for those so detained, such as their right to live in the community, and so on. The third P that I am concerned about is participation. The people in the
driving seat must be those who are using our services.

11:30

I was very struck by recent evidence from the Mental Welfare Commission for Scotland about the development of the Edinburgh crisis centre, which has helped people subject to the necessary intervention of a compulsory treatment order to stay in the community. That has resulted in fewer hospital admissions in the Edinburgh area, as people are now being treated in the community. The centre is a really good example of how people are addressing the issues of prevention, protection and participation.

The question is whether the stakeholder body that you are asking about will address such issues. The important point that emerged from the evidence from the previous panel of service users is that they need to be in the driving seat with regard to what is happening to them. Anything that happens in our services must feed into that message.

Dr Taylor: Before I answer the question, I should point out that I am representing mental health services this morning.

The health and social care partnership board must represent the partnership, and we need corporate governance and a clear understanding that the responsibility of every board member is to represent everyone, not just special interest groups. That is what I expect from health boards, and I assume that the same will apply to local authorities.

There is a need for wider consultation of stakeholders, because we need to involve everyone. The groups in question cover a wide range of people; I know, for example, that my local patient and service user group would like to be represented on each of the health and social care partnerships. We certainly need mechanisms to allow that to happen.

Mental health groups are concerned that they will not be represented because the fact is that not everyone can be represented. However, if your group is not represented, it will become non-functional. I have attended meetings with large groups comprising chiropodists, podiatrists, dentists, mental health professionals and people involved in older people's services. The problem is that things do not function if too many people are present, but I think that those are practical organisational issues that will be sorted out at a more local level.

Bob Doris: I just have another brief question, convener, because I know that we have a lot to get through.

I am struck by the fact that most of the witnesses focused not on structures but on how their own stakeholder group can be actively involved in improving and changing services. Interestingly, Dr Gillies suggested that most stakeholders are interested in locality planning and Dr Taylor mentioned the need to distinguish between the strategic board's corporate governance and the involvement of interest groups in locality planning.

Do the witnesses think that the majority of stakeholder involvement should be focused at a local level and that we should get locality planning correct and then signed off by the strategic board? Going round all the witnesses again will be time-consuming, which perhaps backs up the point about whether a strategic board can comprise everyone and still achieve focused decision making. Is locality planning the issue for most stakeholders?

The Convener: You have asked the question, Bob, so we will just have to take a risk about who comes in. Rachel Cackett and Dr Gillies have already made bids.

Rachel Cackett: Locality planning is a key issue, but the bill is fairly sketchy about it and at the moment we do not entirely understand how it will work in practice. We have been told that it is the way for professions to get involved, but we would disagree. 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.

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.

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.

Dave Watson: We have argued in our submission and elsewhere that services should be designed from the bottom up in conjunction with users and staff, which was a key element of the Christie commission's report. It is not easy to put that into practice, and there is a tendency to look
for top-down solutions, which we would not support.

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.

I agree with Rachel Cackett. My concern is that, given the powers and the strategic role that the bill assigns to ministers, the scope of localities to design services could be prescribed by that top-down driver. We need to have a reasonable input into the strategic as well as the local side.

Dr Gillies: I would not disagree with anything that Rachel Cackett has said. We are talking about “and also” rather than “either/or”—of course, we will need some professional involvement at the quality assurance and strategic commissioning level. However, the things that will make a difference to individual patients and clients will happen in localities. We will need effective partnership and co-ordination between the professionals, the public and the service users at a locality level, and it is very important that the bill allows for the type of subsidiarity that will enable that to happen.

The Francis report in response to the Mid Staffordshire tragedy has been mentioned. Since the report’s publication, we have had two more interesting reviews from England: the Berwick report and Sir Bruce Keogh’s report on hospital services in England. What came through in both those reports was that quality and regulation is determined not only by structures but by the culture and working relationships on the ground.

Determining what happens and building good relationships at a locality level will be the deciding factor in whether or not the bill is a success. That means having the right sort of professional involvement—including from the groups that are represented round the table today—and some involvement with communities and the community planning process.

As Ian Welsh mentioned, we have models for engaging communities and providing access to local services—through the search engine for the access to local information to support self-management, or ALISS, project, for example—which could contribute to the process.

Dr McAlpine: I agree with what has been said. Our view is that there should be some sort of strategic overview and key goals. From a locality point of view, we must acknowledge that, even if we look only at the older population, some parts of Scotland have a very elderly population while others have a younger or a prematurely aged older population. In parts of Glasgow and in other areas of Scotland, locality planning is key to deciding what the particular local needs are for the population.

One thing that could be done is to look at what was funded through the change fund, which has been mentioned this morning. Most people would acknowledge that some of the things that were funded have worked extremely well, while others have worked less well, which has usually been associated with a reluctance to share things.

Our view is that the key to the integration will be trust. The people—service users, carers, professionals and so on—in the locality planning groups have to trust one another so that they are able to work together, reach an agreement and proceed on that basis.

Gabrielle Stewart: There needs to be a local and a strategic element for allied health professionals. Local planning is really important, but in order to have good strategies you need to understand the workforce. We now have one allied health professional director in each health board, and they will be a useful mechanism as there is one person for 12 professions.

We need to understand the potential of the workforce. We already work across health and social care, in housing and education, and with the third sector, so we have quite an integrated professional body that could really help to shift the balance.

Dr Taylor: To support what I said earlier, I answered the question about locality planning, but I took it for granted that we would have robust clinical governance structures that involve all clinicians. Those structures need to be widened to include particular local authority responsibilities, such as the governance of purchasing services and legislation at that level. The structures need to be expanded in order to develop a concept of care governance—that will be key. Any health board would expect that robust clinical governance structures would be developed for any service in which it is involved.

The Convener: I thank Gil Paterson for his patience.

Gil Paterson: My question is on the same theme, convener.

Dr John Taylor, in his first comments, came closest to saying who he thinks should not be on the joint boards. Almost every submission that we have had has mentioned that integration is not about bureaucracy or structures, yet we are
hearing that practically everyone wants to be on the joint board.

The health service is diverse and contains many functions, as is social work, which contains many different sectors. However, it appears that the board will consist of only two sectors, which are the two big vested-interest groups.

Since the private sector and the voluntary sector make up the third leg of the partnership, is there enough room on the board for even just one person to represent everyone else, as well as the two big vested interests that we are trying to bring together, in order to deliver better services?

Does anyone else have any opinion on who should not be on the board, rather than who should be on it?

The Convener: I do not know whether that is a fair question, but the witnesses can go ahead anyway. I see that Rhoda Grant wants to come in. Are you going to answer that question?

Rhoda Grant: No—I just wanted to add something. It is a good question, but do we need everybody on the board if we have the mechanisms right so that people are empowered to make decisions, right down to the service user at ground level? Is the issue who is on the board, or whether we have the structures right with regard to where the decisions that affect individuals are made?

The Convener: Does that bring us back to the comparison between the lead agency model and the body corporate model?

Dave Watson: The obvious answer to the question of who should not be on the board is, of course, “Everyone other than the people we want on the board.” That is a very easy judgment.

More seriously, though, Gil Paterson has made a fair point: there are an awful lot of diverse interests. The problem is partly down to the governance structure, if we go for the body corporate option. If we go for the lead authority model, the structures are already established—although they would perhaps need to be developed, as others have said.

The difficulty in the body corporate option is that putting in another element—whatever that might be; it could be any of the ones that we have argued for, or another—would upset the delicately planned corporate governance structure. Essentially, the model is aimed at providing a balance between health boards and local authorities, with an alternating chair and other such arrangements.

It is important that we get full user engagement. I have also argued that the staff who deliver the services have an important role in terms of influencing. My point is that we need to reach users, not the other delivery arms. Sometimes, there is confusion between those in the charitable sector who deliver services in a semicommercial way, and those who represent a user interest and have no commercial interest in delivery of services. We need to separate those two sides.

11:45

Gabrielle Stewart: If we want to change the culture, we need to change the people who are sitting around the table. If you simply bring together the people who have sat around the table in a council and the people who have sat around the table in a health board, you will not get effective change. We need to bring in allied health professionals, other professionals and users in order that different decisions can be made.

Dr McAlpine: I agree with that. As I said earlier, you have to think about what the people are there for. Historically, a lot of things have been done by lobbying groups, and you have ended up with dementia versus learning disability versus arthritis and so on. Some of that relates to finances and financial perceptions. There have to be on the boards people whose key remit is to work towards goals of integrating services, and who are not there with a particular representative-group hat on, and so are able to consult other parties and relevant people and bring those views back to the board. For example, you clearly could not have someone from every allied health profession, but you need someone who can bring back the views of people from the acute side, from primary care and so on. You want people who are there with a remit to communicate and to make joint decisions, with a clear idea of why the decisions are being made.

Rachel Cackett: In answering the question, I would come back to the first point that I made, which concerns the question of what it is that people are around the table to do. To pick up on Dr Taylor’s point around governance—or clinical governance, as we would have called it in the NHS—there is an important issue about how we can ensure that governance of our services is right from a care point of view.

We have an issue—I think that there are in the bill lots of such issues that we have not yet ironed out—around the fact that we are trying to bring together two quite different organisations. From a health point of view, we would, as a matter of course, have on every board a director of nursing who would have responsibility for the quality of care that is being delivered by that board; in that board, that is the ultimate assurance mechanism on quality of care. That is a standard element of the governance arrangements in the NHS, but that is not replicated in councils, which work on a very
different level and whose directors of social work do not have quite the same role as the directors of nursing in the NHS, because of the structures of local democracy.

The bill proposes, in the loosest sense, to bring together two mechanisms that have slightly different expectations of how we may facilitate governance. The director of social work and the chief social worker are clearly there to give advice to local councils, but they do not do so in quite the same way as the director of nursing would as an executive member of an NHS board. We have to grapple with what that means in the body corporate model, particularly when we are creating a new body, and we have to remember that, as the bill is written at the moment, the strategic plan of the body does not have to get sign-off from the parent bodies; it is signed off at that level, with a lot of responsibility given to that board to ensure that the services that it is designing and planning for the future are the right services and are fit for the local population.

The question that we should keep coming back to is this: why are people around the table? What is their function in the governance, in the body corporate model?

**Ruth Stark:** I want to return to the last point about governance and the point that Dave Watson introduced in relation to where the chief officer sits in the integrated model, and I want to remind people that the chief social work officer has specific statutory responsibilities that relate to people’s liberty, in terms of the powers around child protection, the detention of people under mental health legislation and the advice that is given to courts, in terms of criminal justice. There are some key issues there that are not the same as the health service responsibilities.

When I looked at the provisions in the bill about the person who will be the chief of the integrated body, I was left with a question—I do not know the answer—about who is chief of what and who is the chief when it comes to some of the other statutory responsibilities that fall to the social work profession, and how do they fit into the integrated plan? I envisage that there could, on some issues, be conflict between the chief of the integrated body and the chief social work officer’s responsibilities, and there could be conflict about the health elements, given the statutory responsibilities that certain people have in the NHS.

There is not clarity in the proposed governance structure and I cannot see that it takes us beyond principles that were outlined in the Social Work (Scotland) Act 1968, the children’s legislation, the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000, and adult care and support legislation.

Those are all critical areas that involve social care and social work decisions. How are such decisions to be made under the proposed new legislation? How is the governance worked out? I see no clarity about that.

**Dr Gillies:** The background is important, and I have not heard the issue being raised. When we look at the evolution of the partnerships and the locality planning groups, we see that most people who work for our local authorities and health boards are employees. It is important to note that most general practitioners and some other community providers, including pharmacists, are contractors—we work for the national health service according to a contract, but we are not employees.

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.

**The Convener:** Everybody around the table and all the evidence that we have received agrees that integration is a good idea. Politicians have tried to bring about integration in the past and have not been successful. Maybe we do not all agree about how, but we are all here and maybe there is frustration that we are here considering legislation to produce the general cultural change that has not happened so far.

I have a list of questions. Is legislation necessary? Why have we not made progress without it? How do we create the required cultural change? Is it, as we heard during the previous evidence session, about introducing more positive enforceable human rights for the clients who use the service in order to create a different sort of environment at corporate board level? Is it about incentivisation? Is it about a change in the GP contract? What practical things do we need to do to improve the experience, the quality and the outcome for people who are in receipt of care?

When we spoke to people yesterday in Inverness, they were very enthused about what they can do. They feel liberated by the Highland experience. However, we know from our visit that it is a long-term experience. The real hard choice may be about redesign—or it is, further down the line. What do we do? If we accept that things need
to change, and if legislation is not appropriate, how will we do it?

**Dr Gillies:** I will take up the challenge. 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.

As service users or patients, people do not distinguish between a health need and a social care need; that has been the case for many years. When I started in general practice, the difference between a health bath and a social care bath was carefully explained to me. I had thought it was just that an old body needed a bath.

All the things that the convener mentioned are absolutely necessary. For general practice, we need the continued development of a Scotland-focused contract to ensure that the skills and innovation of GPs can be used outside their practices and at the interfaces with secondary care and social care.

I keep talking about locality planning because I think that the culture change has to happen at local level. We cannot impose culture change from the top. That was attempted in England with the hospital service and it failed. The way forward is a combination of helpful changes at partnership level and strong localities to help to shape the service.

**Rachel Cackett:** The RCN is very clear that services should be seamless wherever you are. I agree that people who are in receipt of services do not perceive a difference between health and social care. Our difficulty at the moment is that our health and social care services are configured so differently, within such different paradigms, that to bring them together is a real challenge.

Do we need the bill? There are things in the bill, and particularly in the policy memorandum, that we support absolutely. There are things that need to change and supports need to be put in place. As I have said, the translation from the policy memorandum to the bill is not always as clear as it could be. Assuming that the bill progresses to stage 2, I am concerned that we may end up with an awful lot of amendments. I hope that that leaves us with a bill that has integrity.

There are many examples where things are already working very well. We have examples in nursing and social work teams of people working together very well on the ground. Our difficulty at the moment in taking that forward and expanding it is that quite often it needs time, and time is an expensive commodity in the public, third and private sectors.

Some years ago, at the start of the single outcome agreements, we held an event for lead nurses to talk about the impact of planning and single outcome agreements, and some of the things that nurses should be thinking about. I talked to two nurses; one was working in an area where integrated working was not going well, but the other said that it was working well where she was. Those two nurses were very close to each other geographically. Their different experiences came down to the amount of time that had been freed up in their teams to allow really simple things to happen—for example 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.

I agree with John Gillies that some of the big cultural shifts will have to happen locally. However, that will mean ensuring, first of all, that there is enough resource—wherever someone works and whether or not they are an independent contractor—to allow the organisational development support and space for that to happen. We are, and we should be, asking our front-line staff to work very differently, so we should be committed to ensuring that they have the resources to do that.

In addition, we need to ensure that, all the way up the chain—to the very top—that push towards integrated working across what are, at the moment, two very different systems is seen and is valued at every level. That comes down to how, at national level, what goes through in the Public Bodies (Joint Working) (Scotland) Bill, what is being done on our community planning processes and what may be going through in the Children and Young People (Scotland) Bill in relation to planning for children, matches up and is as seamless at that level as we expect it to be when it comes to what our front-line practitioners do. Unless all that works together, nobody will make this work.

**Dave Watson:** At the risk of dismaying the convener even further, I have a slide that I use at conferences that lists all the initiatives and legislation on the issue over recent years. Believe me when I say that I had to use very small print to fit them all in. Over recent years, I reckon that, on average, there has been an initiative every 18 months. To be honest, if you talk to representatives of staff at the sharp end about the bill, as I have done, they will tell you that the view...
of front-line staff is, “Here we go again.” They think that it represents another moving around of the managerial deckchairs, and they question whether it will make a huge amount of difference. That is the honest appraisal of staff at the sharp end.

In some areas, the current structure works well, but in others it has broken down. I went to one local authority—which will remain nameless—where the relationship with the health board had broken down. The staff at the sharp end said that they just got on with it anyway; they muddled through. Although they felt that it would have been nice if the high heid yins could have sorted things out, they just got on with delivering the services. Sadly, that is the reality.

To be more helpful, if we look at international studies on the subject, of which there is a long list—I will not go through them; they are mentioned in our submission and in others—they are about getting the relationships right, respecting professional identity, aligning management and getting staff engagement right. Two themes come out of all that work. I have been involved in this area for more years than I care to remember and I was an expert adviser to the Christie commission, which looked at the issue extremely closely. The first thing that hit me was that, as John Gillies said, we need a bottom-up design. There is no top-down, one-size-fits-all solution.

Secondly, it is about people. If we read the bill, we find about one section on staff. The policy memorandum has half a paragraph on staff. The consultation paper, which ran to 64 pages, had half a page on staff. Therefore, my general message would be that, if we are to make integration work, we have to get the people bits right. Frankly, I think that there is too much focus on structures and budgets, and not enough on people.

Dr McAlpine: Similarly, I think that although geriatricians are keen to ensure that older people access acute care when they need it, we are aware that some people do not need to be in hospital, and we certainly feel that some people could leave hospital more promptly. We need to be aware that a big part of the work is to look at how we deal with the increasingly elderly population and the fact that we simply cannot afford to have all those people in hospital in the future. That is a big imperative.

There is sometimes a concern that it all comes down to the view that, given all the different organisations that are involved, if we can just get someone else to deal with the issue, we will shift it out of someone’s responsibility. We have to look at and learn from places such as Highland, which we talked about earlier, and Lothian, which has the comprehensive assessment service for frail older people. Funded through the change fund, it is very much about looking at all the different organisations in primary care, secondary care and social work, seeing how joint responsibility could be taken for improving services, and working together with everyone involved, with the common goal of improving the efficiency and effectiveness of services. There are places where that has worked, but we are probably not always good at spreading information around. It comes back to staff thinking, “That’s this week’s initiative. There’ll probably be another one along next week,” “More pilots than the RAF,” and so on. Unfortunately, those are the sort of comments that we hear from staff.

Malcolm Chisholm: I am prompted by Dave Watson’s comments in the last contribution but one, so I suppose that this question is for him, although it is a more general point. If the approach has to be bottom up and structural change is not the answer, is the bill necessary? More generally, what positive things can we get out of the bill? We have had some comments on that, but I am interested in the comments on quality in the RCN submission. Do the witnesses agree that we ought to build more into the bill explicitly on quality? Another point in the RCN submission that perhaps does not feature strongly in other submissions but which relates to other work that we are doing in the Parliament is about the extent to which it is right or wrong to separate this work from the work on children’s legislation. I am interested in that, too.

As I said, I was prompted by Dave Watson’s comments, so perhaps he can say whether the bill will contribute anything or whether it is just something that he and his members will have to put up with.

Dave Watson: I suspect that I veer towards the latter but, at the end of the day, it can be useful as long as it is enabling legislation that sets a framework. I am simply saying that there is not much in the bill that tackles what needs to be done to get health integration right. If the committee thinks that the legislation and all the words that you put in it will cut the ice, I am sorry to say that they probably will not. It is all the other things that we are talking about that will cut the ice.

I entirely agree with the point about quality. However, although we talk about healthcare integration, the way in which care is delivered in this country, particularly in the community, is a national disgrace. It is delivered by staff who are generally on the minimum wage—sometimes not even that—and certainly not the living wage. They are trekking around. The other day, at a meeting with a group of members, I asked them about the 15-minute care visit, and one of the staff said, “Fifteen minutes? That’s a luxury. You should see what I have to do on a day-to-day basis.”
That is because money is already tight in the area. We can write lovely phrases about quality in legislation—I am all for them and they are great—but we need to address the fact that, by 2030, we will have to find another £2.5 billion to meet the additional costs that are coming down the road when we do not meet the current costs. That has consequences for quality of care, which is the real disgrace. So my answer is this: by all means pass legislation and put warm words in it, but if you want to do something about the issue, you have to sort out issues such as the way in which care is delivered on the ground.

The Convener: We had an attempt at that in a previous committee report.

Dave Watson: Indeed you did.

Ruth Stark: I agree with Dave Watson, as that is what our members say, too, but I want to talk about something that has not yet been mentioned. There is an assumption that we are talking about people who are already engaged in health and social care services. One of our members’ tasks is to reach out to people who are not engaged with services, but those people do not seem to be factored in. We have articulate carers and service users, but an awful lot of people out there who are affecting the statistics on things such as poor health, particularly in places such as Glasgow, are not engaged. Our members reach out to those people, but somehow we seem to have factored them out of the discussion and out of the bill. I do not know how we engage with them, but if we are talking about stakeholders who need to be listened to, they are stakeholders who need to be listened to.

Gabrielle Stewart: I have a comment on the point about including allied health professionals—sorry, but I have lost my train of thought because I was busy listening to Ruth Stark. We want to keep people at home and save the Government money. We have quite a lot of evidence to back up the fact that including allied health professionals in services certainly creates a cost saving.

We have heard about the change funds and good examples. I have my thought back again—it was about being much more evidence based in deciding what we do. That involves looking at things that have worked well, working out what staff ratios made them work well and then sharing that good practice. That is fundamentally important. Although we welcome the bill, it does not talk about quality. The principles are good, but they are not expanded enough. For example, what does “wellbeing” mean? There are risks involved in the bill in that it is purely mechanistic and is not going to create the change that we want to happen.

The other issue was around staff saying, “Here we go again.” A lot of our staff report that they are already working in an integrated way but the systems stop them from working together. For example, they do not have computers that communicate with each other. We had the single shared assessment, but people could not share that assessment other than in written form. In this day and age, we need to talk about integration of the technologies that we use and look at the barriers that prevent communication on the ground.

The Convener: Rachel Cackett was name-checked a couple of times by Malcolm Chisholm.

Rachel Cackett: I was. It will not surprise him to hear that the RCN agrees with the RCN submission that quality should definitely be mentioned in the bill.

On the issues of what is not in the bill and information technology integration, we have talked to our members and there is a report on our website from a member conference that we ran at which IT came high up the list of priorities. We have a system in which front-line practitioners are being asked to share care but they cannot share a medical record. That does not make much sense. There are things that must happen outside the bill that we cannot expect legislation to deal with.

On what Dave Watson said about social care visits, we are interested in seeing quality mentioned in the bill. I hope that it would be more than warm words. It should certainly be about more than looking at the quality of healthcare. One of the reasons for including consideration of quality in the bill is that a consequence of the bill, if we take it to its logical conclusion, is that we will go down a line of commissioning that will almost certainly involve increased procurement. We have some questions about which bits of the budget will go down a line of procurement and which might not—I know that some of that has been dealt with through conversations on self-directed support. In the context of an increased culture of procurement, we should ensure that the quality of care is central to the contracts that will be held and delivered through the new commissioning routes. We should not contract on the basis of cost alone.

I know that we have to be pragmatic and realistic in the landscape that we are in, which is that the public sector does not have the money that it used to have even within what are seen to be protected NHS budgets. Not even the NHS has the money that it used to have because costs are spiralling. In that context, we must ensure that there is something to counterbalance what we see now, which is a tendency to contract on the basis of price. That is not good enough. We need to write something into the bill to deal with that.
The second issue is staffing. At the end of your first evidence session today, a question was asked about the capability of staff, which is central to what we are talking about. It is why we need to think differently about services and perhaps why we have not yet got there in the way that we would have liked. If we are talking about taking services from the health side out of the acute sector and locating them in the community, we need a community clinical staff group that is equipped with the right skills in the right place to deliver the required level of care. In some areas, initiatives such as virtual wards and hospital-at-home services are being developed and delivered across partnerships. Those are important early leaders in how we might go about delivering those services. However, the question is whether we are investing enough to ensure that we have the skills to deliver good-quality care in the community for those who need it, which will become ever more complex given the demography that we are dealing with. I suggest that we are not quite there yet.

The Convener: The financial memorandum to the bill cites a budget of £2 million per annum for health and social care IT.

Rachel Cackett: My understanding is that that is existing money. I know that work is going ahead to look at coming up with an integrated IT strategy by 2014. That is just one year before the process is due to go live. I wait with bated breath to see whether that is enough, given the problems that our members tell us that they see on the ground.

12:15

The Convener: I asked the question in the knowledge that the money is never enough.

Dr Taylor: I go back to the original question, on whether legislation is required. In respect of our members, surprisingly few, if any, psychiatrists said that legislation was not required, partly because I think that it was in answer to the question whether integration was a good idea, and they generally felt that it was.

In many ways, the history of mental health since the 1960s has been about closing large psychiatric hospitals, moving services into the community, and developing community mental health teams, with social workers as core members of those teams as often as not. The best examples of mental health work in Scotland have already gone a long way down that route to achieve what people are trying to achieve in mental health. Obviously, there are variations in different areas.

I suppose that the main concern has been around whether there will be disintegration, and one issue is the number of local authorities and health boards. Is 32 the right number? Is it too large or too small? The number probably matters less than the fact that there are different numbers of health boards and local authorities. We want coherence. Will there be different local authority and health and social care partnerships within the health board area developing different services, or will there be cohesion?

The Christie report often talked about different local authorities working in partnership over areas. An opportunity has been missed to encourage partnership working. It is about having an agreed strategy and agreed coherence of systems. Local authorities already commission services—certainly out-of-hours services—across several health board areas. We have heard other examples, and that is generally considered to be a good idea. A lot of what happens in mental health happens out of hours, so services need to be commissioned over larger areas, and certainly commissioning in individual local authority areas would often not be sufficient. Local authorities will often commission even their own mental health officer services across several local authorities.

Dr Gillies: We made the same point about the need for IT systems that share information across boundaries. As the convener said, there is never enough money for IT. The NHS is famous for throwing money away on IT—certainly in NHS England—but we hope that the bill will be a driver to push that process forward.

Dave Watson and Rachel Cackett brought up the issue of capacity. Last night, I spoke to a GP in Leith who had been on call during the day on Friday. She had had more than 60 patient contacts on the phone, in home visits and in surgery, and she felt that that was possibly beyond the limit of what could be safely dealt with during the day. That was in a fully staffed surgery in Leith.

If we are talking about doing more in the community and adding responsibilities to those of clinicians, doctors and nurses in the community, that will have to be carefully thought through if it is to work. There would be no point in saying that we need to look after more people in the community without having the clinical capacity—I think that I would include AHPs in that—to deal with the resulting workload. Innovative ways of working, including virtual wards, could be used to develop capacity, but we in general practice certainly feel that there is a need to increase the number of GPs to deal with demographic change, and integration will play a part in that.

The Convener: I want to pick up on points that Rachel Cackett made about quality and the impact of commissioning and procurement on that. I am thinking back to our report on elderly care and the national care standards, which are now more than 10 or 12 years old. I think that the Scottish Government accepted that a review was
necessary, on the committee’s recommendation. Is anybody aware of what is happening with that review?

Rachel Cackett: My understanding is that we are now waiting until early next year for the review to begin. I think that work has started and there have been a few public participation and clinician participation events around Scotland.

I agree with where I think your question comes from. If we are going to have a lot of local variation, and we are all talking about the importance of the changes being very much locally led, it should still mean that wherever someone is in Scotland, they should be assured of a national standard of care, even if the way in which those standards are delivered locally is very different. Like you, convener, we are still waiting for the care standards to be updated and made relevant to the situation in which we are all working and receiving services. We should also remember that those care standards, which are setting specific at the moment, do not necessarily cover all the areas of the journey that someone might take from being at home with a low level of services to being in hospital with high levels of acute service.

I would be very keen to see, as I understood we would, the two things happen in parallel. We know that the bill says that the integration plans and the strategic plans must have regard to the outcomes and the principles, but perhaps there is also an argument for them to have regard to care standards as set by the Scottish Government.

The Convener: Does anyone else have a view on that? Is there support for that view?

Dave Watson: Absolutely, but we did have a review of the social care procurement guidance and the rest of it and, frankly, it had no impact at all. You can ask our members in the voluntary sector and even those in the private sector and they will all say exactly the same. Essentially, there is a race to the bottom in that area. Standards are not the issue; it is about how the service can be delivered at the cheapest price.

Gabrielle Stewart: The AHPFS is developing quality service values for all our staff; they should be introduced in the next couple of weeks or so.

Ruth Stark: It is all very well to talk about the standards that are set, but there is the issue of the inspection regimes that are in place to measure the quality of care. They fall very short of doing the task that they are empowered to do. That is partly because authorities and workplaces do not want their dirty linen washed in public. Getting to the root of what some of the issues are in care inspections is a very complex task and it is not sufficiently resourced, or some of the methods are not getting to the issues, and that can lead to unsafe practice.

There are also some issues that my association has tried to take up with the Care Inspectorate and others about employers’ responsibilities in the area of providing high or competent standards of care. We have not yet got that culture right in terms of how we measure standards. We can rewrite the care standards but, if we do not somehow empower the standards that are put into practice, we will have another task to do. That still has to be addressed.

The Convener: The issues about the inspection regime have most recently been in acute settings and residential homes. The committee has had discussions about what will happen when we move to more care being delivered across the community. If we face a big challenge now in hospitals and residential settings, the challenge in the community will be really significant.

Ruth Stark: But the real judges of the quality of care are the people who use the services. How are we listening to them? There is a big issue about how easy it is for people who use services to make complaints or observations to the people who are charged with carrying out the inspections. That level of communication takes us back to the Christie report and to what happens on the ground and how people feel empowered to communicate with one another about the quality of care.

If that does not happen at ground level, we will continue to have incidents in which people are not well looked after. There is a real issue about how to empower people to communicate at that level. You can set standards and goals, but if you do not listen to what happens on the ground, you will not achieve anything.

Bob Doris: I have listened carefully to various things, including the point about the need to get the IT right. I still have the scars from two committees in relation to the IT for waiting lists and the TrakCare system in greater Glasgow in particular.

Although this is not a commissioning bill, commissioning could play a greater role in it, and I have listened carefully to some of the concerns about commissioning.

The key point about the bill is that it aims to compel local authorities and health boards where integration has not happened. That is probably why, for some people round this table, it is a bit sparse because it is almost a bill to compel integration in areas where it has not happened, rather than a bill to dictate what that will look like. I note, however, that COSLA thinks that there is too much in the bill already and that it would like us to strip some of it away. It is important to mention that.
Mr Watson said something that I thought was quite positive. [Laughter.] I will not say that it surprised me.

**Dave Watson:** I like to surprise you.

**Bob Doris:** That is for sure.

You said that there are examples in local areas of people just getting on with it and that there is good practice. This afternoon in the Parliament, we will debate “The keys to life”, the learning disability strategy, which is all about health and social care. This afternoon is the time to debate that. In that debate, we might also mention the situation that has arisen in Glasgow because staff or service users have not necessarily been included in service redesign. I will let that sit, but it is an example of another area in which people could just get on with closer health and social care integration. Much of the focus has been on adults, elderly services and children’s services, but are there other examples of where you would like local authorities and health boards—with the stakeholders of course—to just get on with it?

**Dave Watson:** Given our difficulties with the bill, I would be wary of leaping into new areas before we have sorted the current ones. I find that I agree with the COSLA submission more often than is probably good for my career. COSLA is right about many of those issues.

The example to which I alluded earlier was, interestingly, in learning disability. When a local authority and health board in an area not a million miles away from yours, Mr Doris, fell out and that was all over the newspapers, I spoke to one of the learning disability teams. I asked whether there was a problem, but they said no and that they just get on with it and muddle through. My point is that staff should not have to get on with it and muddle through. It is possible to put frameworks in place. It is a question of getting the balance right.

Where we can do something useful, I agree that it should be bottom up. I have said several times that I agree with COSLA. The problem with compelling is what you compel. The way to deal with the issue is certainly not for a person in Edinburgh to tell everybody what to do. That is where I agree with COSLA in relation to the powers, and we made a similar point in our written evidence. You can help from the centre with the frameworks. We have talked about that in relation to care frameworks and standards and, as we said in our submission, staffing frameworks.

All too often, people in this room, in particular those of us who have a trade union function, spend their time reinventing the wheel with this type of public service reform, over staff transfers, pensions and procedures. That might seem to be boring and mundane, but it is the stuff that causes disputes and difficulties at local level. I hope that you will take from our evidence on this point that we have set out what could be a useful national staffing framework that then educates local staffing frameworks and which stops us reinventing the wheel on some issues. It is not about deciding from the centre, but it is about setting out some common grounds.

As a trade union lawyer, I can see dozens of potential legal difficulties with the bill as it stands in terms of staffing issues. For example, when a hospital closes as a result of a budget change, the question will be who made that decision. Was it the health board or was it the third party? Have we worked out how staff will be seconded? Have we sorted out the issues of staff on different terms and conditions? The answer is no. Such matters are mundane, but they are absolutely key to getting better integration at local level.

**12:30**

**The Convener:** When we were in Highland yesterday, I raised the industrial relations problem and the risk, which COSLA and others have referred to, of underwriting equal pay claims and everything else. We spoke to health people but, perhaps naively, they discounted that level of risk, as the practice in Highland has been free from that. Your experience might be different, but it is important to put those views in Highland on the record.

**Dave Watson:** Sure, but I urge caution for two reasons. First, Highland has not chosen the body corporate model, but most of the legal difficulties that I am highlighting come as a result of the unknown body corporate model. Secondly, in Highland, the difficulties of a straight staff transfer situation and having one clear employer have not all been resolved and there will continue to be difficulties. We had to reinvent the wheel through countless hours of work in Highland just to get things to work, so it was not an easy process. All I am asking is whether we want to reinvent that 32 times in the next few years.

**The Convener:** I appreciate that.

**Dave Watson:** In my view, there is no need to do that. We are a small enough country to be able to do that as part of a national framework.

**The Convener:** You will not want to agree with COSLA again, but it questioned whether the Scottish Government would underwrite any equal pay claims. Do you see that as a significant risk?

**Dave Watson:** Equal pay is certainly one of the risks in a range that includes the equality duty and equality impact assessment duties. Equal pay could certainly be an issue, as the law stands. We have not sorted out the outstanding equal pay issues—that of course is an issue for another.
committee—and health and local government still have outstanding cases. My desk is groaning with the number of legal cases that I have on the issue. Frankly, we would all like to avoid creating a new tranche.

Gabrielle Stewart: I have one more point about the bill’s remit. The integration of two bodies does not prevent integration with other services. However, as Rachel Cackett said, the issues are time and investing in staff, who perhaps have the potential to be more creative with their services. Integration should be seen more broadly as involving services for housing, mental health, children and education. There are many opportunities, and I see the bill as a step in the right direction.

The Convener: On that note, you have the last word, Gaby. I thank you all for the written evidence that you provided and for your appearance here today.

Meeting closed at 12:33.
Public Bodies (Joint Working) (Scotland) Bill

Audit Scotland on Behalf of the Auditor General for Scotland and the Accounts Commission

Introduction
1. Audit Scotland is the public sector audit agency undertaking the external audit of the majority of public sector bodies in Scotland. We do this on behalf of the Auditor General for Scotland (for the NHS and central government) and the Accounts Commission (for local government). We provide this written evidence to assist the Health and Sport Committee’s scrutiny of the Public Bodies (Joint Working) (Scotland) Bill.

Background
2. The Auditor General and the Accounts Commission welcome the opportunity to comment on the Public Bodies (Joint Working) (Scotland) Bill and to contribute to the future integration of adult health and social care in Scotland. This submission refers to the experience and audit evidence gathered through the work Audit Scotland has carried out on our behalf. This response draws on a wide range of audit work, but in particular Audit Scotland’s reports on Review of Community Health Partnerships (June 2011) and Commissioning social care (March 2012).

3. The Committee invites comments on a number of questions and we have focused our response around them.

Question 1: Do you agree with the general principles of the Bill and its provisions?
4. We support the principle that public services should be designed around the needs of the service user, and that public bodies should seek to overcome the organisational barriers that get in the way of delivering seamless integrated health and social care. Over a number of years, Audit Scotland has highlighted the need to improve how health and social care services work together to meet the needs of the people of Scotland. It is essential that services are able to work well together to respond to needs whilst making the best use of existing resources and delivering high quality services. We have highlighted in several reports the need for barriers to partnership working to be addressed and the importance of having a joint vision and clear priorities for the use of shared resources. It is encouraging that the Bill seeks to address these problems.

5. In our previous report on Community Health Partnerships (CHPs), we highlighted that a more systematic and joined-up approach to planning and resourcing health and care services is needed to ensure that health and social care resources are used efficiently. We saw few examples of good joint planning underpinned by a comprehensive understanding of the shared resources available. This message was echoed strongly in our work on Commissioning social care where we found slow progress with strategic commissioning and limited joint working. One of our concerns about CHPs related to their lack of strategic influence over how resources
were used in the local area. The principles in the Bill aim to improve these issues, however, the change needed is significant and this is a challenging agenda.

**Question 2: To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**

6. The Bill requires NHS boards and councils to work together to meet the needs of the people in the local area. There are specific aspects of the Bill that should address some of the concerns we have raised in previous audit work and help to achieve the stated policy objectives. In particular, the obligation to prepare, publish, monitor and report against a local integration plan, and involve and consult with service users and carers in developing the plan, should provide a focus for driving forward the policy intention of the legislation. The extent to which this will be effective will be dependent at least in part on the quality and effectiveness of local leadership and the commitment of local partners to the plan and to the delegation and sharing of resources. Similarly, the role of the Integration Joint Monitoring Committee will be important in providing oversight and challenge.

7. However, the change needed is significant and there are some areas of the Bill where more detail is needed.
   - It is not clear from the Bill how local people will be engaged in the changes proposed, whether the new partnerships will be central or local government bodies and how audit arrangements will operate.
   - To date, GPs, clinical professionals and social care staff have not been fully involved in service planning and resource allocation for health and social care services. The lack of influence that CHPs have had over overall resources has been a barrier to professional staff engaging with CHPs. This needs to be addressed because these professional staff influence a large proportion of the health and care budget as a result of their decisions. The role of professionals is unclear in the Bill.
   - The Bill provides little detail about how locality arrangements might work in practice. There needs to be a real contribution from professional staff groups to informing how resources are used and services improved.

8. In our report on Community Health Partnerships, we highlighted that partnership working between one or more organisations is challenging due to the differences in accountability arrangements and differences in organisational cultures, planning and performance and financial management. The proposals set out in the consultation appear to address some of these challenges but greater clarity is needed in some areas, include how acute NHS resources will be affected and how funds will flow via the new arrangements. The real test will be how the partnerships work in practice.
9. There are lessons to be learned from other partnership arrangements. When commenting on Community Justice Authorities in *An Overview of Scotland’s Criminal Justice System*, we noted:

> “Although CJAs were established in 2007, there are no agreed measures to assess their performance or impact. As a result, CJAs use a range of different performance indicators developed locally with different systems for reporting and presenting data. CJAs have recently agreed to improve information sharing and to look at developing a common set of core measures and associated information requirements. The lack of agreed performance indicators across the range of services designed to reduce reoffending means the cost-effectiveness of different local projects cannot be compared.”

10. The proposals set out in the Bill seek to avoid some of the above limitations, for example, the expectation that the local strategic plan will have regard to national health and well-being outcomes should ensure a greater focus on performance expectations.

**Question 3: Please indicate which, if any, aspects of the Bill's policy objectives you would consider as key strengths**

11. Our reports on CHPs and Community Planning Partnerships (CPPs) highlight the importance of applying certain key principles to underpin successful partnership working. It is encouraging that the Bill recognises the importance of these key issues, including the need for leadership, vision, clear roles and responsibilities and for risks to be identified and managed. Accountability arrangements and processes also need to be clear. Partners should have a shared understanding about what success looks like and that there are arrangements in place to monitor and publically report on progress. Although these issues are identified in the Bill, this needs to be an area of focus when the Bill is implemented.

12. We have commented in a number of our reports about the lack of joined-up, transparent and comparable performance measures for health and social care services. This makes it very difficult to build a clear picture of relative performance and does not help the public or the Scottish Parliament to be assured about the quality and efficiency of the service. Therefore, we welcome the proposal for a set of nationally agreed outcome measures. When taking the Bill forward, it is important to be clear how these new measures will fit with existing frameworks such as Single Outcome Agreements (SOAs) and HEAT.

**Question 4: Please provide details of any areas in which you feel the Bill’s provisions could be strengthened**

13. There are a number of key issues not addressed within the Bill or associated documents, and further information is needed to understand how these changes will work in practice. If these issues are not addressed in the Bill, they need to feature in subsequent implementation guidance. These issues fall into six main areas:
• **Resources.** In previous audit work we have highlighted that, for successful partnership working, it is essential that budgets and resources are clearly set out and agreed by all partners. The partners should be clear about the rationale for how money is allocated and spent, and efficiencies should be sought through sharing of resources and improved ways of working. There needs to be transparency about how devolved budgets have been determined and what resources are included in the devolved budget. Our work has shown that these key principles have not been applied fully in partnerships in Scotland to date.

From the information in the Bill, there are clear potential risks and tensions around how organisations will determine which budgets will be included in the integrated budget and the implications of this for their own governance and accountability arrangements. It is essential that there is clarity at a local level about governance and accountability arrangements and how risks will be identified and managed, and that there are effective dispute resolution arrangements in place. There is no minimum requirement for resources or services to be included in the new arrangements. This creates a risk of significant differences of approach across the country.

Linked to this point, it is unclear from the Bill the role that other policy areas will play, specifically housing. It is important that the new arrangements maximise the valuable contribution that housing can play in improving care and support for older people. More details on how self-directed support and personalisation of care will be addressed through the new partnerships would also be useful.

• **Links between health and social care integration and Community Planning.** The relationship between the new partnerships and the existing Community Planning Partnerships (CPPs) is not clear from the Bill. There is a need for a clear articulation of how these new arrangements fit with CPPs given the significant leadership and co-ordinating role for local public services that the Scottish Government/COSLA see for CPPs in their Statement of Ambition for Community Planning and Single Outcome Agreements. That document identifies community planning arrangements as being at the core of public service reform and ‘providing the foundation for effective partnership working within which wider reform initiatives, such as the integration of health and adult social care… will happen.’ Specifically it is not clear how accountability and outcomes/performance management will link between CPPs and the new health and social care partnerships. It essential that sound governance and accountability arrangements are in place. Any new governance and accountability arrangements should be effectively aligned with existing arrangements to avoid further complicating approaches to governance and accountability - we noted in our report on Community Health Partnerships that:

   “Approaches to partnership working have been incremental and there is a cluttered partnership landscape. CHPs were set up in addition to existing health and social care partnership arrangements in many areas. This has contributed to duplication and a lack of clarity of the
role of the CHP and other partnerships in place in a local area. There is scope to achieve efficiencies by reducing the number of partnership working arrangements”

Given that the new integrated arrangements will be responsible for significant resources, and may opt to include other services, such as services for children, it is even more important that the links to CPPs are clear and fully understood.

- **Implications for audit and scrutiny arrangements.** The Bill does not set out whether the corporate body will be a local government or central government body. This has significant implications for financial arrangements and for the audit function. There are other potential issues for auditing and other scrutiny arrangements because of these changes. Specifically, if local partners opt to establish a body corporate there will be implications for internal and external audit arrangements. For example, the VAT status of the new body will need to be clarified. These issues have implications for audit and inspection arrangements as well as Parliamentary scrutiny. Furthermore, there are different budgeting cycles for NHS and Local Government bodies. It is also unclear from the Bill and associated documents, how the external audit function will be funded and arranged and how it will work in practice. In taking forward the new arrangements, consideration will need to be given to audit committee and scrutiny arrangements, alongside the external audit issues we have raised. There is a need for more detail on how these integrated services will be regulated and inspected through the work of Healthcare Improvement Scotland and the Care Inspectorate to ensure that there is appropriate independent public assurance about the performance of the new partnerships.

- **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 needs 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.

- **The role of health and care professionals.** The Bill recognises the importance of health and social care professionals being at the heart of making the partnerships a success. However, there is a lack of detail on how this will work in practice. We recognise the need for a degree of local
flexibility to allow partnerships to respond to local needs, but we have noted in previous audits that historically these professional groups, such as GPs, have not played a key role in partnership working to date. Their involvement will be critical to the success of the new arrangements.

- **Ministerial powers.** The Bill gives Ministers wide-ranging powers to make certain decisions about how services are planned and delivered locally, including powers to issue directions to local authorities, health boards or integration joint boards, about the functions related to the Bill, or in the integration plan. These powers are potentially significant, in particular in relation to the role and responsibility of local government. For that reason, more information on the circumstances in which Ministers might seek to exercise these wide-ranging powers would be useful.

**Question 5: What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

14. The new arrangements will require NHS boards and councils to improve and share information on how resources are used locally for specific groups within the local community. Audit Scotland has highlighted a number of gaps in information which could be addressed through this approach. Specifically, we have highlighted previously a lack of information on community services to inform how best to use shared resources for the local area. The new arrangements may make it easier for health and social care providers to see their services as part of a single system of care, making it easier to reduce overlaps and to ensure that people receive the care they need, while best use is made of existing resources.

15. We recognise the major challenge in integrating health and social care services. We have previously commented that there has been no large-scale shift in the balance of care to community services and on the lack of joint resourcing in Scotland, and consider that many partnerships will find agreeing on the resources to devolve to the integrated budget difficult. Our recent report on Commissioning social care found that there was a way to go to develop how services are planned and commissioned within a single agency, not least between partners. This will be a major change for partners and require strong leadership, investment and support to make the change.

**Question 6: What effect do you anticipate integration plans will have on outcomes for those receiving services?**

16. The intention from the Bill is for a clear change to how services are planned and managed as a result of the proposals. The Scottish Government, and local agencies, will need to consider the potential cost implication of these changes and the impact on professional staff who deliver frontline services. The focus should be on improving outcomes for local people as well as on integrating systems and services. 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 are welcome. The Bill provides the opportunity for better
coordination of services and making better use of available resources at a local level.

17. Any outcome measures must be transparently reported and available to the public and this information should be used to drive improvement. National measures are useful but partners also need a mechanism for ensuring local needs and priorities are met and for measuring the difference that specific services are making to the individual.

18. The Scottish Government, together with NHS boards and councils, will need to ensure there is minimum disruption to existing services and service users during the move to better integration. NHS boards and councils need to continue to deliver services to those who need them during this period of change and must ensure that people are not adversely affected. Whilst these changes are under way, it will be important to maintain the progress made by CHPs at a local level.

Audit Scotland on Behalf of the Auditor General for Scotland and the Accounts Commission
2 August 2013

Further information
We hope that you find our comments helpful. Should you require any further information please contact Fraser McKinlay, Director of Performance Audit and Best Value, Audit Scotland, 18 George Street, Edinburgh, EH2 2QU, e-mail fmckinlay@audit-scotland.gov.uk.
Public Bodies (Joint Working) (Scotland) Bill

The Care Inspectorate

Introduction

1. The Care Inspectorate is the independent scrutiny and improvement body established under the Public Services Reform (Scotland) Act 2010, that brings together the scrutiny work previously undertaken by the Care Commission, HMIE child protection team and the Social Work Inspection Agency. Our role is to regulate and inspect care and support services (including criminal justice services) and carry out scrutiny of social work services. We provide independent assurance and protection for people who use services, their families and carers and the wider public. In addition, we play a significant role in supporting improvements in the quality of services for people in Scotland.

2. We are responding to this call for evidence on the basis of a range of inspection findings. In addition to our ongoing inspection and regulation of registered care services, our views are informed by six years of inspections of social work services and two three-year programmes of joint inspection of services to protect children. We have also developed and piloted a new model for scrutiny and improvement of services for children, young people and families provided in local authority areas. The new approach, undertaken in partnership with colleagues from other inspection agencies, is based on the premise that positive outcomes are achieved when agencies work effectively together with a clear focus on the interests of children and young people at the heart of their activity. We are also piloting joint inspections of adult services in partnership with Healthcare Improvement Scotland (HIS). These inspections are intended to align with the Scottish Government’s policies for the integration of health and care.

Do you agree with the general principles of the Bill and its provisions?

3. We fully support the principle of a person-centred approach to service planning. We also agree with the principles of continuous improvement, particularly with regard to the focus of improving personal outcomes for people who use services. From experience of inspecting, we are aware that whilst there is evidence of good practice there is still work to be done to ensure that all services are delivered in an integrated and seamless manner. We would like to see a consistency of good practice across Scotland resulting from the implementation of this legislation.

4. We support the planning principles set out in section 4 of the Bill. We have evidence, in particular from the inspection of child protection, that when these principles are realised it is more likely that better outcomes

---

1 Education Scotland, Healthcare Improvement Scotland (HIS) and Her Majesty's Inspectorate of Constabulary for Scotland (HMICS)
will be achieved. We are also fully supportive of the principles which focus on prevention as stated in the Bill. We would, however, highlight that there needs to be appropriate management of risk to service users while systems change to reflect the principles of the Bill.

**To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**

5. We welcome the approach to develop high level national strategic outcomes with regard to health and wellbeing and look forward to seeing the detail of the work on outcomes. We are also happy to provide advice and support based on our inspection findings. From a regulatory perspective, we would suggest that the work currently underway on the National Care Standards be linked to the strategic outcomes for health and wellbeing. We also believe that placing human rights and dignity at the heart of standards would help ensure a person centred focus. Involving, empowering and supporting people who use services and their carers in the identification of personal outcomes cannot be overemphasised. Any future development of inspection methodology could focus on the agreed outcomes and base accountability and improvement on these agreed measures.

6. From our experience of regulation and inspection, we believe that structural change alone will not achieve the desired change and improvement. We, therefore, welcome the approach that has been taken to create a framework to support integration at local level. The impact of the proposals will rely on effective and robust partnership working. We support the need for effective partnership working as a tool to achieve improved outcomes by committing partners to mutual objectives. We have observed that where there is effective strategic leadership and partnership working then the desired cultural change can be achieved and does lead to improvement for people who use services. Cultural change and a willingness to share resources, alongside better and quicker decision making can lead to better outcomes for individual service users.

7. Effective self-evaluation and improvement at all levels underpin success in inter-agency delivery. Overcoming technical difficulties is key to supporting effective joint working by those who are delivering the service. For example, from our pilot inspections of older people’s services we have found that it can be difficult to access records for service users across services. Ensuring more effective information sharing across partnerships will be a key enabler. We would suggest that mutual ownership of robust performance information is desirable.

**Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths.**

8. **Joint Commissioning:** The proposal to strengthen joint commissioning arrangements is welcomed. In our experience, local
authorities, health services and Community Planning Partnerships are at different stages of readiness in this work. Through our joint inspections, the Care Inspectorate and HIS are well placed to focus on the effectiveness of joint commissioning, and the Care Inspectorate can examine the outcomes of those commissioning strategies on service users through inspections of regulated care services. Effective strategic commissioning is essential to the success of the partnership, however the complications involved in assuring quality in this area need to be recognised.

9. **Joint accountability**: We welcome the jointly accountable nature of new ‘partnership’ arrangements, including the leadership of one jointly accountable officer. This should strengthen joint ownership of processes, services, resources and, ultimately, outcomes for people. We would wish to note the importance of co-ordinated financial management and financial governance in ensuring that partnership working is effective and delivers desired results.

10. **Outcomes focus**: We strongly support the emphasis on outcomes-based practice and the reinforcement this gives for service commissioners, providers and stakeholders. We also strongly support outcomes being individually based and strategic outcomes being rights based.

11. **Major social policy change**: We recognise the degree of cultural change needed and that this will have far reaching consequences for providers, commissioners, stakeholders, practitioners, carers and service users, and we welcome this approach. Through our joint inspections, the Care Inspectorate and HIS will be able to report on the reach and impact of cultural and organisational change on realising improved outcomes for people.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.

12. **Governance routes**: Whist recognising the need for local variation, we believe it would be helpful to have more clarity about the existing and proposed governance routes and the definitions and decision-making capacity and accountability of each - community planning partnerships; boards; and joint partnerships. We also recognise that partnerships will follow either the lead agency or new corporate body model and as such will have different accountabilities and governance arrangements. Through our joint inspections, the Care Inspectorate and HIS we will be assessing the impact of each model.

13. **Aligning targets and standards**: We would welcome further detail and guidance on the alignment of current targets with the proposed national health and wellbeing outcomes, and the subsequent scrutiny of each, linked with joint accountability.
14. **Information sharing:** We welcome the inclusion in legislation of information sharing, and would suggest that this needs to be more robust. Existing data sharing partnerships and the Data Protection Act, which should both act as an enabler to information sharing across boundaries of confidentiality, are all currently available. However, in inspection we have found that information sharing can and does cause a degree of anxiety. Our evidence from inspections is that sharing information and access to shared information can be challenging and not always overcome. Our experience in joint inspections of services to protect children and joint inspections of services for children and young people is that a clarity about expectations of when, how and what to share is of great benefit for staff and highly supportive of robust and consistent practice.

15. **Models of scrutiny:** We believe that scrutiny at all levels can contribute to and support the implementation of joint working. We understand that as scrutiny bodies we will require to be responsive in designing inspection processes in order to ensure consistency of approach whilst reacting to local arrangements. We would propose to adapt our inspection approaches to be able to evidence quality and to support improvement.

16. **Joint performance:** From our inspections to date, it is rare to find models of joint performance management and where it has been implemented, it is in its very early stages. Exceptions may be found in some areas, for example, where child protection committees have strengthened the suite of management information being gathered and analysed routinely and then used it to monitor performance, but even here, finding accurate and useful sources of joint data is a challenge. Guidance regarding scrutiny processes would provide consistency in measurement and evaluation across the board. We would propose that inspection could focus on key themes, such as the effectiveness of preventative work and the impact of strategic commissioning.

17. **Co-production:** Working with local communities in the development of integration plans, including those who currently use services, should be emphasised and is as important as the involvement of service users in the design of their own care plans.

**What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

18. **Integration plans:** We hope that integration plans will follow clear, consistent and accessible guidance regarding content, format and style. There will be benefits for scrutiny processes in terms of inspecting consistently and to a single shared format and understanding. In this way, service providers and service users, their families and carers will understand what is being measured, in what way and to what standard. In turn, this will allow a more global measurement and trends to be evaluated and best practice to be
disseminated nationally as well as locally. Clarity of plans and monitoring the effective implementation of local plans will allow scrutiny bodies to identify that services are delivering improved care for people who use services and their carers.

19. **Outcomes focus:** The focus on personal outcomes for people who use services will reinforce both the national agenda and provide the basis for scrutiny which is in line with the recommendation of the Christie Commission. For this to be relevant to individuals, it also must be linked to strategic commissioning plans which focus on the individual receiving a service.

**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

20. Inspection findings show that the most effective plans are those which are well understood and delivered as intended. We believe, therefore, that this is strengthened through effective quality assurance and scrutiny processes both internally through self assessment and externally via scrutiny bodies.

21. 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.

22. The involvement of NHS acute services in the partnership is crucial to the effective delivery of services to people as they move from home (including a care home) to hospital and back home.

23. We believe that the governance arrangements still need to be further clarified through partnership arrangements. From inspections, we are aware that, often, levels of administration or bureaucratic processes within services can create challenges for service delivery to people who use services, their families and carers. We would welcome further clarification within the Bill.

24. We are not yet clear about what will happen to partnerships who do not comply – for whatever reason – with the requirements to have integration plans in place. As a scrutiny body, we would seek to clarify whether we have a responsibility or role in this area.
25. The Care Inspectorate looks forward to playing a key role in the scrutiny of care services that are integrated, ensuring that everyone who uses these services receives a quality of care that reflects their needs and promotes their rights.

The Care Inspectorate
2 August 2013
Healthcare Improvement Scotland is working closely and effectively with the Care Inspectorate on the joint inspection of health and social care and related activities, as detailed below. While we are in agreement in our support for the policy objectives of the Bill and several other aspects of our responses, we have agreed that submitting separate responses will provide the best opportunity to reflect the respective strengths and expertise of our organisations.

Introduction
Healthcare Improvement Scotland is a health body formed on 1 April 2011 and was created by the Public Services Reform (Scotland) Act 2010. Our key responsibility is to help NHSScotland and independent healthcare providers deliver high quality, evidence-based, safe, effective and person-centred care; and to scrutinise services to provide public assurance about the quality and safety of that care.

The Public Services Reform (Scotland) Act placed a number of duties and powers on Healthcare Improvement Scotland which are relevant to the policy ambitions of the Bill, specifically powers to inspect services provided by NHSScotland or independent healthcare services and to conduct joint inspections with other scrutiny authorities, and to support, ensure and monitor the public involvement activities of NHS Boards (through the Scottish Health Council).

The integration of health and social care will have a direct impact on our role: the Public Bodies (Joint Working) Bill's Explanatory Notes and accompanying Policy Memorandum, which refer to Healthcare Improvement Scotland and the Care Inspectorate's joint scrutiny role in relation to integration authorities. At present there is no reference to scrutiny on the face of the Bill and we discuss in further detail below our recommendation that this be addressed.

We are already 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. A further role has been identified for the two scrutiny bodies in the joint inspection of integration authorities' strategic commissioning plans, a new area of work for this organisation.

The Scottish Health Council, which is part of Healthcare Improvement Scotland, is submitting an additional response focusing specifically on the public involvement aspects of the Bill.
Response to Health and Sport Committee questions

1. Do you agree with the general principles of the Bill and its provisions?
We are supportive of the framework provided by the Bill which supports the integration of health and social care in Scotland - encouraging local authorities and health boards to move forward together in achieving better outcomes for people using health and social care services.

We welcome the focus in the Policy Memorandum on the perspective of the patient, service user or carer, along with the references to consultation made in the Bill. As an organisation, we aim to ensure that the views and experiences of patients and the public are used to improve the quality of healthcare services. The Public Services Reform (Scotland) Act 2010 places upon us a Duty of User Focus and involving the public in our work is an integral part of everything we do, including scrutiny activity. The Scottish Health Council supports NHS Boards to carry out their legal duty to encourage public involvement, and reports on how Boards involve patients and communities when making major changes to local health healthcare services. Its response to the call for evidence discusses these aspects in further detail.

The Policy Memorandum makes reference to the fact that “better integration of health and social care services is required in order to ensure the on-going provision of high quality, appropriate, sustainable services” and “The fundamental purpose of the policy on integration, which underpins the legislation, is to improve people’s wellbeing”. As an organisation we are considering how we can assure that integration is delivering this (by contributing, for example, to reductions in lengthy hospital admissions for older people and support for care at home and the community); however there is scope to further emphasise this within the principles underpinning the Bill.

2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
We welcome the outcomes-based approach to the planning and delivery of health and social care services and note that the nationally agreed outcomes for health and social care will be consulted on by Scottish Government. 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 a dignity are central to the patient experience, no matter where the care is delivered.

It is vital that we continue to assure the quality and safety of health services under integrated health and social care. The quality of health services is currently measured against standards and indicators that are developed from a robust evidence base, using a synthesis of research and other knowledge on how to achieve optimal outcomes. The challenge of measuring quality achieved under integrated health and social care is in defining a similar evidence base. Despite these challenges, HIS is already starting to consider how to widen the methodologies used to develop such standards and indicators to incorporate the extant evidence base for integrated services. In addition HIS can learn from the evolving processes being developed by the National Institute for Health and Social Care Excellence (NICE) in England.
3. **Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths.**

We welcome the alignment of outcomes between health and social care, which is central to shaping future policy at a corporate level in these sectors. It should be noted that local authorities and health boards will continue to report separately on other targets and performance indicators and there will be a need to ensure a proportionate and consistent approach.

In relation to strategic commissioning activity, we welcome the strengthened role of clinicians and social care professionals, along with the full involvement of the third and independent sectors, service users and carers. We also welcome that strategic commissioning plans should assure that sound clinical and care governance is embedded.

4. **Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.**

**Scrutiny**

One of the policy ambitions for integrating health and social care services is ‘to improve the quality and consistency of services for patients, carers, service users and their families’. Scrutiny of integrated working is central to ensuring the quality of services delivered and outcomes are achieved, therefore we believe that scrutiny should be explicitly reflected on the face of the Bill.

We have identified that there are three aspects of scrutiny and assurance activity in relation to the integration of health and social care:

- scrutiny of integrated services (through joint inspection)
- scrutiny of strategic commissioning (review / quality assurance of strategic plans)
- ensuring appropriate public involvement in the planning and commissioning of integrated services

However, it is also important to consider those elements of scrutiny that may pertain exclusively to healthcare provided by health and social care partnerships such as by local GP practices and primary care teams. Healthcare Improvement Scotland will further develop its approach to scrutinising the quality of care delivered in primary care and the interface between primary and secondary care. The powers to do so exist within the Public Service Reform Act and it will be important to ensure that there is clarity in respect of the powers to act between the current and proposed legislation.
The approach to scrutiny will further develop as specific client groups fall within the ambit of joint inspections such as adults with learning disabilities etc. It is important to anticipate the further broadening of the inspection programme and ensure that this extension does not undermine the principles set out in the Crerar Review.

Our experience of joint inspection through the pilots which have been undertaken with the Care Inspectorate has shown that there are a number of powers which are fundamental to effective scrutiny activity: to enter and inspect a service, to require information, to conduct interviews and to share information. The application of such powers to the inspection of integrated services will be essential. It is obviously essential that Healthcare Improvement Scotland has sufficient powers to scrutinise the new ‘bodies corporate’. Information sharing is a particularly challenging issue, demonstrated through our pilot inspection of older people's services. The ability to scrutinise information related to integrated services will be fundamental to effective joint inspection.

The Policy Memorandum highlights that strategic commissioning is an area for development across local authorities, health boards and other strategic partners. It is essential that capacity and capability building in this area is supported to ensure that it delivers the Government's intention that it is through the strategic commissioning process that the required shift in the balance of care will be achieved.

Healthcare Improvement Scotland has substantial experience of scrutinising healthcare systems, processes and planning through our clinical governance activity. The scrutiny of the resource and financial planning aspects of strategic plans will require specific financial expertise and it is our view that Audit Scotland / Accounts Commission should be involved in joint working in this area, especially as such plans will interface with Community Planning Partnerships and Single Outcome Agreements. Healthcare Improvement Scotland will consider the mix of skills to support such broader roles.

**Commissioning**

As stated above, we welcome the strengthening of joint commissioning arrangements with stakeholder involvement. It is also essential to strengthen arrangements in terms of outcomes for patients. The Winterbourne Review highlighted the issue of a disconnect between the commissioning of services and ensuring positive outcomes and experience for patients. The scrutiny of joint commissioning arrangements will need to ensure that they will yield benefits to users and carers and this may, sometimes, be difficult to evidence in strategic commissioning plans.

It will be important to be explicit about the relative roles of different parties in the assessment of the joint commissioning of services. This is work which Healthcare Improvement Scotland would like to explore further with Scottish Government, Joint Improvement Team and the Care Inspectorate.
5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

From a scrutiny point of view, the delivery of integration plans will allow Healthcare Improvement Scotland to share expertise, approaches and business intelligence, and streamline data collection with other scrutiny bodies. It is hoped that a more holistic approach, which follows the patient journey through primary and acute care, would further enhance our role in providing public assurance about the quality and safety of healthcare, no matter where treated. The sharing of business intelligence between scrutiny bodies may also provide a further safeguard and minimise risk in relation to public assurance of the quality and safety of care.

6. What effect do you anticipate integration plans will have on outcomes for those receiving services?

It is unclear at present how the creation of partnership arrangements between health and social care, set out in integration plans, will ultimately result in improved outcomes for users of health and social care. Consideration needs to be given to how the achievement by integration authorities of national outcomes - and ultimately improved care for users - can be demonstrated and assured, both internally and externally, through strategic plans.

We note the role of Joint Monitoring Committees and Integration Joint Boards in assuring partners that the arrangements are achieving the aims and objectives set out in the integration plan as well as delivering the outcomes set out in the strategic plan. It will be important to establish how the joint scrutiny activity of Healthcare Improvement Scotland and the Care Inspectorate will align to this activity.

There should also be further consideration of enforcement activity which may be required where partners are not delivering requirements in relation to integration plans or strategic commissioning or where these are not felt to be sound. Clarification of the roles of the Scottish Government and scrutiny bodies will be important in this.

Concluding remarks

Healthcare Improvement Scotland welcomes the opportunity to contribute to the Health and Sport Committee’s scrutiny of the Public Bodies Bill. We would further welcome the opportunity to contribute to the planned oral evidence sessions, to discuss the implications of the Bill and integration more broadly for healthcare quality assurance and scrutiny. As stated above, we believe that scrutiny should be on the face of the Bill, being central to ensuring high quality services and outcomes. We will continue to work with colleagues in Scottish Government, and through representation on a number of strategic groups, to explore and develop the practicalities of health and social care integration and its impact.

Healthcare Improvement Scotland
2 August 2013
The Public Bodies (Joint Working) (Scotland) Bill

The Information Commissioner’s Office

Introduction

The Information Commissioner’s Office (ICO) welcomes the opportunity to respond to the Health & Sport Committee’s stage 1 consideration of the Public Bodies (Joint Working) (Scotland) Bill (the Bill).

Given the ICO’s role as regulator of the Data Protection Act 1998 (the Act), this response will be limited to those aspects of the proposals which relate to data controller responsibilities and the processing of personal data. More generally, some comments are provided on Privacy Impact Assessments and the value they can add to policy considerations.

Data Controller Responsibilities

The ICO recognises the many benefits that can accrue from integrated service provision. However, in complex organisational relationships involving the processing of personal data, it is often difficult to determine which party is a data controller and which is a data processor for the purposes of the Act. The Act defines a data controller as:

…a person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or are to be, processed.

A data processor is defined as:

…any person (other than an employee of the data controller) who processes the data on behalf of the data controller.

In response to the Scottish Government’s consultation on the proposals, the ICO highlighted its concerns over establishing different models of integrated service providers as creating ambiguous accountability structures which have the potential to be confusing to users. It was felt that individuals seeking to exercise their rights under the Act could be confused as to who would be the data controller and in which organisation(s) these obligations would reside.

For this reason, the ICO welcomes the clarification provided in Part 1 of the Bill. In particular, section 21 places responsibility and liability squarely on the person to whom functions are delegated and section 43 clearly identifies the responsible organisations in each of the proposed models set out in section 1(4). Where the model is an integration authority as set out in section 1(4)(c), it is assumed that the Health Board and Local Authority will be joint data controllers as they will be acting ‘jointly’.

The importance of identifying correctly the extent of liability for data protection in the proposed structures is paramount as such liability cannot be abrogated
or delegated and the processing of users’ personal data will be sensitive for the purposes of the Act. It is noted that further guidance is to be provided in respect of the functions under, or in relation to, the provisions of the Bill and the ICO would be happy to assist in any areas relevant to data protection.

Processing of Personal Data

In its submission to the Scottish Government consultation, the ICO also recognised that the sharing of personal and sensitive personal data will be fundamental to the effective operation of the integration authorities. It is imperative that any such data sharing is carried out in a safe and secure manner, fully underpinned by an agreed Information Sharing Protocol to outline the broad aims and extent of sharing, with a robust Data Sharing Agreement to define the detail.

Under section 52A of the Data Protection Act, the Information Commissioner is required to publish a Data Sharing Code of Practice. Although it is not mandatory for data controllers to follow the Code, their compliance with it will be taken into consideration in the event of a breach. Given its status, the ICO would recommend that in any reference to sharing personal data, cognisance should be given to the Code when formulating information sharing protocols and/or agreements.

As well as considering the requirements of the Code, any data sharing must be undertaken in a safe and secure environment. The seventh Data Protection Principle requires that:

...appropriate technical and organisational measures are in place to prevent the unauthorised or unlawful processing of personal data, or the accidental loss, destruction, or damage to personal data.

Often more weight is given to the technical fixes to the extent that paper files and physical security are on the periphery. However, this can be the area of greatest vulnerability as can be seen from some of the breach cases on the ICO’s website: Taking Action - Undertakings, Enforcement and Monetary Penalties - ICO. It is important, therefore, that mutual understanding of security issues is included within any agreements/protocols on the practicalities of data sharing.

Privacy Impact Assessment

The ICO advocates the use of Privacy Impact Assessments (PIA) at an early stage of policy development. A PIA is a process which helps assess privacy risks to individuals in the collection, use and disclosure of information and helps identify privacy risks, foresee problems and bring forward solutions. Whilst there is currently no statutory requirement to undertake a PIA, the Scottish Government has endorsed the process within its Identity Management & Privacy Principles which were published in 2010. For example, Principle 2.1(a) requires that a PIA or proportionate equivalent is conducted and published prior to the implementation of a project which
involves the collection of personal information whilst Principle 2.9 states that wherever proposed legislation has a privacy dimension, a summary of the impacts identified in the PIA should be submitted for consideration by the lead committee in the Scottish Parliament.

The ICO is not aware of any PIA having been undertaken in relation to these proposals despite the likely sensitive nature of the information to be shared under the proposals. The ICO recommends, therefore, that a PIA is carried out in conjunction with the establishment of the integration authorities and would welcome this requirement being included on the face of the Bill or in relevant Regulations.

ICO summary of recommendations

**Recommendation one: Data Sharing Code of Practice**

Given the importance appropriate and proportionate sharing of personal and sensitive personal data will have to the successful operationalization of the integration authorities, the ICO recommends that the Bill and/or relevant Regulations requires cognisance be given to the ICO’s statutory Data Sharing Code of Practice.

**Recommendation two: Privacy Impact Assessment**

Given the nature of the data involved, the ICO recommends compliance with the Scottish Government’s Identity Management & Privacy Principles by the inclusion of a requirement to conduct a PIA in conjunction with the establishment of integration authorities.

The Information Commissioner’s Office
2 August 2013

About the ICO
The ICO’s mission is to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals.

The ICO is the UK’s independent public authority set up to uphold information rights. We do this by promoting good practice, ruling on complaints, providing information to individuals and organisations and taking appropriate action where the law is broken.

The ICO enforces and oversees the Data Protection Act 1998 and the Privacy and Electronic Communication Regulations 2003, as well as the UK Freedom of Information Act 2000 and the UK Environmental Information Regulations 2004, both of which apply to reserved matters in Scotland.
Public Bodies (Joint Working) (Scotland) Bill

Scottish Public Services Ombudsman

I am writing in response to your call for written evidence on the Public Bodies (Joint Working) (Scotland) Bill.

I am not responding to the specific questions you have raised because I am not writing in response to anything in the bill but to what I consider is an omission from that bill. The bill looks at organisations and their obligations. It also talks about outcomes for people. However, it 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, an issue that remains outstanding from the recommendations of the Sinclair report in 2008.

I recognise the potential benefits in delivering integrated, joined-up services and support the aims of the bill. However, as I and others have previously raised with the Committee, the areas of health and social care contain competing legislative complaints processes and, without legislative change, there are barriers to these processes working together. As an example, a resident of a care home may need to access three different procedures to question the way their needs have been assessed by the local authority, how their care is being delivered by the care home and their treatment by any NHS staff who visit them there. Should they choose to take their complaint to independent review they would, potentially, be faced with different routes to the Care Inspectorate and SPSO, with SPSO then having different powers over health and other areas of jurisdiction. This means that, while the bodies and delivery of the service may be integrated, there is no integration of the complaints process. As the Chief Executive of Highland NHS informed the Committee in March 2012, they are currently having to use the NHS process initially but then escalate social care through a separate route.

I do not intend to remake my arguments in detail. I have enclosed copies of our response to the Scottish Government consultation on social work complaints which sets out the context and describes the current landscape as well as how this is dealt with elsewhere in the UK as well as our response to their consultation on integration. The Committee will remember the comments we made direct to them about this matter in relation to your inquiry into the regulation of care for older people.

The Scottish Government and Parliament have made a number of positive commitments over a number of years to improved complaints handling. I would like to highlight the commissioning and endorsement of the Sinclair review, the commitment to complaints in the Patients Rights Act; a public statement of complaint handling principles which has the endorsement of the Parliament; and the extension to my powers which has resulted in the implementation of one standardised process across most areas of the public sector. Last year, the Scottish Government commissioned a working group, including the SPSO, to look at Social work complaints which are one part but
a key part of the complex landscape that bodies who work more closely together will have to deal with. I do not doubt the commitment to make improvements but it is a matter of regret that this is not yet reflected in specific measures to match the pace of change in the way complaints processes work together with the pace of change in the way bodies work together.

Ensuring complaints processes are accessible, simple and clear is important in ensuring the quality and consistency of public service delivery. The complaints landscape across health, social work and social care remains complex and the move to enable organisations to provide integrated services in this area should include the provision to the public of easily accessible, straightforward complaints processes. Failure to address this lack of integration in the Bill would mean that users would potentially have no clear route to complain about jointly-delivered services and public bodies would be restricted in their ability to investigate and respond to complaints in a joined up way. This presents a risk to vulnerable service users and I would ask that the Committee highlight a need to include provision for complaints in this legislation.
Annex A

SPSO response to the Scottish Government consultation on the Integration of Adult Health and Social Care in Scotland

Background and context
The Scottish Public Services Ombudsman (SPSO) is the independent body that investigates complaints from members of the public about devolved public services in Scotland. This includes, amongst others, local government, the National Health Service and a range of public bodies including the Care Inspectorate.

We recognise the Scottish Government’s objectives in moving towards the integration of health and social care to improve outcomes and, in particular, the aim set out in the consultation to ensure that “services are planned and delivered seamlessly from the perspective of the patient, service user or carer, and systems for managing those services that actively support such seamlessness”.

There is an important barrier to this seamlessness which is not dealt with in the consultation - the complexity of complaints processes. We appreciate that the consultation says that it cannot refer to all the details. However, although we have had discussions with the Government’s team working on this area over the last year, we remain concerned that despite this engagement, this barrier may not be being considered. We have also raised these issues in response to the Government’s consultation on Social Work procedures, and these are outlined more fully later in this submission.

Complexity of complaints processes
The barrier relates to the inconsistent and conflicting complaints processes that operate in the health, social care and social work areas. We do not think that this is a secondary issue. The laudable aim to put the person at the centre of care can only work if that person also has a clear route to raise concerns and questions about that care and the key decisions made which impact on them.

There are three key complaints processes operating within this area.

- Complaints about the local authority’s assessment of a person’s care needs or about social services provided. Such a complaint would be subject to the local authority’s social work complaints procedure and the statutory directions issued by the Scottish Government.

- Complaints about a registered care service. Such a complaint would normally be made to the provider in the first instance or directly to the Care Inspectorate. The latter has a duty to operate a procedure for receiving complaints about registered care services under Section 79 of the Public Services Reform (Scotland) Act 2010.

- Complaints about NHS services. These complaints would be directed
to the statutory NHS complaints process which is now set out in terms of regulations made under the Patients Right (Scotland) Act 2011\(^6\).

In our view, there is already a danger to vulnerable citizens in the overlap and confusion between complaints handling for health, social care and social work services. There is further scope for additional confusion as the move towards integration progresses. This is not a theoretical concern. In their evidence to the Health and Sport Committee, NHS Highland reported that they did not realise complaints would be an issue until late in the process\(^7\). They told the committee that they would be operating two separate complaints processes depending on the underlying legal accountability.

The confusion affects not only the point where the user wishes to make a complaint to the service and may not know which route to use, but also has considerable potential to add to the complexity in terms of our own role.

**The SPSO’s dual role: complaint handling and standardisation**

There are two key issues. The first relates to the different ways we can look at complaints that come to us through the three different routes. The second relates to our new role in some areas as the body charged with improving and standardising complaints processes in public services.

1. **Our role in complaint handling**

In terms of the NHS complaints process our role is straightforward. Once the NHS complaints process has been completed, the person has the right to complain to us. We can look not only at issues relating to maladministration and service failure but, uniquely in terms of our remit, can review clinical decisions. This allows us to consider fully all aspects of the complaint made to us.

When a complaint is made to us through the social work complaints process, our role is normally restricted to investigating complaints about the operation of the social work complaints procedure rather than the substance of social work complaints.

If a complaint is made to the Care Inspectorate, we are only able to consider the way the Care Inspectorate has handled the complaint. This is because we do not normally\(^8\) have jurisdiction over social care providers themselves - that role is a function of the Care Inspectorate.

2. **Our role in improving complaints handling**

The SPSO has recently taken on a new statutory function, empowered by the Public Services Reform (Scotland) Act 2010 (the Act), to improve complaints handling in bodies across the public sector through a programme of standardisation and simplification of complaints handling procedures. This is in line with the recommendations of the Sinclair Report and with the backing of the Scottish Parliament and the Scottish Government. To deliver this function we have created the Complaints Standards Authority (CSA), an internal unit within the SPSO.
Model complaints handling procedures

Following a full public consultation and with parliamentary approval for our Statement of Complaint Handling Principles, we have developed model complaints handling procedures for all local authorities and registered social landlords. All organisations in these sectors are now required to adopt this standardised procedure involving only two internal stages – a frontline resolution stage of 5 working days and an investigation stage 20 working days. This streamlined approach is based broadly on the NHS complaints process in Scotland and will shortly be rolled out to all other sectors of the public service within our jurisdiction.

Since 2010, therefore, the work of ourselves and many others has created what is becoming the national standard for complaints in the public sector and brings us significantly closer to the goals of the Crerar and Sinclair reviews. However, because of the statutory requirements that regulate these areas, the SPSO does not have the power to develop and enforce a model CHP for either social care or social work providers. This is problematic for those public service organisations such as local authorities and housing associations who are generally under our jurisdiction and will now be applying the model for complaints about all other service areas. The current position requires them to comply with different processes, and in some circumstances this may mean different process for a single complaint brought by one member of the public. Integration will only further complicate this issue as it may bring together bodies who are and are not applying the standard model but who will be providing a joint service.

Social work
We have worked in partnership in creating the model procedures and we are continuing to do so to seek to resolve these issues. We have already had discussions with the Association of Directors of Social Work (ADSW), Convention of Scottish Local Authorities (COSLA) and the Scottish Government on reform of the existing statutory directions on social work complaints and will shortly be joining a working group set up by the Scottish Government for this. We have also had discussions with the Care Inspectorate about improvements to complaints handling procedures for care providers. For both of these areas we have recommended an alignment with our guidance in line with our plans for the wider public sector. However, given our more limited role in relation to revising complaints handling procedures in these areas of service, we are only able to recommend and have no power to direct improvements. Scottish Government leadership and the leadership of other key organisations is required to ensure that clear and simple complaints processes do cover the whole public sector including those areas not formally covered by our guidance and models to ensure that whoever and whatever citizens are complaining about, the public service they are complaining to can provide a clear, simple process for doing so.

Other jurisdictions
There are examples from other parts of the UK and Ireland of different routes
that operate to allow for the integration of services. In Ireland, services are delivered by a single Health and Social Care Executive, making complaints more straightforward. A consultation on complaints handling in care and social services procedures has recently closed in Wales. It is anticipated that the Public Services Ombudsman for Wales will be given additional powers to look at social care and social service complaints as a result.

England has operated a single approach for dealing with complaints about NHS and adult social care services since April 2009. They have done so without significant structural change. Department of Health guidance requires or encourages joint working and investigation where a complaint cuts across health, social services and social care. This applies both at the level of the initial complaint and also at the Ombudsman level.

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 which came into force on 1 April 2009 represented a significant simplification and shift in the complaints process. The Regulations cover the NHS and social services provision by the local authority and there is an explicit duty placed on the NHS and local authorities to cooperate if a complaint appears to relate to more than one body. The Department of Health has provided guidance on joint working and recommends that a protocol be put in place where care is provided jointly. The guidance stresses that "if a complaint is made about care delivered by more than one organisation, it is important to provide a single point of contact and a single response to the complainant."

The Regulations also deal with complaints that reach local authorities but deal in part with a breach of care standards or social care provision. As these can relate to private bodies, the local authority is required to ask the complainant’s permission to pass the information to the registered person or adult social care provider. Once this has happened, the local authority is required to cooperate as far as is reasonable and practicable to ensure a single, coordinated response for the complainant.

Complaints about health, once they have completed the local complaints process, go to the Parliamentary and Health Services Ombudsman (PHSO). Complaints about local authorities including social work and social care provision funded by the local authority, are dealt with by the Local Government Ombudsman (LGO). Again, the local complaints process must have been exhausted before a complaint can be reviewed by the LGO. In October 2010, the LGO’s remit was extended to include adult social care not funded by the local authority, so all adult social care complaints are now dealt with by the LGO. The Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007 allows the PHSO and LGO to work together jointly to investigate complaints.

**Conclusion**

The integration of health and social care has the potential to add to the complexity of the complaints handling arrangements. There is an increasingly urgent need to amend the statutory schemes guiding social care, social work
and NHS complaints to ensure that complaints that involve several or jointly delivered services can be dealt with effectively and to minimise potential confusion amongst members of the public. Agency clarity is essential and we support the idea of setting up a working group that would develop revised procedures not only for social work, as outlined in the Scottish Government’s consultation, but for wider social care. The integration proposal allows for a number of models of delivery and any complaints process would have to reflect this flexibility.

We have already suggested in our response to the Government’s consultation on reviewing social work complaints that the option we favour is that the local authority model CHP be extended to cover social work complaints. We have also asked to be given the same powers over social work complaints as we do on health to review professional judgement. This is not a new power as Complaints Review Committees which would be replaced under changes to the social work complaints procedures have long had this power, but it would allow health and social work procedures to align which would help resolve the problems identified by Highland NHS.

For social care, we will continue to work with the Care Inspectorate to align providers’ complaints processes. We would also like to suggest changes to allow us to undertake joint investigations with the Care Inspectorate where a complaint relates to matters which cover both our jurisdictions. In order for this to come about, changes may need to be made to our respective statutes to allow for this.

These two moves - changes to the social work complaints procedures and to our relationship with the Care Inspectorate - would resolve a problem of overlaps and gaps which has been raised ever since our creation; and greatly simplify the landscape for the service user. It would also allow for service providers to have clear and simple procedures.

As a point of principle, simplicity from the complainant’s perspective should be uppermost, as underscored in the Sinclair Report. Whatever the complexity of the service delivery, there should be a single point of contact for the complainant and a single, co-ordinated response to their complaint.

References:
2. A good summary of the complexity can be found in the case study from Fife Council in a paper provided for the Sinclair report. This can be found in the papers for the meeting of 13 May 2008 (Paper 2). http://www.scotland.gov.uk/Topics/Government/PublicServiceReform/IndependentReviewofReg/ActionGroups/FCSAGPapers
4. This may be a service directly supplied by the local authority; commissioned by them and supplied by a private provider or supplied as a result of a private contract between the user and the service. 
5. Their interim complaints procedure is available here: http://www.scswis.com/index.php?option=com_docman&task=doc_details&gid=514&Itemid=714
7. Official Report, Health and Sport Committee 6 March 2012 column 1092
8. Some social care providers – local authorities and housing associations are in jurisdiction
REVIEW OF SOCIAL WORK COMPLAINTS

RESPONDENT INFORMATION FORM

Please Note this form must be returned with your response to ensure that we handle your response appropriately.

1. Name/Organisation

Organisation Name
Scottish Public Services Ombudsman (SPSO)

Title Mr ☒ Ms ☐ Mrs ☐ Miss ☐ Dr ☐ Please tick as appropriate (double click on the relevant box to complete)

Surname Martin
Forename Jim

2. Postal Address

4 Melville Street
Edinburgh

Postcode EH3 7NS Phone 0131 240 8850 Email fpaterson@spso.org.uk

3. Permissions - I am responding as…

- Individual ☐ / Group/Organisation ☒ Please tick as appropriate

(a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

Please tick as appropriate ☐ Yes ☐ No

(b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

☐ Yes, make my response, name and address all available
☐ or

☐ Yes, make my response available, but not my name and address
☐ or

☐ Yes, make my response and name available, but not my address

(c) The name and address of your organisation will be made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your response to be made available?

Please tick as appropriate ☒ Yes ☐ No

(d) We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Please tick as appropriate ☒ Yes
The final stage of current social work complaints procedures provides for complaints to be considered by a Complaints Review Committee (CRC) when all other avenues of redress have been explored. The guidance says that CRCs should aim to bring an objective and independent eye to bear on complaints to give the public additional safeguards that their wishes and needs are being fairly considered and their complaints properly investigated. The Directions specify that the CRC should have an independent chair and the expertise that members are required to have.

The Sinclair Report recommended that the SPSO should take on the CRC stage of social work complaints. Alternatives to this would be to retain CRCs but modify and improve them or align social work complaints with the standardised Model Complaints Handling Procedure currently being developed by the SPSO and local government for all local authority services.

Q.1a Please choose which of the following options you would prefer for dealing with complaints about social work services, providing reasons for your choice:

- **Option 1** – Social work complaints to be dealt with in line with all other local authority complaints through the process set out in the SPSO model CHP for local government.

    
    Yes
    
    Reason

We are of the strong view that revised arrangements for social work complaints should align with the SPSO’s model CHP for local government and, in particular, the 2-stage process and timescales contained within that procedure. The consultation document sets out well the background to the Sinclair report, including recommendations, and I will not set these out again here. However, in summary there was a clear conclusion from both Crerar and Sinclair that there was a need for consistency and standardisation in relation to complaints handling across the public sector, particularly in relation to local government and social care. The focus was very much on a streamlined approach which was more focused on the user and on obtaining consistent measuring of outcomes.

The SPSO’s Complaints Standards Authority (CSA) has taken forward the development of a standardised model process which will apply to all public sector bodies within our jurisdiction. This model is based broadly on the streamlined approach adopted across the NHS in 2005 and on the recommended model outlined in the Sinclair report. Our view is that the
2-stage model process is an appropriate and robust model for handling all complaints irrespective of sector. We believe the adoption of this model, with no additional stages of review, will help to focus service providers on moving towards a culture of ‘getting it right first time’ and will reduce the cost of handling complaints through the removal of multiple stages of review. This also applies within sectors and we have not, in the course of our discussions with stakeholders, seen robust evidence which would justify a deviation from the streamlined model in relation to social work services.

We outline below our view on the possibility of extended timescales. We remain open to this possibility but believe that this should only be considered on the basis of sound evidence that this is in the interests of the user and that there is a specific need which is different from the needs of users in relation to similarly sensitive complaints in other areas, for example around sensitive or serious health provision. This would also apply in relation to additional stages of review. In our guidance on model CHPs, published in 2011, we stated that:

‘We…recognise…that there may be a need for additional stages of review in some circumstances, particularly in relation to sensitive complaints or those involving vulnerable individuals where set criteria are met. The CSA will work in partnership with service providers to identify circumstances where there is a strong justification for an additional tier of review and to develop appropriate criteria. Any justification should be supported by robust evidence.’

In discussions with service providers we have not heard any strong justifications for this and remain of the view that the 2-stage process within the CHP timescales remains the correct approach. We remain open to further discussion but believe that the Government should provide a clear steer on the back of consultation responses to inform the proposed working group’s remit.

We do, of course, recognise the particular importance of social work services and the significant impact these services can have on individuals and families. However, the importance and pressing nature of many of the issues underlying social work complaints makes it all the more important that complainants have a clear, streamlined process to follow allowing to them to receive a prompt response to their complaints from the provider and the opportunity to seek independent external review within a similarly quick timeframe rather than have to negotiate a number of time-consuming and complex stages of review.

**Next steps**

In terms of taking forward the work to align social work complaints with the model CHP we agree with the Government’s suggestion of a working group involving representatives with expertise in all aspects of social work complaints. The CSA would contribute to that discussion. The group
must, however, have clear terms of reference within which to operate. We believe that the Government should provide a very clear steer in relation to the preferred option (1-4) rather than delegate this consideration to the working group. It is also important that consideration is given to the wider arrangements for social care complaints to ensure a holistic approach focused on the user. This is considered in more detail below in our response to question 4.

The local authority CHP will be published in March 2012 and will be implemented over the course of 2012/13. Provision has been made to revise the model CHP in due course until the social work provisions have been revised and this will be something to be discussed by the working group.

- **Option 2** - As with Option 1 but with additional scope for increasing the working day timescale at stage 1 or 2 for social work complaints when circumstances require this. (Details of the circumstances in which timescales can be extended could be developed by the working group if there is support for this option.)

  **No**

  **Reason**

As stated above in our discussions with service providers we have not seen any strong evidence justifying extended timescales which would differentiate social work complaints or users from those involving other areas such as health. We remain of the view that the 2-stage process within the CHP timescales remains the correct approach.

However, we remain open to this possibility but believe that this should only be considered on the basis of sound evidence that this is in the interests of the user. It should also be emphasised that the existing model CHP for local authorities allows discretion on the part of local authorities to extend the 20 working day timescales at investigation in cases where this is clearly justified.

If evidence was available to suggest that there was a clear need it would be necessary to ensure that this applied only to specific complaints relating to particular issues of vulnerability, for example. It would not seem appropriate for all social work complaints to have an extended timescale simply because they were provided by social work services. Many social work complaints will not involve issues of significant vulnerability or complexity, for example, and certainly no more than many complaints from other service areas.

If this were the preferred option, therefore, we would recommend that very
clear criteria are set for the types of complaint where an extension to the standard process was available.

- **Option 3 - Modified and improved CRCs operating within local authorities.** CRCs would be retained but improved (e.g. faster time limits within which a committee must be convened and reach a decision). Please specify the improvements you would recommend.

  No

  Reason

We do not believe that there is a justification for a continued role for CRCs. The CRCs (even if improved in terms of time limits) add an unnecessary stage to the complaints handling process which adds complexity for service users and may act as a barrier for many in progressing their complaint through to independent external review by SPSO. The current statutory social work complaints procedure has three stages with a total minimum timescale of 112 days from the complaint being made to a local authority to the CRC reporting at the final stage. The aims of the Crerar and Sinclair reports should be central to any decision on future arrangements. We believe the user is better served in having a simplified approach to complaints handling which is in line with that in relation to other public services.

As we have documented (for example in SPSO commentaries and annual report 2010/2011\(^1\)), the experience we have of reviewing CRCs has caused us concern. We agree with the issues raised in the consultation document relating to the independence, timeliness and membership of CRCs. We also question the consistency with which the CRCs are being applied across the 32 local authorities and the scope of what the CRCs are currently considering.

Fundamentally, it remains vital that complainants have access to a streamlined process to follow allowing to them to receive a prompt response to their complaints from the provider and the opportunity to seek independent external review of the decision and the administration of the service within a similarly quick timeframe rather than have to negotiate an additional and time-consuming stage of review.

  If Yes, recommended Improvements

  N/A

---

\(^1\) Available on www.spso.org.uk
• **Option 4** - The SPSO expanding its remit to take on a similar role to that of the CRCs. This would provide the SPSO with a remit over social work decisions in line with its role in relation to NHS complaints. Please specify the main benefits of the SPSO taking on this expanded role.

**Yes** – However, it is important to point out that this option, were it to be supported by stakeholders and the Scottish Government, would need to be considered more formally through the parliamentary process and would require input from the Scottish Parliamentary Corporate Body (SPCB) from an early stage. It would also be subject to the considerations below in relation to how exactly this new role for SPSO would be defined and in relation to resource implications for this organisation.

**Reason**

The importance of social work service decisions and the impact that they have on individuals and families mean that it is an area where there is a strong argument for a fully independent external review. One of the aims of the original CRC model was to “bring an objective and independent eye to bear on complaints to give the public additional safeguards that their wishes and needs are being fairly considered and their complaints properly investigated”. As the consultation paper sets out, the current CRC model provides for CRCs to express disagreement with, for example, policies or professional judgement.

**Investigative powers**

Under the SPSO Act 2002 (The Act) the SPSO currently has the power to investigate complaints about maladministration or service failure. We cannot overturn decisions where a body has made a decision within its discretion. We can look into whether a body has followed a proper process in reaching its decision but, if the body has followed a proper process, the SPSO cannot decide that the wrong decision was made. There is one exception to this within the SPSO Act and this relates to decisions made by the NHS on clinical judgement where the SPSO does have a power to investigate decisions.

Matters considered by CRCs include the provision or non provision of social work services, the quality, extent and operation of social work services, the way in which decisions were arrived at and the decisions themselves (including financial assessments). The SPSO currently investigates the handling of the complaint by the CRCs, including, for example, whether the CRC was conducted properly, whether the CRC received all relevant information or whether the council had properly considered a CRC decision or recommendation. However, we can’t look at the subject of the complaint such as decisions or professional judgements about a person’s needs or the services they get. Neither can we look at complaints about financial assessments, although we may be able to consider complaints from people financing their own care arrangements
through Direct Payments. We can’t be used to ‘appeal’ a CRC decision. In short, we can normally only consider an outstanding administrative or procedural matter relating to the CRC or the subsequent actions of the council.

It is clear, therefore, that, if a decision was reached to abolish CRCs and provide SPSO with a similar role, this would require a wider SPSO remit over the substance of social work decisions. This would require legislative change to the SPSO Act 2002 to provide the SPSO with a remit over social work complaints, similar to the role SPSO has on health.

Resourcing
As well as legislative change, it would require additional resource for the SPSO to recruit and develop skills and advisors in social work services to enable it to make judgements in relation to the substance of social work complaints. The SPSO currently has a bank of advisors available to provide advice to SPSO on clinical matters. A similar arrangement would be required in relation to social work. It is not possible to provide an estimate for this without further definition of the exact remit proposed for the SPSO and the exact definition of complaints to be subject to this remit. However, our experience of changes in complaints handling arrangements suggests that we may see an significant increase in the volume of complaints in this area at least in the short term (on taking on the role of the Scottish Prisons Complaints Commission in 2010 SPSO received an average rate of approximately 50% more cases than the SPCC considered in its final year). There would, though, also be savings for the 32 local authorities who would no longer have to administer the additional CRC stage.

Independence
We have said above that, in practice, the operation of CRCs has caused us concern. The fact that it is administered by the local authority and only has the power to make a recommendation to the appropriate local authority committee has led to a perception that CRCs are not independent enough to undertake the role of reviewing the merits of the decision. Providing SPSO with this role would ensure a greater degree of public transparency and should increase confidence that, as originally intended, there is an objective look at such decisions.

Social care/health/social work – aligning complaints
The strength of option 4 is that it would fulfil both the need to have a streamlined internal model for handling the complaints as set out above while ensuring that the individual could have an objective, external view of decisions which may, as decisions made by the NHS also do, have a profound impact on them.

It is also a model that would be adaptable enough to cope with the changes which are being brought about by the move towards integrating health and social care. It is currently the position that if matters previously the responsibility of a social work department are transferred to the NHS,
the NHS not only needs to run two complaints processes but our organisation will be in the position of having to consider whether the judgement is NHS clinical judgement and we can review or not.

As we expand on below in relation to question 4, there is an important consideration in relation to wider arrangements for social care, health and social work complaints. With the move to integrate social care and health we believe there would be a benefit in aligning the SPSO’s role in social work with its role in relation to health complaints.

**Question 1b Are there any of the above options that you do not feel should be considered? please give reasons why.**

For the reasons outlined above we do not support option 3 for the retention of CRCs. We also do not feel that option 2 relating to a model CHP with longer time should be considered without strong evidence that there is a need for this in relation to the complaint.

**Scottish Ministers’ Regulations and Directions**

Section 5 B of the Social Work (Scotland) Act 1968 provides that Scottish Ministers may by order require local authorities to establish a complaints procedure. Such an order is in place – *The Social Work (Representations Procedure) (Scotland) Order 1990* (SI 1990/2519). Sections 5 and 5B also provide guidance and direction making powers in respect of local authority complaints procedures. SWSG 5/96 contains such guidance and directions. Local authorities have a duty to comply with directions made under the 1968 Act.

The Regulations and Directions can be amended in line with the new social work complaints procedures, but we’d welcome your views on whether or not they are still needed.

**Q. 2 Are Regulations and Directions still required in order to ensure that appropriate social work complaints procedures are adopted by all local authorities or will clear guidance be sufficient? Please tick and give reasons if you wish.**

- Directions still needed

  - [ ]

  or

- Clear Guidance Sufficient

  - [X]

**Reasons**

The Public Services Reform (Scotland) Act 2010 provided the SPSO with a statutory role in relation to the publishing of model CHPs for authorities under
its jurisdiction. Once published, authorities to which these CHPs apply are under a duty to comply with this CHP. If they do not comply, the Ombudsman has a power to declare an authority non-compliant. We believe that the local government CHP will provide sufficient guidance for local authorities and the Ombudsman’s powers provide sufficient statutory authority to ensure that the arrangements are adopted. There will though be a need for statutory changes to our own powers if it is decided that we should fully take on the role of the CRCs.

**Appeals**

The SPSO guidance on model Complaint Handling Procedures explains the importance of being clear about what a complaint is. This is an issue that needs to be carefully considered for social work services and it would be helpful to have views on whether or not there would be benefits in drawing a distinction between:

- complaints about policies and how they have been applied that may be more appropriately dealt with through an appeals process e.g. disagreement with the result of a financial assessments, the way eligibility criteria have been applied, or charging policies; and

- complaints about practice e.g. the way an individual has been treated by a social worker, delays in processing enquiries etc

The current guidance states that:

*People with social care needs and their carers are entitled to have some-one take a second look at assessments, service decisions and the way in which matters have been handled. It is a clear aim of Government policy, reflecting the Citizen’s Charter, to expose procedures and professional decision-making to more scrutiny than hitherto and it would be inconsistent with that policy to restrict the types of case to which complaints procedures relate. Local authorities can have alternative appeals arrangements for responding to certain types of complaints. However, complainers must have the right to refer their complaint to the formal complaints procedure at any stage, and should be made fully aware of this right.*

**Q 3a Should appeals procedures be established by all local authorities.**  
(In the interests of good administrative justice – individuals would retain their right to complain at any stage.)

No

We have argued above that there is a need to retain what was originally planned to be the CRC role, that is to retain a place for an independent and objective look at decisions made. We have argued that the best way to achieve this is to give us the same powers over this area as we do over health
In theory, this could be achieved by having an appeals process separate from the complaints process and leaving our powers as they are. However, the benefit of looking at the decision within the complaints process is that it allows for one body to take a holistic look at the whole experience and journey of the person. It can be difficult, for example, to take out concerns about the outcome of an assessment (the decision) from the complaint that the person was not treated with appropriate dignity and respect during that process. There is a need to focus not on the decision but on the person and an approach which starts with decisions and appeals can run the risk of being decision-centred rather than person-centred.

In arguing for this position, we do accept that local authorities have significant democratic accountability and also that not all local authority decisions should come under either any broader remit of this organisation or a formal appeal route. The argument here is one which we are narrowly applying to this area where there may be particular vulnerability and also where separating service decision from service delivery may not be appropriate.

We would, though, like to mention that, in our experience, purely financial decisions, such as those relating to the possible sale of a family home for care funding, do not sit easily alongside issues about service delivery and it may be both possible and desirable to deal with these separately through an appropriate appeal route.

Possible changes in the delivery of health and social care may also be significant. As we move to shared services and joint delivery, individuals should be able to raise issues about the whole of their experience easily and without having to access different systems. It may be difficult to explain to someone, for example, that we can look at the decision made by an NHS member of staff in some cases but not if they are providing social work type care.

**If YES**

Q 3b Would it be helpful for the working group on social work complaints to develop good practice guidance on appeals procedures?
Q 4  Do you have any other comments you would like to add?

As is clear from our response above options 1, 2 and 4 are not mutually exclusive and it is possible to envisage a solution where more than one of these options apply.

As we have said above and also in our responses to the Health and Sport Committee’s Inquiry into the Regulation of Care for Older People, it is also important to widen the focus of the review to ensure future arrangements align with the wider arrangements for handling social care complaints and, in particular, arrangements arising out of the future integration of social care and health.

We continue to have concerns with the overall complexity of the current arrangements for handling social care complaints and feel that further detailed work is required to ensure future integration of social care and health does not add to the confusion. This will require a holistic look at the existing statutory schemes guiding social care, social work and NHS complaints.

The current arrangements for social care and social work complaints remain complex with different routes, different procedures and different powers for complaints, depending on the provider and depending on the route chosen by the complainant. It is possible for complainants, currently, to have their complaint looked at by three different agencies with differing routes of escalation (NHS, local authorities, Care Inspectorate).

The SPSO does not have jurisdiction over social care providers themselves. That role is taken by the Care Inspectorate, with the SPSO only able to consider the way the Care Inspectorate has handled such complaints. As we have outlined above, our role in relation to social work complaints is normally restricted to investigation of complaints about the operation of the social work complaints procedures rather than the substance of social work complaints.

Given this complexity we believe there is a need to review the statutory schemes guiding social care, social work and NHS complaints to ensure that complaints that involve several or jointly delivered services can be dealt with effectively and to minimise potential confusion amongst members of the public. It may be that such a review is required before consideration is given to the review of social work arrangements by the Government’s proposed working group. Agency clarity is essential and we would support a discussion looking at revised arrangements for wider social care as a whole.

As a point of principle, simplicity from the complainant’s perspective should be uppermost, as underscored in the Sinclair Report. Whatever the complexity of the service delivery, as a minimum, there should be a single point of contact for the complainant and a single, co-ordinated response to their complaint.
On resuming—

Public Bodies (Joint Working) (Scotland) Bill: Stage 1

The Convener: Agenda item 3 is our last evidence session on the Public Bodies (Joint Working) (Scotland) Bill at stage 1. We will have a round-table discussion with what I could loosely call regulatory, scrutiny and complaints bodies. As is usual with a round-table session, I will introduce myself and ask everyone to do likewise, although there are many well-kent faces around the table. Many of you have been here before, but it is useful to have that information for the record. I am the convener of the Health and Sport Committee and the MSP for Greenock and Inverclyde.

Bob Doris: I am an MSP for Glasgow and the deputy convener of the committee.

Claire Sweeney (Audit Scotland): I am from Audit Scotland.

Annette Bruton (Social Care and Social Work Improvement Scotland): I am from the Care Inspectorate.

Richard Lyle (Central Scotland) (SNP): I am an MSP for Central Scotland.

Paul Edie (Social Care and Social Work Improvement Scotland): I am from the Care Inspectorate.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the MSP for Clydebank and Milngavie.

Dr Denise Coia (Healthcare Improvement Scotland): I am the chair of Healthcare Improvement Scotland.

Rhoda Grant: I am a Highlands and Islands MSP.

Jim Martin (Scottish Public Services Ombudsman): I am the Scottish Public Services Ombudsman.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

Robbie Pearson (Healthcare Improvement Scotland): I am director of scrutiny and assurance at Healthcare Improvement Scotland.

Nanette Milne: I am an MSP for North East Scotland.

Maureen Falconer (Information Commissioner’s Office): I am from the Information Commissioner’s Office.

Mark McDonald (Aberdeen Donside) (SNP): I am the MSP for Aberdeen Donside.
Paul McFadden (Scottish Public Services Ombudsman): I am from the office of the Scottish Public Services Ombudsman.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I am the MSP for Edinburgh Northern and Leith.

The Convener: I thank all our guests for that. Richard Lyle will open up the discussion with the first question. As always, we will give our witnesses preference over the politicians around the table. We want to listen to what you have to say today—it makes a change from having to listen to politicians. We will see if we can keep to that.

10:00

Richard Lyle: I welcome all the panel members. I will begin with the subject of public involvement. The committee has heard extensive evidence about the involvement of key stakeholders such as the third sector and different professional groups. However, the committee has heard less about public involvement. Last week, our witnesses stressed the importance of including the public, patients and carers. How should the bill involve the public, and is it clear about the involvement of the public?

Maureen Falconer: One of the issues that we have with the bill relates to the models that are used. I am thinking specifically about how the public will exercise their rights under the Data Protection Act 1998 should they either wish to make a subject access request or have an issue with the information that is recorded about them. Of the two models of public involvement, we would go for the body corporate model as opposed to the delegation model because we see the latter as being quite confusing for members of the public who want to engage with the organisations concerned regarding the delivery of services.

Annette Bruton: From a regulatory point of view, we believe that hearing the public voice as part of the evidence for our inspections is really important, and there are a couple of areas in the bill that might help to increase public participation in the inspection process. One of those is the principle of person centredness. We involve laypeople in our inspections, and we take more than 3,000 complaints a year from members of the public specifically about services, which we investigate. That already gives the public a voice. The protection of people’s human rights is also fundamental to the bill, and the public could either come to us with complaints or raise such matters as part of the work that they do in inspections to ensure that those rights are being upheld. We think that there is some potential for us to increase public participation in our inspection regime.

Claire Sweeney: Audit Scotland has long advocated users and carers being at the heart of the way in which services are delivered, and what is coming through strongly is the important role that local professionals such as general practitioners and social work staff play in shaping how services develop over time. However, it is less clear how the public will be involved and, as the bill develops, we are keen to hear more about how their voice will be heard, as it is very important that it is at the heart of service delivery.

Dr Coia: I echo what has been said. The Scottish health council, which is part of our organisation, is responsible for delivering the Scottish Government’s national person-centred health and care programme, which will extend out through community services. We also have a statutory duty of user focus and feel that, in addition to what the bill provides, we already have the framework in place for that.

Robbie Pearson: The Scottish health council already has a participation standard that is mandatory for national health service boards. We assess NHS boards against that standard in terms of how they engage with the public and service users. In addition, local authorities have the national community engagement framework standard. We have an opportunity to align the Scottish health council’s participation standard and local authorities’ community engagement framework standard. That would give us an indication of how we could join up and arrive at a common language about engagement with communities and individuals.

Jim Martin: Structures can be very easy for administrators to find their way around. The issue that I have is that, whichever structure is in place, it must be easy for the ordinary person to access and get around. When we look at structures, the first thing that we should look at is not how they will be administered but how accessible they will be.

Secondly, when people are in that system—one that is easy for them to access—there must be a simple and standardised way for them to raise any issues that emerge. The question was about involvement, and there is a difference between involvement and access. If people are genuinely to be involved in the care and the healthcare that they receive, they must have a simple, standardised and effective means by which they can engage.

Richard Lyle: Those were interesting answers. I have a follow-up question: does the bill comply with the Christie vision of services that are designed with and for people and communities?

The Convener: Do the witnesses think that the bill will make things better? Is it designed around
the needs of service users? Is it accountable to those people?

Annette Bruton: As we said in our submission, we believe that that is what the bill’s principles seek to do, so it has the potential to do that.

The Convener: Does anybody want to be more enthusiastic? I do not intend that to sound too sarcastic, because I think that what has been said reflects a lot of the evidence that we have already heard. Many MSPs, including members of this committee, are ambitious to make the bill work because what is already in place could be better for service users and others. However, there is much more work to do, between the bill and delivery. Does Robbie Pearson want to come in?

Robbie Pearson: Yes, I just want to develop that. It is about how we engage not just with service users but at a locality level. There is a real opportunity through the bill and locality planning for communities to be more closely engaged than they have been hitherto.

Paul Edie: As Annette Bruton said, the bill’s principles are right. One of the biggest obstacles to getting better outcomes for service users is entrenched organisationalism. Anything that we can do to break down the barriers is to be welcomed. Across the Scottish body politic in general, there is consensus on that. Politicians will perhaps disagree about the emphasis in how that is done, but the general direction of travel is to be welcomed. What we are all about is trying to get better outcomes for frail and vulnerable people.

The Convener: How do we change the culture?

Claire Sweeney: That is the point that I was going to make. There have been lots of attempts to resolve some of the challenges around the lack of integration of health and social care services. We welcome the approach that puts the user at the heart of the changes, which is important. In theory, the bill is about trying to get round artificial divisions between services. There is a real appetite for that to be taken forward at a local level, and we are certainly starting to see signs of the development of partnership work in a much more serious way than we have ever seen in Scotland.

Dr Coia: Just to build on that, one of the great opportunities in the bill is the commissioning powers that it will give health and social care partnerships. The commissioning powers will be partly based on standards. Apart from having both health and social care standards, it is important that we have standards and outcomes that are about what people genuinely think about the services that are being delivered. To build on Robbie Pearson’s point, it is about asking people in a locality what they think about the services. I think that we will be able to answer the question in

the next couple of years, if commissioners adhere to the standards that have been set and have person-centred outcomes.

Mark McDonald: On the public interface, Mr Martin said that there needs to be standardisation, which leads us on to issues around the complaints system. NHS Dumfries and Galloway told us that it felt that there was no urgent need for a standardised complaints procedure. However, the ombudsman’s submission states that

“the areas of health and social care contain competing legislative complaints processes and, without legislative change, there are barriers to these processes working together.”

Perhaps Mr Martin could comment first, but I would also be interested to hear other views on the urgency of the standardisation of complaints. How do you envisage the complaints procedure working in a standardised way? To whom would complaints be directed? Would there be a hierarchy within which complaints could be escalated? That happens now, albeit that we have different hierarchies. My question is really this: what is the urgency and what would the ideal complaints procedure look like?

The Convener: I think that that question is directed to you, Mr Martin.

Mark McDonald: Initially.

Jim Martin: It sounds like it.

I ask you to look outside this room for a second. A parallel development is happening in which the Government is trying to bring the social work complaints procedure more into line with what is happening in other parts of the public service. The word “service” is an important one. The question for me is whether, with integration, we are creating a service or finding a means by which we are delivering services. In my view, the public look at this as a service, so the case for standardisation is clear in the public mind: if we do this, it has to be about that.

At the moment, there are many different routes on the complaints side. For example, I am restricted in what I can look at in social work, but if the Government reforms go through in the way in which they look as if they will, I may have more powers to look at social work issues. I have different powers in relation to what I can look at in social work and health. In health, I can look at clinical decision making, but in social work I cannot look at the professional judgments of social workers. We might have a holistic approach to delivering services to ordinary people, but we make it extremely difficult for people to find their way through the system when things go wrong.

I understand that the procedure in Highland, where services have been brought together, is that
the opening portal for complaints is through the health system, and thereafter people are signposted to either local authority complaints or health complaints. To make a mess of the English language, I note that that is non-joined-upness. 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.

I do not think that the social work provisions will change at the same pace; they might lag a year or maybe two behind the bill. If we are really being public and patient centred, we should look at the system from the perspective of the client and the customer on the way in. Do they see one service or a multiplicity of services? What do we want them to see? Can we arrange things so that, when something goes wrong, it is as simple as possible for them to get things fixed as quickly as possible?

The Convener: Does anyone else want to comment?

Annette Bruton: I absolutely agree with everything that Jim Martin has just said. However, I want to make sure that we protect the level of complaints handling that the public currently enjoy. When we carry out our complaints investigations, we do so on behalf of the complainants and we try to work out with them what they are complaining about and how we can help them to resolve the issue.

Last year, we looked at more than 3,000 complaints. Notwithstanding all the things that Jim Martin said—we come up against barriers too, because we cannot go any further than the social care environment—the advantage for people of the current complaints system in social care is that, when we carry out a complaint investigation for them, it prompts an inspection. If someone comes to us and complains about the care that their mother is receiving in a care home, we can not only investigate the complaint but, depending on its seriousness, immediately go ahead and inspect the home.

It is 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.

The Convener: You must concede that the number of people round the table is a physical representation of the complexity of the system. In many cases, it is difficult even for elected representatives, with the resources and help that we can get and our experience of casework, to get families through the system, so how much more difficult must it be for others? We have two inspection agencies—Healthcare Improvement Scotland and the Care Inspectorate—and we have all these people round the table. We want seamless services so that, irrespective of where someone is on their journey, they can expect the same quality of care. It seems obvious that we should have a system with one entry point to ensure that people are picked up and supported.

Mark McDonald has another question.

10:15

Mark McDonald: My question is on the scope for standardisation. The bill will not cover all social care and health services—it focuses on adult social care and health services, although obviously there is scope for expansion, depending on the use of ministerial powers. How do you envisage the standardisation approach? Do you see the bill as an opportunity to standardise complaints procedure across the board, even though we perhaps do not have integration across the board? We could end up with a complicated picture if one part of the complaints process is standardised, but individual complaints procedures remain for the rest of the system.

Jim Martin: I refer the committee to the work that was done by Lorne Crerar and then by Douglas Sinclair. As I think I have said to the committee before, one of the most frustrating things that I find about the Parliament is that the pace that we go at between taking a decision for change and implementing the change sometimes seems very slow. Lorne Crerar was asked to start his work on standardisation and scrutiny in 2007. We are now in 2013 and we have just begun to implement standardisation across local authorities, housing associations and other bodies. If we are serious about integration, all aspects of integration should be looked at, which should include complaints. It is a matter of some urgency. I would not want a system to be put in place and then have a lag on the complaints side that causes people to become frustrated with the system and begin to lose confidence in it. I urge people to think carefully about that.

Annette Bruton makes a good point about the way in which we handle complaints. The bodies that are represented around this table have greater scope for joint investigations on some aspects. Bodies such as HIS and others have greater scope to use the information that we have in our databases to inform their inspections.

The Convener: We are on the same channel, and we share that frustration. It is 18 months since the committee made what I think were decent recommendations on HIS and the Care Inspectorate working together, and we raised all the issues that have been raised today. We share that frustration with slow progress. Do we have
around the table the same scenario that exists on the ground, which is that everybody is for change and working together until it impacts on them? We need to take pretty difficult decisions within organisations to break down those barriers. Is the cultural resistance that we perceive on the ground at the point of delivery reflected right the way up? Are we not all guilty of that?

Dr Coia: I do not think that we are culturally resistant. We have a huge opportunity in the integration bill. The Care Inspectorate and Healthcare Improvement Scotland have begun pilots on integrated scrutiny, which have been successful. Also, I do not think that we have issues about feeding in complaints. As organisations, we have started meeting regularly with the Scottish Public Services Ombudsman to look at the pattern of complaints in different areas.

Annette Bruton made the point that the issue is not reluctance to join complaints systems together; it is how we ensure that we provide absolutely the best service when somebody complains. I think that she was saying that the Care Inspectorate’s process for dealing with complaints is to look at them properly and work out what is actually wrong. The same system exists in the Scottish Public Services Ombudsman in relation to clinical care. The public ombudsman’s office can do huge in-depth deep dives into what is really happening clinically. Our challenge is to join the two together. I totally agree with you on that, and we would love to join them together but, when we do that, give us a chance to have some pilots to ensure that we do not lose any of the specialist expertise. I would say that it is not a cultural issue.

The Convener: The frustration expressed by Jim Martin and by ourselves is shared by the cabinet secretary. That is why we have the legislation, as Claire Sweeney said. Malcolm Chisholm, who is here today, previously attempted to encourage that change over a long period of time. The legislation has been brought about by frustration at not having been able to change the landscape and focus on people who are using the services. That is why we are here. What is Claire Sweeney’s view on that?

Claire Sweeney: The scale of the challenge becomes clear to us through local audit work looking at how public resources are being spent across Scotland. It is a huge cultural change for people at all levels and there is a need for really strong, clear, local leadership and a shared vision, and for clarity about how resources will be used and to what end. Most important, the thing that has been missing in the past is focus on the impact, on the difference that it is actually making to people, and clarity about what the intended change is supposed to be. Those things will help to move us forward, but the scale of the challenge is significant.

We have talked about complaints, but there is a raft of other issues around workforce, skills, whether the resources are in the right places, and giving people time to think differently. For example, GPs are important, but do they really have time and do they really have space to contribute to a challenging agenda that involves working in a different way? There are lots of issues to unpick.

The Convener: Does anyone else want to respond to that? Does silence indicate agreement?

Robbie Pearson: I am certainly in agreement. A crucial element is ensuring that, when we talk about health and social care integration, we bring together elements such as GPs in local communities. The increasing engagement of GPs in this agenda will be a marker of success in the future, whereas it has not been so robust with the community health partnerships.

Rhoda Grant: We have spoken about complaints, and I note that Audit Scotland’s evidence also mentioned the fact that it was not clear that the different bodies making up the new corporate body would have different audit procedures in place. We also heard previously that there are different statutory procedures in place for such things as staff governance between health and local government. I wonder how a new body gets over that, because we have heard in detail about how messy complaints can be. Once you get into staff governance, audit and the like, how can you ensure that the new body is workable? That is one of the concerns that has been brought to us.

Claire Sweeney: Audit Scotland’s submission raised technical issues and broader issues that we would want to see addressed going forward. There are technical issues around how the body corporate would work in practice, with questions such as whether there would need to be a set of accounts, whether auditors would have to be assigned to the new bodies, and other technical details underpinning how the body corporate process might look.

Highland is up and running with the lead agency approach, so we are already tackling the challenges around the financial audit process for that model, and there has been a lot of useful learning from that approach. One of the bigger issues that we flagged up in our response is that the new organisations will be responsible for a significant amount of resource across the local area, and there are also issues of local power balance, the capacity to provide strong, local leadership, and the technical skills needed to
support that arrangement. We want to see those issues addressed.

Dr Coia: I want to raise the issue of clinical governance in the new bodies corporate. In Healthcare Improvement Scotland, we currently assure clinical governance throughout the NHS. As far as the body corporate is concerned, it is important to have arrangements around both clinical governance and care governance in order to deliver the quality and safety of services in clinical terms. We are now beginning to have discussions about clinical governance within the body corporate.

Malcolm Chisholm: Claire Sweeney’s contribution, and her paper, raise two of the central issues: governance arrangements and resources. I suppose that the question of how resources will be determined is a straightforward one. We might wish to discuss that in more detail in a moment.

The discussion around governance raises wider issues. In the first evidence session, quite a lot of people were wondering what the relationship was, within the body corporate model, between the chief officer and the health boards and local authorities. There is still a lack of clarity on that. Audit Scotland says:

“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 its report makes various other comments on the matter. I do not know whether people have a view on that, or whether the bill needs to be tightened up in that regard. To quite a lot of people, it is not entirely clear what that relationship is. There is a shifting of power towards the chief officer, but it is not clear how complete that is.

Another angle came from the Information Commissioner’s Office. Its submission states:

“section 21 places responsibility and liability squarely on the person to whom functions are delegated”.

That is presumably the chief officer in the body corporate model. However, the ICO submission goes on to say:

“It is assumed that the Health Board and Local Authority will be joint data controllers”.

Even on the issue of responsibility for information, it is not entirely clear to me whether it is the host bodies from which power is delegated or whether it is the chief officer and the board to whom power is delegated.

The last point on governance is about exactly who will be involved on the board. We had long discussions in the previous two evidence sessions about the involvement of the public on the board. Audit Scotland has said that the role of health and care professionals is unclear. There seems to be a lack of clarity about the governance issue; I do not know whether people think that it should just be left to local arrangements. It seems that there needs to be more clarity on that nationally, as some aspects have significant legal implications.

Claire Sweeney: I refer to our submission, which set out some of our concerns about that lack of clarity and the need to be clearer in future. We know from previous work that we have carried out around community health partnerships, for instance, that clear accountability and a clear sharing of resources are a very powerful combination. The potential is there, but the question is how it can be taken forward in a practical sense, and that will be interesting to see as the bill develops.

Maureen Falconer: From the perspective of the Information Commissioner’s Office, the issue is about who is a legal entity. When it comes to pointing the finger of accountability on behalf of data subjects, the body corporate is easier for us, in a way, as it is a legal entity, and that is what we would pursue for some kind of redress, or to determine whether there had been a breach of a nature that was serious enough to impose a civil monetary penalty. That penalty would come from the legal entity, which is the body corporate.

Things become much more difficult, as Audit Scotland rightly says, in respect of joint data controllers. Part of the lead agency model addresses the question where we would point the finger of accountability in the event of a breach. If the breach was significant enough for a civil monetary penalty to be imposed, from whose budget would that have to come? If we have a joint data controller relationship, we have to tease out all those details very carefully in any joint data controller agreement.

That is why I said at the outset that the body corporate model is the easier one from our perspective—and also from the public’s perspective, I think. When people are engaging with a service, they point to that service as being the person from whom they will seek redress. If the board then says, “We are giving you the service, but it is not really us. You will have to go somewhere else because we are joint data controllers and that bit of the service is actually provided by another data controller,” everything becomes very messy.

10:30

Rhoda Grant: That is interesting, but one of the concerns is that, if we are to make the system work, we will have to set up a body—an entity on its own—and then reproduce all the functions of the two parent bodies such as audit, staff governance, clinical judgment and so on. How
much would that cost and how much would it remove from the services that we are trying to provide? The bill is designed to provide better services to those on the ground, but what if we spend much of the existing budgets on setting up a new service? Will it need to be funded by central Government? Will it need to be a body in its own right? How does that work and what costs will be attached?

Maureen Falconer: I am afraid that I do not have an answer to that. My perspective comes from the Data Protection Act and thinking about individuals and their rights under that act. What I am advocating will not necessarily be the best thing for costs to the Scottish Government. I could not answer that question.

The Convener: I suppose that it takes us to another question arising from previous evidence about how the organisations here fit in with the health board, the local authority, or three local authorities, the body corporate, or the community health partnerships. How do you all fit in to that? Is it a structure or structures? How does it all fit together with budgets going here and there? Who is accountable? How are the additional ministerial powers to be used if we do not understand the body corporate structure and what we should expect from it? How will we know when it is appropriate that the minister should intervene?

Claire Sweeney: Audit Scotland will clearly take a close interest in any area of the public sector that is going through a time of significant change. Resources are involved and we will be interested in how public money is being used, not least because the risks at that time are greater and significant.

There are two issues for Audit Scotland. The first is the technical arrangements around the finances. We have already touched on those and referred to them in our response to the committee. To understand what they will look like in practice, we need to understand a bit more about how those local arrangements will work in practice. It is very hard to say at this stage whether financial auditors ought to be appointed. To go back to the model being used in Highland, arrangements are already in place there. As I mentioned, lots of lessons have been learned from going through that process and those lessons are transferable to a body corporate arrangement in some cases.

Secondly, we also have a broader interest in how the inspectorate approach is working for that integrated system and, more generally, how good value from all the public sector resource is being achieved through that change. We are keeping a close eye on that and will continue to do so as some of the technical issues become resolved. Work is under way to address some of those challenges.

Dr Coia: Healthcare Improvement Scotland’s perspective is that, if we start with an older person who ends up in accident and emergency, we are interested in what they are interested in and in quality assuring the pathway that gets them from primary care, through social care, into an accident and emergency department.

We get too bound up with structures. We can set outcomes and standards for each stage of that journey so that the person can look back and reflect on whether they had a good or bad experience. In our joint inspections, we are going out and looking at those pathways to see whether they are working. A pathway will take a patient from primary care into strict nursing, through the body corporate, which I hope will have a great opportunity to provide intermediate care in the community, which would be a step up from having to use an accident and emergency department.

If we set the right standards, measure the right outcomes and ask people how the pathway experience was for them, that is what we and the Care Inspectorate quality assure. We will not be quality assuring the structures that are in place.

Annette Bruton: To build on the point that Dr Coia has just made, the new inspections that we are developing will be able to be carried out irrespective of the structure and will follow outcomes for people.

We have been able to demonstrate over the past seven or eight years how we do that with child protection and children’s services where, irrespective of the structure inside a local authority or, indeed, the community planning partnership, we have been able to examine the outcomes and impact on children and young people. In our triennial report, we have recently been able to reflect on where that partnership working has got better.

To support Denise Coia’s point, if we work back from the outcomes, inspection can probably be flexible enough to deal with the structures that are deemed to be necessary locally.

Bob Doris: It is almost as if we had discussed how to provide a seamless link, because I have been sitting patiently waiting to ask about the inspection process.

Sometimes, the Care Inspectorate can move quickly. Before the committee’s inquiry into care for older people ended, Nicola Sturgeon, who was then the responsible cabinet secretary, moved to improve the inspection regime for the sector. Sometimes, things can move quickly and effectively. It is important to put that on the record.

I am interested in care pathways. I know that there has been joint working between the Care Inspectorate and Healthcare Improvement
Scotland. How close are we to having one inspection regime? We are talking about integration, so rather than the Care Inspectorate or Healthcare Improvement Scotland going out, can we not just have the relevant inspector—I am not fussed what the organisation is called, to be frank—going out alone with a joint assessment tool and doing the inspection?

I hope that that is where we are going, so some comments on that would be useful, but I should stick to the details of the bill. I notice—I will read from the notes—that

“The policy memorandum to the Bill outlines that the Care Inspectorate and HIS will be required to ‘scrutinise strategic plans for quality and standards, and to ensure the plan will effectively achieve the objectives of the integration plan and the nationally agreed outcomes.’”

That is a widening role and an important check and balance within the system for the strategic plans.

I would welcome comments from Healthcare Improvement Scotland and the Care Inspectorate about how ready their organisations are to do that. How close are we are to having a single accountable officer for those inspection bodies—rather than both organisations doing it—doing the job so that the service and the inspection side are integrated?

Annette Bruton: I am certain that Robbie Pearson will also want to come in on that question.

If we look solely at older people’s services, we would say that we are making really good progress. As far as those who are being inspected and, more important, those who receive the services are concerned, it does not matter whose logo is on the report; they will get a single report that will pull together expertise from Healthcare Improvement Scotland and the Care Inspectorate that will comment on, and provide assurance about, the care pathway.

The landscape is a little bit more complicated than that, however; in terms of children’s services, Healthcare Improvement Scotland will be involved to some extent, but so will Education Scotland. We face in different directions for different stakeholder groups, so we need to think about the landscape for protecting all vulnerable people, including through housing support and criminal justice. The work that we have done on children’s services has demonstrated that those who receive inspections and those who benefit from them see it as a single inspection methodology and do not distinguish between inspectors.

Robbie Pearson may want to comment on the progress that we are jointly making on older people’s services.

Robbie Pearson: There is a real appetite and opportunity to do something imaginative in the joining-up of scrutiny. It would be difficult for us, through scrutiny, to make demands about integration in service delivery but not to demonstrate integration ourselves.

We have already undertaken three pilots—in West Lothian, Inverclyde and Perth and Kinross—which have been excellent opportunities to demonstrate joined-up working between HIS and the Care Inspectorate.

However, we also need to respect the different skills and expertise that each body brings. Healthcare Improvement Scotland will bring certain specialist expertise, as will the Care Inspectorate in relation to social work input, for instance. Notwithstanding that, our inspections are now looking at the journey of patients. In one inspection, for example, we looked at the case records for about 90 older people, of which about 20 were identified as including areas for further follow-up.

Such inspections provide a real opportunity to show that we are looking at the pathways of care, the things that precipitate hospital admission and the things that prevent discharge from acute hospital settings. As we take that forward, the bigger opportunity for us will be to link that to a broader and more comprehensive assessment about the quality and safety of NHS care within individual systems, in the context of what we are doing with the Care Inspectorate.

The Convener: Did those pilots include residential acute settings as well as community settings? What did the pilots examine?

Robbie Pearson: The pilots looked very much at community-based services. Obviously, we have a separate inspection regime for acute hospital settings, but the issues that we identify within acute settings, including the things that bring people into hospital through accident and emergency departments or the things that prevent discharge, have resonance with our wider inspections with the Care Inspectorate.

The Convener: When will that information be available?

Robbie Pearson: Do you mean information on the joint inspections?

The Convener: Yes.

Robbie Pearson: We will share the key messages from that in due course. We will not publish reports on the three pilots, but we will learn from them how to apply the methodology.

Dr Coia: I add that we should remember what both our organisations need to do in addition to straightforward inspections. In looking at care
pathways, it is important for conditions such as asthma or diabetes that the right treatments and facilities are available. The evidence that Healthcare Improvement Scotland uses for that comes from the SIGN—Scottish intercollegiate guidelines network—guidelines and a wide range of standards that we produce. In the same way, the Care Inspectorate has specialist expertise in children’s inspections, with links across to education.

It is nonsense to talk only about the structures, but it is important that we do not, in terms of standards and outcomes, lose specialist expertise when we combine the inspections and complete the circle. I agree that it is nonsense for the public that institutions are inspected by different people from different organisations doing different things. When we go out to inspect, there should be one group of people doing one thing.

Claire Sweeney: It is also worth mentioning that there are processes whereby inspection agencies come together to share knowledge about their local area, to think about the risks and to consider what those mean for inspections. Post Crerar, a process was established to draw those issues together in a place-based focus, I guess. That is a slightly different cut of the same issue.

Bob Doris: I accept that the important thing is that the public have an identified individual who is responsible for the inspection and to whom they can go for information. We also need to keep the expertise behind the scenes, in whatever way that is done most efficiently. However, no one has made specific reference—I do not know whether this omission means that you are supportive of the proposal—to providing quality assurance of the strategic plan for integration. Can we get something on the record about that?

Also, given that the bill is not simply about health and social care integration but about public bodies’ joint working, there is scope to include a range of services that are provided by local authorities and health boards—older people’s care, children’s services and housing—in partnership working in the years ahead. Therefore, are there other agencies that should in the future provide quality assurance for the strategic plan? It is getting ahead of ourselves slightly, but as well as hearing about the importance of your input in signing off such strategic plans, I would be interested to hear whether you anticipate that any other bodies might have an overview of plans in the future?

Annette Bruton: That is a very important point and we missed it out. The Care Inspectorate has certainly been discussing with Healthcare Improvement Scotland what we could bring to strategic commissioning, which we think will be a key part of the plan. Obviously, Audit Scotland will be interested in strategic commissioning from a governance point of view, but we believe that jointly, we could bring quite a lot of assurance and, indeed, could undertake follow-up action if necessary.

We can look at whether the intelligence that is being used to commission services strategically is having an impact on the front-line services that we inspect. In other words, a strategic commissioning plan may seem like the right plan for an area, but we can test that by examining the services that people receive and working back from that.

We believe that we have, collectively, a lot to offer on that aspect of the bill, but I can see that Audit Scotland would also want to have a view. We work jointly with Audit Scotland on a number of strategic inspections when we might want to have a view about leadership and governance, as well as a view on the quality of people’s care outcomes. It is a very important point.

The Convener: Is there anything to stop you from carrying out that assurance now? I think that the HIS submission mentioned sufficient powers or additional powers.

Robbie Pearson: Certainly, there is nothing that cuts across our being able to do that at the moment; the work that we are already testing out with the Care Inspectorate demonstrates that. We would encourage the inclusion of a reference to scrutiny on the face of the bill, through an amendment. We should be working within our existing relationships, not letting structures get in the way, and we should push on with assurance, which is what everybody wants.

The Convener: To go back to cultural change and what makes it happen, we have just heard from Robbie Pearson that there is really nothing to stop us—we have sufficient powers to carry out that cultural change. I suppose the obvious question is, “Why aren’t we getting on with it?” What is going to drive that cultural change? Will it be the legislation itself? Will it be the ministerial powers? Will it be the shifting of budgets? Will the more focused human rights agenda that is at the heart of the matter help to change the culture?

Dr Coia: I will base my answer on my experience, because I am very old.

The Convener: Not at all.

Dr Coia: I have been through this before. I have worked in integrated teams; as you know, psychiatrists have long had integration with community mental health teams. For me, it boils down to leadership. It is about setting the right space. Once you have that and the principles, it is
about leadership at local level because it is people and leadership that drive change. The bill gives us a very good framework, within which we have sufficient powers in which to operate.

**The Convener:** Do service users have sufficient powers, in terms of their enforceable rights, to change the culture to one with a person-centred focus? That is a change that everyone believes should happen.

**Dr Coia:** It absolutely part of our job in the Care Inspectorate and HIS to be working for the public. We should be held to account for how we involve the public in our quality assurance of services, including how the new community health and care partnerships are involving the public. It is very much part of our role to answer that question.

**Annette Bruton:** Our involving people group met last week; it was keen that I say to the committee that one way to hold people to account is to listen equally to the voices of service users and of those who provide the services. The group believes that holding the people who run services to account for the outcomes is how to get integration.

**Malcolm Chisholm:** I agree with what has been said—cultural change rather than structural change is the thing. However, I still think that the resource issue will be key to this and there is not really that much in the bill about that. There is scope for great variation in terms of what money is put in and how it is put in.

I know that Audit Scotland had serious concerns about the arrangement, in terms of how budgets would be determined. Do the witnesses have any views on that? Most of the witnesses have been content to leave that to local discretion, but one or two have said that there should be more central determination of budgets because otherwise there will be enormous variation. The key issue that people have flagged up—how acute budgets will be involved—will be left to the discretion of health boards. I am interested to hear comments on the resource question.

**Claire Sweeney:** It is difficult to say how the audit process would follow the money because it is not clear yet how the body corporate—our model—will work in practice. In previous audit reports that we have presented to the Public Audit Committee we have been clear that sharing of resources is very powerful, but there is a need to be clear about what is devolved, who is responsible for what and where the focus will be. We would not comment on the extent to which that should be prescribed, but there is a need for real clarity about what is involved in that sharing of resources and how it will be accounted for. It will be interesting to follow that through the strategic commissioning arrangements and to consider the impact that that shift makes over time. It is a challenge. We are considering services for older people and we can see the scale of the challenge in terms of how resources across both systems are used. It is very difficult.

**Richard Lyle:** A question about VAT arose at a meeting that I attended yesterday. Does Audit Scotland have any views on how VAT will be tackled with merging budgets and so on?

**Claire Sweeney:** That is another issue that we have raised in our submission and which needs clarification. What type of body is the body corporate? That has to be decided. There are different VAT arrangements for the NHS and local government, so we need to understand what type of body it will be. Once that is established, the VAT arrangements should be clear.

That goes for several different technical issues. There are different arrangements, for example, for the finances and the accounts for health and social care services. That all needs to be much clearer so that we understand what arrangements and legislation apply and when.

**The Convener:** Has Audit Scotland been involved in that process? Other issues that have been raised include pension implications, and we have a note from the Finance Committee—it is really for the Cabinet Secretary for Finance, Employment and Sustainable Growth—about the equal pay, pension and VAT risks. Has Audit Scotland done any work on those matters?

**Claire Sweeney:** There are several strands of work that touch on that process and a lot of local financial audit work deals with those issues, so they have been addressed in the audited accounts and the annual reports for the local bodies. We produce overview reports for the NHS and the local authorities each year, and some of those pressures and risks recur. We have flagged them up over several years and we have been involved in discussions about how they could be resolved.

**The Convener:** To link that directly to this legislation, has any correlation been made—

**Claire Sweeney:** We are keeping a close eye on how those discussions evolve, but we have flagged up the risks around the need to be clear about which type of body corporate it might be. There are implications; there is a raft of issues that need to be resolved.

**The Convener:** Is all that on the record?

**Claire Sweeney:** Yes, it is—through submissions to the committees and discussions with the Scottish Government.

**Nanette Milne:** We have heard a lot this morning about the need for good local leadership. I was lucky enough to be in Inverness last week
and in West Lothian yesterday where, in their different models, there is good leadership and great enthusiasm, and everyone seems to work well together. What about areas where there is not good leadership at the moment? We know that different organisations are at different stages of this journey towards integration. Will the bill help in the areas where there is no leadership?

The Convener: Is there any response? There are no takers.

Rhoda Grant: My question is for Maureen Falconer; it is about information sharing. Last week, we heard—from the British Medical Association, I think—concerns about the single shared assessment being shared only in paper form. The view was expressed that if services are to be integrated, information technology needs to be integrated into how information is shared. That is a big challenge, given that we are talking about a body corporate, two different organisations and data protection, especially in a highly sensitive area such as health. Have you had any thoughts about how that could be done?

Maureen Falconer: With great difficulty. It is a challenge now; it will not be the case only when we have whatever body ends up being set up as a result of the bill.

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.

We are contacted more and more about information sharing in the public sector. It is a question of getting it right and setting things out in a protocol. It is about understanding what we are sharing, why we are sharing it and with whom we are sharing it. It is about accountability and responsibility. Once the information is there, who is the data controller for it? There are many questions, but they are not new questions.

A round the public sector, there are good examples of good information-sharing protocols having been used successfully, which allows information to be shared and services to be delivered properly and on time. Equally, there are bad examples. The difficulty is that, for understandable reasons, the health service tends to be extremely protective of its information. That does not mean that information cannot be shared; at issue is how people go about that.

Paper is no better and no worse than electronic processing. If you look at our website, you will find that many of the breaches that occur relate to information on paper going astray or something untoward happening to it. That is less common with electronic versions, although there are issues with electronic processing, too.

It is a matter of understanding what you want to do and of having a system that allows you to do that. When new structures come on stream, people often think about getting new systems. There is a cost involved with that. An issue that we have is that people will say, “We have the very system for you,” which they sell on the basis that it is an all-singing, all-dancing system with buttons and bells on it, but when someone tries to use it, it turns out that it does not do what it was supposed to do. In that respect, as we mentioned in our submission, we think that a privacy impact assessment should be carried out, so that people can raise issues to do with privacy, and can look at where infringements of privacy could be possible and how they might be mitigated in some way.

For us, it was a disappointment that a privacy impact assessment was not done alongside the bill, because the policy development to which it relates would be perfect for a privacy impact assessment that highlighted all the privacy concerns, including those about information sharing, which is fundamental to what is proposed. Integration will not happen unless there is information sharing; our fervent hope is that, at some point, a privacy impact assessment will be done that will look at information sharing in particular, as well as issues to do with the data controller and where responsibilities lie.

The Convener: We have covered a number of issues, as we expected to do. We said that we were here to listen—I suppose that there was a bit of tokenism at the end.

We will welcome your on-going observations and input, as people who are interested in and affected by the process. Thank you very much for all the time that you have given us and for your written evidence.

11:00

Meeting suspended.
On resuming—

Public Bodies (Joint Working) (Scotland) Bill: Stage 1

The Convener: Our final agenda item is an evidence-taking session with the Cabinet Secretary for Health and Wellbeing on the Public Bodies (Joint Working) (Scotland) Bill at stage 1. The cabinet secretary has been joined by the following Scottish Government officials: Kathleen Bessos, deputy director, and Alison Taylor, team leader, both from the directorate for health and social care integration. John Paterson stays with us from the previous session.

I invite the cabinet secretary to make an opening statement.

Alex Neil: Thank you for the opportunity to discuss the Public Bodies (Joint Working) (Scotland) Bill. I will take a few minutes to say a word or two about the bill.

First, in terms of the overview, as the committee is aware, the bill provides the framework for the integration of health and social care and sits alongside the Social Care (Self-directed Support) (Scotland) Act 2013 and other key policies to deliver the Scottish Government’s personalisation agenda. The bill promotes person-centred planning and delivery to ensure joined-up, seamless health and social care services, with the aim of improving outcomes for service users, carers and their families. We will do that by legislating for national health and wellbeing outcomes that will underpin the requirement for health boards and local authorities to plan effectively together to deliver quality, sustainable care services for their constituent populations.

Importantly, the bill aims to bring together the substantial resources of health and social care to deliver joined-up, effective and efficient services that meet the increasing number of people with longer-term and often complex needs, many of whom are older. We are all aware of the Audit Scotland criticism on the failure of community health partnerships, which is why the bill focuses on bringing together the accountability of statutory partners, health boards and local authorities to jointly deliver better outcomes for patients, service users and carers. For too long, health boards and local authorities have ended up in a cycle of cost shunting. The bill requires health boards and local authorities to, first, establish integrated arrangements through partnership working; and secondly, to provide for two models: delegation to a body corporate, established as a joint board, or delegation to each other as a lead agency. The health boards and local authorities will be required to delegate functions and budgets to the
integrated partnership; as a minimum, those will be adult primary care and community care; adult social care; and aspects of acute hospital services.

Secondary legislation will set out functions that integrated partnerships will be able to include, such as housing or children’s services, where there is local agreement to do so. Indeed, there are areas across Scotland, such as West Lothian and Highland, where that is already working well. Each partnership will be required to establish locality planning arrangements, which will provide a forum for local professional leadership of service planning and will encompass an assets-based approach, building on local knowledge and best practice to meet the needs of the local population. The integrated partnership will be required to prepare and implement a strategic commissioning plan, which will use the totality of resources available across health and social care to plan for the health and social care needs of local populations. Importantly, professionals, service users, GPs and the third and independent sectors will be embedded in the process as key stakeholders in shaping the redesign of services.

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.

The Health and Sport Committee has not only taken evidence from a range of stakeholders this month, but has heard during its inquiry into integration that there is wide support for the bill’s principles. For some who are already progressing well with shadow integrated arrangements, the bill might seem unnecessary. However, I think that we are all in agreement that not enough progress has been made under the existing permissive legislation. We have not started from a blank sheet of paper, because many areas across Scotland are already working in partnership to deliver integrated services. Furthermore, we have considered the evidence from across the UK and we are mindful of applying that in a Scottish context. However, I am clear that in order to achieve consistency of progress, it is necessary to set out a legislative framework that will deliver the necessary changes to meet future demands on services.

I believe that the bill strikes the right balance in setting the framework integration, making the necessary requirements on health boards and local authorities to deliver effective integration of health and social care and providing the flexibility to develop arrangements that best suit local circumstances. I welcome the opportunity to clarify the bill further.

**The Convener:** Thank you, cabinet secretary. Gil Paterson will ask the first question.

**Gil Paterson:** It is safe to say that the oral and written evidence that the committee has received so far shows that there is unanimity across the sector that integration is a good thing that people would like to see happen. Officials may correct me, but I do not think that a single submission has said that integration would be a bad thing. However, there are some ifs, buts and maybes. It has been suggested that the reason for failures in the past has been a lack of good leadership—that seems to be one of the key factors—and that there is a need for cultural change. Given that we are hearing from everybody who is involved that integration would be welcome and should happen, why is there a need for legislation? Why not just let it happen?

**Alex Neil:** 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.

**Gil Paterson:** I am grateful for your answer, but it leads to another question. If people are saying that the problems were due to a lack of leadership, where is the provision for good leadership? Or is that an excuse and are people protecting their empires?

**Alex Neil:** Leadership is part of the equation. It is part of the jigsaw of making it happen, and we are providing leadership at the national level through the bill. I have spoken to Iain Gray, a
former minister with responsibility for social justice, and he told me that he regrets the fact that he did not underpin the plans that he had at that time with legislation. Without the legislation it will not work, but the leadership tends to pull the other way because of the vested interests of local authorities and health boards. The bill will ensure that the leadership must pull with integration in both the health boards and the local authorities. In the body corporate model or the lead agency model, the leadership comes from the chief accounting officer or the lead agency. Therefore, the bill will ensure good leadership at the national level as well as at the local level.

**Kathleen Bessos (Scottish Government):** We have made it clear from the beginning that legislation in itself will not change the mindsets of the practitioners on the ground and create the leadership. Alongside the legislative work, we are undertaking a significant piece of work on strategic workforce development; I can say a little more about that, if you would like. For us, strategic workforce development plus the work to support locality development and strategic commissioning is where all this will land—or not land—appropriately. The strategic workforce development group will produce, probably by the end of October, a framework for action that will cover the issues that the member has raised around the support for organisational development; the support for the joint boards regarding culture, language and communications; and the support that chief officers will need to provide the strategic leadership that will be required in a complex situation.

We will say something about management development, education and training for professionals and about our on-going work to develop commissioning skills to create a proper commissioning framework. We are going to do a whole load of work. The financial memorandum identified resource that we will make available to partnerships to support their transition into a new working environment.

**Alex Neil:** I will just add a point about the areas where integration is already happening, such as Highland. A few months ago, I was up in the Royal northern infirmary in Inverness, where people who previously worked with the health board now work with the local authority in an integrated setting. Some of them admitted that they were a bit sceptical, but they now say that it really is the right way to go. I have found many examples of that where integration is already working on the ground.

**Gil Paterson:** To be honest, I am not entirely sure that leadership is the real question. There are some real good people, but they have not engaged.

**Alex Neil:** I think that it varies between different areas.

**Gil Paterson:** In business or in local or national Government, there are always vested interests. I do not think that we can ever take vested interests out of the equation—that is just the way that it is. People protect their budgets and their own wee areas, or big areas for that matter. Do you agree that, in effect, the bill will mean that the vested interests will get much wider and will encapsulate a much greater area? The sphere of influence and vested interest will encapsulate most of the population. Perhaps I should not say that, but that is what I see in the bill and it is my interpretation of what you are trying to achieve.

**Alex Neil:** We certainly want to ensure that everyone has a vested interest in delivering what will be the national outcomes. It is clear that, whether we are talking about strategic commissioning, budgetary procedures, how the constitution of the bodies is established or reporting mechanisms, we are trying to ensure that everybody’s vested interest is in providing the best possible service to the end user.

**The Convener:** We know that you are having discussions with the Convention of Scottish Local Authorities. You might want to bring us up to date on those discussions but, to summarise—I am not saying that this is how it is, but it is how I view it—COSLA says that you are taking wide powers without our knowing how you would use those powers and the circumstances in which you would use them. COSLA’s fear is that you are taking all these powers, but there are no rules of engagement.

In addition, there is a question about how you can be impartial in the process. The Cabinet Secretary for Health and Wellbeing is there to protect, sustain and promote the health service. COSLA perceives an imbalance that it is crucial to resolve as we go forward. Do you agree or disagree with those issues about where the power lies and your role in the process? In what circumstances would the powers be used? Do we need clear rules of engagement?

**Alex Neil:** The first thing to say is that, although I am called the Cabinet Secretary for Health and Wellbeing, I am also the cabinet secretary responsible for adult social care, so it is just not the case that there is a conflict of interest, because I already have responsibility for adult social care. I exercise those responsibilities today and my predecessors exercised the same responsibilities.

Secondly, COSLA has expressed concern that it believes that there is a need for tighter definition of what we mean by the term “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 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 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.

11:45

Thirdly, on rules of engagement, a lot will be followed up in secondary legislation and guidance, but fundamentally the point of the bill is that it should provide a national framework and binding principles—for example, strategic commissioning and the national outcomes—and define the different models in principle that are available to deliver them. We have been very clear about that and have agreed right up front with COSLA and others on it from day 1. It has always been agreed that, beyond that, we want to leave as much discretion as makes sense to local areas to make their own detailed arrangements, and for the bill not to be overly prescriptive. That is a sensible way to go.

I sat through the last 20 minutes of the previous panel’s discussion. Some of the issues that were mentioned will be covered in secondary legislation for various reasons that we will no doubt discuss in more detail later. It does not make sense to put some of those things in the bill; it makes more sense to put them in either secondary legislation or guidance.

The Convener: I am sure that you understand that, in the evidence that we have taken, people have been all on board, as Gil Paterson said.

Alex Neil: Yes.

The Convener: Indeed, the committee is on board, but a specific example is the contention about the shifting budget. The evidence that we have heard is that we can put everything in place, legislate and enable. However, according to COSLA in particular, if we do not shift the budget from the acute sector into the community, the approach will not work. I think that your position on whether you could deliver substantial money would be tested at that point, given that what was wanted was a top cut of money from the health service into the community. That is a difficult call for the Cabinet Secretary for Health and Wellbeing.

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

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.

I will get Kathleen Bessos to talk about this in a bit more detail, but let me give an example. In my estimation, one area in which we can substantially reduce the number of unnecessary hospitalisations is the long-term condition of chronic obstructive pulmonary disease. We hospitalise many people who would not need to be hospitalised, or hospitalised as often, if the proper support were available in the community. Because of the rate of hospitalisation, the budgets for dealing with those people are covered in the acute budget. We want to move some of that into the community. The strategic commissioning plan—it would be a plan—would say that, over a period of years and in agreement with the acute providers, resources will be shifted into the community in a planned way so that within three or four years’ time, say, many more people who suffer from COPD will be treated in the community rather than in the acute setting, and the money will effectively follow the patient in those circumstances.

The Convener: So you agree with COSLA and others that one of the key aspects is to shift the flow of people and budgets from the acute sector into the community.

Alex Neil: That is one of the things that we want to achieve, because we know that people are being hospitalised far too often. If the resources were available in the community, those people would not need to be hospitalised. Let us look at the economics of that. On average, it costs £4,600 a week to keep somebody in an acute hospital in Scotland and around £300 a week to treat a person at home. For those with serious chronic conditions, the average is probably nearer £800 or £900. It makes economic sense to treat people at home, but the really important point is that, where that has been done, patients’ health outcomes have substantially improved. That is particularly true for older people. One of the worst things that we can do is to hospitalise them unnecessarily. We are all at one on that.

I am not sure whether Kathleen Bessos would like to spell out the budgetary aspects of that—she can perhaps do so later.

Nanette Milne: Some of us were in West Lothian yesterday. The question is one of
widening the integration agenda. It is clear that they are working on adult health and social care, but they were also talking about how important housing and children’s services are. How does that tie in with what COSLA is saying to you about restricting integration?

Alex Neil: We are talking about the core of the joint board. The voting membership of the joint board in each local authority area that has the body corporate model will be made up of equal representation between the health board and the local authority. If the board decides that it wants to co-opt non-voting members on to the board, it will have the right to do so. There will be a host of infrastructure around the board and that is where services such as housing will be heavily involved—housing has a particularly important role to play in locality planning. The secondary legislation and the guidance will spell that out in more detail.

Malcolm Chisholm: What Kathleen Bessos said about the wider agenda is very important. All the witnesses have said that structural change in itself cannot deliver what is required. Most witnesses, with the exception of the Chartered Institute of Public Finance and Accountancy, have gone along in general terms with what is in the bill.

What interests me is the detail and there are two areas where I seek clarity. We have already started talking about one of them—acute budgets. In your opening statement on the bill, cabinet secretary, you spoke about aspects of acute hospital services and you gave the example of COPD. First, there is the question of who will decide. I presume that, in terms of what you propose, it is up to—in fact, I do not know. Will the health board decide, or will it be the partnership? Who decides?

The more fundamental question is, how much of the acute budget is to be shifted? Is it money to pay for reprovisioning in the community, or is it a much larger block of the acute budget? You are probably aware of NHS Lothian’s concern that it sounds as though you might be taking a much larger block of the acute budget. You would then be getting a position in which the body corporate commissions from the acute sector. That is where the return of language such as “commissioner-provider” or even “purchaser-provider” has come in. It is important to know in detail how the proposals will work. How much money is being transferred and what is the relationship between the body corporate and the rest of the health service?

Alex Neil: I will get Kathleen Bessos to explain the exact mechanics of how things will work. It is important for people to understand the detail of those mechanics.

I will not be reallocating anything. It will be an entirely local decision and it will be driven by the joint board—by the body corporate or by the lead agency in the Highlands. It will not be me making the decisions; there will be 32 decision-making bodies across the country that will be making the decisions.

Malcolm Chisholm: I understand that—but some people have expressed concern about that.

Alex Neil: A key point of this whole exercise is substantially to increase acute care in the community. If we were not going to give the joint boards some responsibility for the acute budget, that would defeat that particular purpose of the integration agenda.

We should not think in terms of a precise percentage of the acute budget, and I will tell you why. If you pick an acute hospital—say, Perth royal infirmary—and compare it with the Glasgow Southern general, you will find that the Southern general has a much wider remit than just the local authority area that it is serving. Perth royal infirmary does serve people outside the Perth area, but Glasgow Southern general is a teaching hospital with a range of other responsibilities. 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.

Kathleen Bessos will explain the budgetary process and how we deal with the acute plan, which starts with the unprecedented transparency of the acute budget.

Kathleen Bessos: That is right. 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. That is the important point, and that can be clearly articulated. The key question then becomes which aspects of acute resources lend themselves to being used in a different way. Clearly, there are services such as neurosurgery that do not lend themselves to being redesigned to support an improved pathway of care, particularly for older people.

As the cabinet secretary said, we have been working closely with the chief executives of the NHS boards to unpick the complexities—how do you land this thing so as 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?

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.

For example, in community acute hospitals it is likely that all of that budget will go with the functions and be in the integrated pot, so that that resource can be used flexibly on a daily basis. However, 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.

Clearly, it is not the whole of the acute budget, but we think that we have a model. The deputy director for health finance in the Scottish Government has already asked partnerships to give an early indication of what percentage of resources would be in scope, and I am sure that once she has a comprehensive picture she would not be unhappy to share the generality of that, given that the partners are in the early days of working through the amount. However, there is a significant amount in scope.

Malcolm Chisholm: It would be helpful if some of that detail could be provided to the committee and made available more generally. It has become one of the main points of interest in the discussions and I know that there is concern about it in some health boards, so I could probably ask lots of follow-up questions. One basic question might be whether the decision about how much money is in scope is a decision of the body corporate or a decision of the health board. There is lots of scope for tension between those two and I suppose, is that general point, as everybody knows, is that even in shifting the balance of care, because of demography, it is not as if acute budgets can be decreased in absolute terms. There are so many questions around that.

Alex Neil: The key tool is the strategic commissioning plan. Let us take COPD as an example, and let us say that it is for Edinburgh, Malcolm Chisholm’s area, because the health board and the council have signed up to the scenario. Part of the strategic commissioning plan is to treat far more COPD patients—a percentage might be specified—in the community. To provide that service will require not just GPs, but acute consultants to work in the community. The pace at which it is done, the resource allocation and the way in which it is done should all be part of the strategic commissioning plan, which must be drawn up by the joint board—obviously, Edinburgh is a body corporate model—in wide consultation with not only the health board and the local authority but a range of other bodies. The requirement for a consultation group on the strategic commissioning plan is in the bill. It is not a case of a unilateral decision being made. Everything must be done in consultation with the key stakeholders and then, once the plan is agreed, everybody is signed up to it.

12:00

Alison Taylor (Scottish Government): To pick up on a technical detail, the bill sets out that the original agreement between the health board and the local authority, which the bill describes as the integration plan, sets out the functions and the method of calculation for payments to go with the functions in the integrated arrangement. Therefore, at the overarching level—the level of the framework about which the cabinet secretary has been talking—the health board and the local authority will have that initial discussion within the parameters of what must go in, which will be in regulations. Then, once we get into the mechanics of working out how to improve outcomes, it is exactly as the cabinet secretary said: the determination comes into the strategic planning process.

Malcolm Chisholm: That is fine for the management of a particular condition such as COPD, but when it comes to the more general question of shifting the balance of care and reducing emergency admissions, it becomes a bit more difficult. It would be helpful to have some more detail on that.

The second matter on which there has been much discussion is the precise governance arrangements, particularly the position of the chief officer of a body corporate. Again, I am drawing on what the people in my area are saying. The City of Edinburgh Council and NHS Lothian are both saying that there is a view that the balance has shifted more than was intended towards the chief officer, that, in fact, far more responsibility and decision-making power will be located there and that, in some ways, there will be a weaker relationship with local authorities and health boards than was intended in the consultation document.

I would welcome any views on that. Have you had discussions with various health boards and local authorities about it?
Alex Neil: 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. They have to be employed by the local authority or the health board for a host of other reasons.

However, that is not to say that somebody who is not currently employed by the health board or the local authority could not be the chief officer. It could be that such a person applies for the job, but it would then need to be decided who their employer was. That is a technical issue.

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.

Malcolm Chisholm: The view has been expressed that the policy intention has not been translated into the wording of the bill. We will have to consider that at stage 2.

Alex Neil: We will do that.

Kathleen Bessos: That is right. We have a human resources technical working group considering the matter. The comment has been made—and we have registered it—that the chief officer will be accountable to the joint board for developing and delivering the strategic plan. However, they will have an operational line to the two chief executives for the operational discharge of that responsibility. We will do further work to clarify that, because it is a legitimate point.

Alex Neil: We are considering whether we need to lodge an amendment at stage 2 so that there is no dubiety on the issue.

The Convener: That was an interesting exchange. I have a wee parochial comment on it. I am concerned about the answers about the flow of acute budgets coming from non-specialist hospitals and worry about the sustainability of local hospitals that provide acute services. It seems that that will be the focus of drawing some of the budget out. I might be wrong, but I note the concern.

Richard Lyle: I say again that I welcome the intentions and objectives of the bill. Yesterday, I was fortunate enough to be part of a delegation that visited West Lothian, and I was impressed with what is being done there, including in the local hospital. I take on board the comments that you made about that.

You mentioned that you want disabled people to be involved. Later yesterday afternoon, we had another visit and we were asked how involved disabled people will be. You talked about who will be on the boards and said that there will be voting rights for the councils and health boards, but which independent people will we have on the boards? Will the bill state who will be on them? In response to a question that I was asked yesterday, I said that it might be that 100 organisations want to be on the board, but we cannot have that number at the top table. How do you intend to specify or decide who should be at the top table?

Alex Neil: There is a specification that, for example, there should be a representative from the staff side and a representative of the public, but there is a wider question about the accountability of the bodies. We have a piece of work going on to look specifically at how we can enhance the accountability of not just the health service in general, but the integration joint boards in the future. We do not think that we need to do more on that in the bill, as we believe that we have all the powers that we need. If we need to do anything by way of secondary legislation, we will do it. However, as I said, we are looking at the wider issue of accountability to ensure that there is genuine public accountability.

I would have thought that the fact that half of each board will be made up of elected councillors will, in itself, enhance accountability. The other half will comprise representatives of the health boards, and we are looking specifically at how we can enhance their accountability. As you know, we have trialled direct elections to health boards and some other ways of improving accountability, and I hope to make a statement sometime soon—before Christmas—on general issues of improving accountability.

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.

Richard Lyle: I welcome that comment as I believe that they should be involved.

When I was asked this question yesterday, I could not answer it. Why did we change the name of the bill to the Public Bodies (Joint Working) (Scotland) Bill? I think that COSLA got a bit upset and thought that you and other cabinet secretaries
were going to grab extra powers from everywhere else. Why did we change the name of the bill?

Alex Neil: I point out that it is not an enabling bill of the kind that has been introduced in previous periods of history by other regimes.

This is where the lawyers come in, including the Parliament’s lawyers. What initiated the change to the title is that, under the bill, what used to be called the Common Services Agency will now be able to provide services much more widely and not just to the health service in Scotland. The fact that it will be able to provide services across the entire public sector will be good for public sector efficiency and cost effectiveness and will improve the delivery of services. However, because we included that provision in the bill, its original title was no longer legally competent, so we had to amend it. I fully accept that it is not the sexiest bill title in the world, but the important thing is the bill’s substance, rather than its title.

Richard Lyle: My last question is on VAT, which you will have heard me ask earlier. Different arrangements for VAT apply to local government and NHS boards. Do you have any concerns about that? What work is being done to ensure that no extra VAT will be paid once the bill is passed?

Alex Neil: 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.

Of course, in 2016 we will have powers over HMRC so we can rectify any outstanding matters after that.

Richard Lyle: I certainly agree with that comment.

The Convener: I think that Bob Doris has a supplementary question on that.

Bob Doris: Mr Lyle used the expression “top table”, and I think that the cabinet secretary gave a hint about this in an earlier answer when he mentioned locality planning. Is there any information available on who would sit at the table—let us call it a wider strategic table rather than a top table—to sign off strategic plans? There has been almost an expectation that various other bodies might sit at that table—I will not list them, because any that I miss out will take it as a slight that they are not considered as strategically important as the others. Who might sit at that wider strategic table and who will have voting rights?

More important, can you say a bit more about the locality plans that joint boards will be under a statutory obligation to produce? The expression “top table” motivated my supplementary question because I see this bill as being a community planning initiative as much as a top-down initiative. Therefore, it would be helpful to hear a little more about the importance of locality planning. Perhaps that is an area where other stakeholders from the front line could be involved.

Alex Neil: As I said earlier, the key thing is the strategic commissioning plan, which will determine exactly what each board will do. That is one area in the bill where we have been quite prescriptive both about the consultation group that must be set up and about the people who need to be involved in the development of the strategic commissioning plan. Clearly, I would like the process to be as much bottom-up as it is top-down because the strategic commissioning plan should be largely determined by the adult health and social care needs of the community.

Perhaps, without going into inordinate detail, Alison Taylor can give you a flavour of how we believe that the locality planning mechanism would typically work and who would be involved in that.

Alison Taylor: 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.

The bill provides various powers to set out the range of people who need to be involved in strategic planning and who need to be consulted. Again, I do not think that ministers are minded to be particularly prescriptive about the numbers of people who would be involved or that sort of thing, because those are matters that the evidence tells us work better when they are agreed locally. In locality planning, I think that there needs to be a very strong role for local clinical professionals. From memory, we can see some good examples of that in NHS Grampian and there is an interesting model at work in Nairn. A lot can be learned from those places, and that is where our attention should go.

Bob Doris: Will there be guidance on local engagement?
Alison Taylor: Yes, absolutely. I apologise, as I should have said that.

Bob Doris: Regarding the wider strategic plan, although other bodies are not mentioned on the face of the bill, I understand that the bill is not restrictive. There is nothing to stop joint boards co-opting other partners on to the board, perhaps without voting rights, for example.

Alex Neil: I think that a good comparison can be made with the process for going for planning permission to build a new building. There are statutory consultees, who absolutely must be consulted, but developers must also show that they have consulted the wider community. The process will be similar. There will be statutory consultees, but that is the de minimis position.

12:15

Bob Doris: Will there be best practice guidance on that?

Alex Neil: Yes, there absolutely will.

Kathleen Bessos: There is guidance about strategic commissioning, from which we are learning a lot of lessons. We will produce guidance on the bill that builds on what we have learned.

We have sent out the “All Hands on Deck” report, which describes the key principles of locality planning, and we have asked partnerships to look at the report and consider, with support from the joint improvement team, how it fits their local circumstances. Partnerships can use it as a template as they start to work things through. In January we will get some feedback about putting the report’s guidance into practice, which we will use as we develop proper guidance, on which we will consult.

Bob Doris: That is helpful, thank you.

Rhoda Grant: In evidence, we have heard concern about matters such as governance, finance, audit, staffing and sharing information—the list goes on and on. How can such issues be satisfactorily resolved?

Alex Neil: That was a long list. I think that some concerns are misplaced. For example, I am sure that we will reach agreement with COSLA on amendments at stage 2 that are needed to address its concerns about governance. It was never our intention to give me wide-ranging powers over local authorities beyond what is intended in the bill.

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.

When the system is fully operational, I think that there will be much more efficient and efficacious use of public funding. A good example of that will be a reduction in unnecessary hospitalisations. If we can do that, there will be much better patient outcomes, and treating people at home instead of spending so much money on keeping them unnecessarily in the acute setting in hospital will free up resources that can be used to improve the quality of care more generally.

We have listened and are listening carefully to what people are saying. We have any number of groups. There is the bill advisory group, on which all the key bodies are represented. We have a ministerial steering group, which I chair. We have an implementation group and eight working parties on all of this—just for starters. The one thing that we have done on this bill is consult, and we continue to consult widely. When we get the committee’s stage 1 report, we will take any recommendations very seriously, as we always do.

Rhoda Grant: I will be more specific, because I think that you have already made those points. There are different criteria for audit in local government and in health—there are internal and external audit processes and the like. What will the body corporate’s audit function be, and how will it carry it out? What will it need to put in place?

Alex Neil: Audit Scotland is part of a group that is looking at the bill, so there is active involvement from Audit Scotland on the issues that might need to be consulted on. The audit trail will need to be clear, so that we know what happens after the money goes into the new organisations. We need to know how the money is being spent and whether it is being spent on the right things, what the approval mechanisms are and so on. The audit process is part of that. Alison Taylor will explain the mechanics of how that will happen.

Alison Taylor: We have an overarching integrated resources advisory group, which is looking at all aspects of the finance and accounting procedure that relates to what we are proposing under the reforms. Sub-groups are looking at specific topics, such as audit.

As has been raised by committee members, we have heard concerns since the bill was published that we need to be clearer on aspects such as audit, which we have taken on board very seriously. The expert groups, including Audit Scotland, have been looking at those questions. With our legal colleagues, we are considering
whether any amendment to the bill might be necessary. Obviously, that will come forth in due course if it is decided that that is the best way in which to achieve clarity. Quite aside from that, there will be very detailed guidance on all these matters, an early draft of which we will share with a very large group of professionals and stakeholders at the end of this week.

We recognise that the answers to the concerns need to be clear and clearly stated. We have the work in place to get that into the parliamentary process.

**Rhoda Grant:** Does the same apply to staffing? We have heard evidence that there are different legal requirements for interaction with staffing and training. How will that work in a body corporate that is made up of two legal entities?

**Alex Neil:** I will get Alison Taylor to answer some of the detail, but 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.

**Rhoda Grant:** But that will surely require more work. If someone is seconded to the body corporate but kept on the local authority payroll, who will do their local authority work when they are doing the new job? Do you understand what I am driving at? There is a cost involved that is not covered in the bill, and there is no additional funding for it.

**Alex Neil:** In terms of the joint accounting officer, his or her salary and associated costs will obviously be met out of the integrated budget.

**Kathleen Bessos:** It will be jointly paid for by the board and the council.

**Alex Neil:** Obviously, bodies can make their own arrangements, but if the local authority or health board seconds somebody to the body corporate, it will do what it does whenever it seconds anyone, which is to make the necessary arrangements for somebody else to do the job that the person was doing, if it still needs to be done. That is normal procedure.

**Rhoda Grant:** That would surely mean additional costs for covering for backroom staff, which would take away money from front-line services.

**Alex Neil:** No. The person being seconded will do a job that will have previously been done by the local authority. It will be the same job, but it will be done under the aegis of the joint board.

**Rhoda Grant:** Let me just pursue this. For example, an HR officer who works for the local authority may be seconded to the new body. They will have done work for more than one department when they were part of the local authority. That work will surely need to be covered by somebody else, which will mean an additional cost.

**Alex Neil:** To be honest, I think that, to start with, that kind of central service will still be provided by the local authority and the health board, because the people working under the aegis of the body corporate will still, as I said earlier, be employed by the health board or the local authority.

**Rhoda Grant:** Okay. To take the example that you gave earlier of acute clinicians going out to work in the community, could somebody work in the community beside a social worker or care worker and have a different chain of command, line of management, personnel officer and pay structure?

**Alex Neil:** The chain of command for the job that they do will be with the body corporate. Obviously, there is a wide range of pay structures and pay scales within health boards and local authorities, let alone between them, so that will just continue.

**Rhoda Grant:** So they will remain their employees. Who will the body then employ?

**Kathleen Bessos:** It will not have to employ anybody. It will not be an employing body at that point. The people delivering the services will still be employed by the council or the NHS board. They will not have changed their employers and there will be no requirement to do so.

**Rhoda Grant:** Who, then, will give directions for what happens? How will a body share resources, put a budget together and then get people to work across sectors if they are still in their silos? How does this work? I am getting more and more confused by the answers.

**Alex Neil:** This concerns the legalities.

**John Paterson (Scottish Government):** For somebody in the local authority who provides social work services, the line management is through the local authority and ultimately to the chief executive. The chief executive directs that they follow direction from the chief officer in the chief officer’s role as operational director. They are
then required to follow that direction from the chief officer as operational director.

**Rhoda Grant:** If they are still paid by the local authority, why does the body corporate need a budget? If all the costs are undertaken, why do we need audit? If the body corporate only directs how services happen on the ground, why does it need a budget at all?

**Alex Neil:** It is a question of control over the resource.

**Kathleen Bessos:** It needs to direct how that resource will be deployed by the people in the local authority and the NHS. The chief officer has the overall budget, and on the back of the strategic commissioning plan there will be changes required over a period of time. The chief officer, on behalf of the joint board, will direct those services to be delivered in a way that complies with the strategic plan.

John Paterson’s point is that this bill enables the chief officer to give directions to the health board and the local authority to ensure that the staff employed fulfil that requirement. It is all tied up legally.

**The Convener:** I suppose that this gets to the difference between the body corporate model and—

**Kathleen Bessos:** —and the lead agency.

**The Convener:** The lead agency model in your area, Rhoda, does not require that transfer of employment.

What is the downside in terms of co-location of people? Does it drive the cultural agenda forward? Will it be able to achieve the results that you have witnessed and testified to in the Highlands?

**Alex Neil:** Some folk were at West Lothian yesterday, where it is already done and works very effectively. It is done very effectively on the lead agency model in the Highlands. Even in areas that have not had formal partnership agreements in the past, such as parts of Fife, it is done. For example, there is co-location in Queen Margaret hospital in Dunfermline between social workers and health professionals who all work as one team. It is done in Grampian.

**The Convener:** You should curb your enthusiasm or any minute now you will be scrapping this legislation.

**Rhoda Grant:** I want to get to the bottom of this. If, for example, you shift the balance of care from acute to care in the community and the body corporate decides that it does not need a consultant in an acute hospital but that it needs five or 10 more care workers for the cost of a consultant, does it tell the NHS to terminate that contract or not fill the contract as it would normally have done? Does it then go to the council and tell it to employ maybe five more workers? Is that how it would work?

**Alison Taylor:** There will be guidance about the directions that need to go to the health board and the local authority from the body corporate. That will be developed in good time. We would not envisage that they would be at that level of granularity. We would expect to see an expression in the strategic plan of a shift in investment and activity from one bit of the system to another.

The other important point is that the joint board is composed of members of the health board and the local authority. The chief officer has a strategic role in relation to the joint board, and an operational role in relation to the health board and the local authority. The key to all of this is that people work and plan together across the totality of available resource. Yes, there will have to be a discussion about how to deploy resources to best effect locally, as there is now. There are places which, for example, have quite significantly shifted their consultant geriatric input from hospital to community.

**Rhoda Grant:** The body corporate will not have the powers to direct. It may make up a strategic plan, but it has no way to fulfil that plan.

**Alison Taylor:** It has powers to direct delivery on the back of the strategic plan.

**Rhoda Grant:** The accounting officer answers to the chief executive. Surely the chief executive can say, “No, we’re not going to do this.”

12:30

**Alison Taylor:** The chief officer will be accountable to the joint board for the functions that are delegated to that board to strategically plan the delivery of services. The chief officer will have a day-to-day role. That is built on models that are more or less in place—it is similar but not exactly the same. On the operational side—in the day-to-day role in the delivery of services—the chief officer will have a close relationship with the two chief executives.

**John Paterson:** I talked about directing, which is separate from exercising the power of direction. A power of direction ultimately allows a direction to be given to tell someone that they must do something. In the way in which organisations operate normally, a formal direction does not require to be given on everything that is done. Normally, people are asked to do things and they do those things. It is only when conflict happens and a requirement arises for a formal direction to be given that one is given.

**Rhoda Grant:** You seem to be trying to legislate for good will. If the good will existed, integration
would be happening, as in the Lothian and Highland areas. The bill will push people down a street. Unless somebody is empowered to take the lead when consensus does not exist, you are trying to legislate for good will.

**Alex Neil:** The body corporate and the chief officer are empowered. Everybody needs to work on the basis of good will and trying to take people with them, but the body corporate has the ultimate power to do what is necessary to deliver an integrated service. The powers of direction to deal with a recalcitrant health board or local authority are vested in the body corporate. That has been missing and is why we have failed on integration for many years.

**Nanette Milne:** Given the available time, perhaps some of my questions could get written responses rather than answers now. Someone has told us that the term “public services” would be more appropriate than “public bodies” in the bill’s title, given what we are trying to achieve. Do you have a comment on that?

**Alex Neil:** I do not see the advantage in changing the bill’s title at this stage. What matters is the bill’s substance, rather than its title. However, I agree that it is always desirable to have a sexier title if that is at all possible.

**Nanette Milne:** It was the independent sector that made the comment.

I totally agree about the involvement, particularly at the locality level, of clinical health professionals. I lived through the GP frustration and disillusionment with CHPs.

It is crucial to involve GPs and other professionals. You said that they must be embedded. How will you enthuse them about that?

**Alex Neil:** A lot of enthusiasm is out there, because people realise that we are serious this time. 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.

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.

**Nanette Milne:** The CHPs were not local enough—they lost the locality. That is terribly important.

**Alex Neil:** That is right.

**Nanette Milne:** A lot of concern has been expressed that no complaints system is spelled out. Will you give detail—not necessarily now—on that? In particular, the disabled groups that we met yesterday said that, as have a number of other people. That is a concern given the different complaint routes—it is a bit like what Rhoda Grant has said about other issues.

**Alex Neil:** We have a stream of work on exactly the issue of establishing a complaints procedure that is fit for purpose. Obviously, local authorities and health boards have different complaints procedures. We are working on that, but we certainly do not anticipate needing a big change in primary legislation to do it. I mentioned that we have eight working parties. We have a stream of work specifically on complaints, which will, I hope, report by, roughly, the turn of the year.

**Kathleen Bessos:** Yes, it will have reported by the end of this year.

**Nanette Milne:** My other questions probably should be given a written response. One is about the options that are being considered in relation to pension funding, including the costs.

**Alex Neil:** Again, that is 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. Obviously, however, over time, they might employ people, so there is an issue. If in future years somebody transfers their employment to a body corporate and their pension fund is in deficit, we have to ensure that we do not inherit a share of the deficit, which is historical. A technical amendment to the bill is probably required to deal with that. However, beyond that, we do not see a big issue with pensions, for the simple reason that the bodies corporate will not actually employ anybody.

**Nanette Milne:** The point was in connection with what is set out in the financial memorandum—at paragraph 116, to be exact.

**Alex Neil:** I think that the Finance Committee drew that issue to the committee’s attention, but it is well in hand.

**Nanette Milne:** Okay. Another issue from the same source is whether any additional funding is to be provided in the event of a successful equal pay claim.

**Alex Neil:** No, because it is nothing to do with us. If there is an equal pay claim in the local authority, whoever works for the local authority will be part of that settlement. If there are equal pay
claims outstanding in health boards, the same thing will happen. We are not employing anybody. It is the employer who has to settle with the employee on equal pay.

Nanette Milne: Almost finally, do we have costs for the provision of funding for delivering Healthcare Improvement Scotland inspections under the integrated model?

Alex Neil: At the moment, the Care Inspectorate and Healthcare Improvement Scotland can with my permission carry out joint inspections. We will lodge an amendment to allow them to carry out those joint inspections without always having to come to me for permission—in fact, I think that that is already in the bill. As you probably heard earlier, the Care Inspectorate and HIS are working together on the implications of integration for the delivery of inspection services. HIS will launch a consultation fairly soon in which one of the subject areas that will be covered will be the implications of integration. Obviously, eventually, we will need a more integrated inspection regime.

Another strategic challenge is that, as we drive more and more to have people have their health and social care delivered much more at home, we need to be satisfied that we have robust systems in place for picking up any problems of abuse that there might be, particularly in relation to dementia patients, for example, who perhaps are not capable of reporting incidents themselves. I have charged officials and the agencies to look at that as a strategic issue that we need to address. Clearly, we cannot put a closed-circuit television camera in everybody’s house—I hope that nobody is suggesting that we do that under the bill—but there is an issue about abuse at home. South of the border, there was a recent example in which a TV company installed a CCTV camera, and the way in which the older person, whom I think had dementia, was being so badly treated did not make for pleasant viewing. We need to develop more robust systems for ensuring that we pick up any abuse of people who are being treated at home.

Nanette Milne: Finally, we know that most partnerships, apart from Highland, appear to be going down the body corporate route, but do you have final figures on that yet?

Alex Neil: A couple of areas have explored the lead agency model but, to the best of our knowledge—we are in pretty close touch with all 32 areas—the only part of Scotland that is likely to use the lead agency model is the Highlands. That is our clear impression at the moment.

Mark McDonald: I will try to keep this brief, not least because I have a meeting to get to at 1 o’clock.

This morning, we heard from the Scottish Public Services Ombudsman and others that the complaints procedures should be standardised under the new model. We heard different evidence from NHS Dumfries and Galloway: its view was that there was no need to rush at standardisation. What is the Scottish Government’s view on complaints procedures? Do you think that there would be merit in some form of standardisation?

Alex Neil: Inevitably, there has to be a clear single complaints procedure to allow people to make complaints against the body corporate or the lead agency. There is no doubt at all in my mind that people need to have clarity on the complaints process. That is the stream of work that is being done that I mentioned earlier. The SPSO is involved in the group that is undertaking that work. It will report by the turn of the year. At the appropriate time, we will share the outcome of that with the committee before we proceed. We will consult on the working party’s recommendations, but my view is that the ombudsman is right about the need for a single complaints procedure for the services that will be covered. However, we will wait and see what the working party says.

Mark McDonald: The ombudsman expressed concern that work on complaints and scrutiny can sometimes drag on. He pointed to the Crerar review, which was commissioned in 2007. Some of its recommendations have still not been fully implemented. Do you intend to pursue the issue with some vigour, to ensure that there is not an unacceptable lag between implementation of the legislation and implementation of a standardised complaints procedure?

Alex Neil: I say unequivocally that there will be no dragging on my watch.

Mark McDonald: Thank you very much.

The Convener: I understand that you were not here for the whole of our earlier session, cabinet secretary. As I said to the ombudsman, we made similar recommendations about complaints, commissioning, the development of the new workforce and national care standards in January 2012. Many of those recommendations were accepted by the Government. That was 18 months ago, so there are significant questions to be answered.

Can I clarify that we do not need legislation to address the issue of national care standards or the integration of the Care Inspectorate and HIS? Is there a contradiction, in that one has statutory powers and the other does not?

Alex Neil: As far as the way forward that we have agreed is concerned, we do not see any need for additional primary legislation beyond what is in the bill. On the complaints procedure, there is already a substantive legal framework for
complaints in Scotland. We are talking about the process, rather than the statutory basis of the complaints procedure.

If there is a requirement to make any legislative changes—on complaints, for example—we believe that we have the powers to do that in secondary legislation. I think that the Public Services Reform (Scotland) Act 2010 allows us to do that. It probably gives us the powers that we need to do anything that we might want to do in secondary legislation.

The Convener: To support the ombudsman’s claim, there is much that could have been done on the national care standards and outcomes—on which the committee made unanimous recommendations that were accepted by the Government—over the past 18 months. What has held us back?

Alex Neil: I do not think that we have been held back. Certain things happen at certain times. The priority has been to get the principles of the bill agreed. On complaints, we have not been sitting back doing nothing. Work has been going on on complaints over the past 18 months. Obviously, we have to try to take people with us. In this case, that means COSLA, and it is heavily involved in the complaints work that will report at the turn of the year.

12:45

The Convener: I am sorry to press you, cabinet secretary. You said earlier that we do not need the bill to deal with complaints or the national care standards. If the national care standards have not been reviewed in nearly 12 years, why has that work not been completed in the past 18 months?

Alex Neil: First, in terms of complaints, what I am saying to you is—

The Convener: We were talking about the national care standards, not necessarily complaints.

Alex Neil: Sorry—I thought that you were talking about both. On the national care standards, we looked carefully at the committee’s recommendations and accepted in principle the need for review. One issue is that we need to consult the appropriate people before we announce a national review of the national care standards. Also, we wanted to be a bit further down the road with the bill and all the infrastructure around it so that, by the time that we reviewed the national care standards, people could look at that in the context of knowing the shape of the bill, which will impact on what people say about the future of the national care standards. In particular, there is an issue around the future interplay between clinical standards and the national care standards. This is the appropriate time to review the national care standards, now that people know exactly what is happening on integration.

Kathleen Bessos: In the parliamentary debate at the beginning of the process, the cabinet secretary gave a commitment to Parliament that we would ensure that the review of the care standards was carried out with our informal process for looking at outcomes. The national outcomes that we have put into the consultation must link together with the care standards. As we speak, we are going around the country asking members of the public, including older people’s groups and broader groups, “This is what we’re planning around care standards. What do you think about the future? Here is what we’re saying about the national outcomes.” We have brought the two processes together. My team and colleagues from the care standards and sponsorship branch of the Scottish Government are jointly going around the country, talking to people on the ground about the care standards and the national outcomes. We wanted to avoid totally confusing everybody about what the care standards and the national outcomes are, so we are having joint presentations, joint discussions and joint debates both with members of the public and with the professionals.

The Convener: I am pleased to hear that, but I must have missed it in my constituency. I do not know whether any other committee members have come across it. It would be interesting to hear about it.

Kathleen Bessos: We could give you a list of places where we have been. We started in Shetland and have been down to Dumfries and Galloway. We have also been to Paisley, Dundee and Aberdeen. We can give the committee information on that.

The Convener: It would be nice to hear about that work. I make a plea on behalf of the committee. We have done a lot of work in the area and have made a number of recommendations. There was an indication that the committee would be kept up to date with that work, and it would be useful if we were. I am glad to hear that we are making progress in and around the complaints work.

I know that the cabinet secretary is under pressure and that committee members have another meeting to go to, but there are some issues and questions that have not been covered today, including some of the financial issues. Would it be okay if we wrote to you to get responses on those on the record?

Alex Neil: Yes. That is no problem at all. If there is anything that the committee feels that it needs
additional information on, we will supply that—no problem.

The Convener: I thank you and your colleagues for your attendance this morning.

Meeting closed at 12:48.
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
Barnardos 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
Glasgow City Council
Housing Coordinating Group
Association of Directors of Social Work
Alliance Boots
NHS Highland
Scottish Health Council
Public Bodies (Joint Working) (Scotland) (Bill)

Rev Donald Prentice (Individual)

Unfortunately the cultural realities for an integration of NHS and Social services, highlighted by recent efforts at joint working, predict an intransigent inertia from the social services who see themselves already overworked and better educated than a bunch of Nurses.

So those liberal democrats who have a rosy glow feeling about everybody being nice to each other and also putting the patients / client needs first, are going to be shocked by the petty fogging power games that will be acted out at a personal level. Going by Foucault's analysis of the abuse of power and how people do violence to others, in subtle ways, the only solution, is for a robust NHS leadership which the social services will have to respond to (with a robust audit to ensure that happens). So I recommend the NHS Lead Agency Model with both agencies being held to account for shortcomings and failures.

One salient question... can integration to cover care gaps be achieved without more staff and incentive funding (e.g. for out of hours evenings and weekends crises)

Rev Donald Prentice
2 August 2013
Public Bodies (Joint Working) (Scotland)(Bill)

North Ayrshire Council

1. Do you agree with the general principles of the Bill and its provisions?

Yes, North Ayrshire Council welcomes the general principles of the Bill and is committed to making the integration of health and social care work as well as we possibly can.

We welcome the local flexibility which the Bill has captured and this has allowed us to agree to integrate our children and family services within our local partnership agreement.

2. To what extend will the Bill achieve stated policy objectives?

We believe that the Bill will achieve the delivery of more effective and efficient services over the next five years. The Bill provides the governance structures to bring together decision makers from the Council and the NHS, and for the first time provides an opportunity for local elected members to directly influence the priorities for the NHS.

The Bill also provides a vehicle to more effectively implement joint leadership and management of resources through the Chief Officer post.

Overall, we welcome the focus within the Bill on outcomes for the citizens of Scotland and the drive to judge partnership effectiveness through nationally agreed outcomes. We expect that in addition to national outcomes the partnership will also agree local priorities and outcomes.

One of the challenging aspects of the proposed legislation is the requirement for locality planning and prioritisation and the involvement of the full range of interested groups. Our Community Planning Partnership has been developing a neighbourhood planning approach and we see this as a good fit with the approach within the Bill.

One aspect that does concern us, is the need to balance the views and influence of all interested groups so that one group does not dominate others. This will be challenging given the range of interested groups. Having said this, we are very committed to viewing our service delivery through the lens of those who use our services or care for people who use our services.
3. *Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths?*

We consider one of the Bill’s key strengths to be the aspiration of providing seamless, joined up, quality health and social care services in order to care for people in their homes or homely setting making it safe to do so:

We are particularly pleased to see this detailed within the legislation as at paragraph 25 integration delivery principles (i) is integrated from the point of view of recipients and (ii) takes account of the particular needs of different recipients.

We are wholly committed to delivering the best possible services we can, designed around the needs and desired outcomes for individuals, their families and carers. This is an important principle to remember when tackling inter-professional or organisational disputes. Service delivery should be driven by this principle rather than organisational or professional boundaries.

4. *Please provide details of any areas where you feel the Bill’s provisions could be strengthened?*

It is difficult to identify areas to be strengthened as much of the detail of this legislation will be contained within regulations and guidance. The draft Bill does have a Financial Memorandum (FM) attached. This FM seems to be very much focussed on costs to the NHS and misses many of the very real costs to Local Authorities. Unfortunately this gives a very one sided view of financial requirements.

As in all aspects of partnership working, it is important to be seen to be even handed and fair to all partners.

5. *What are the efficiencies and benefits that you anticipate will arise your organisation from the delivery of integration plans?*

This is a difficult question to answer at this stage and is one of the difficulties within integration. Local authorities have made substantial savings over the past four years, while the NHS has been protected. This is likely to mean the level of savings available without affecting operational capacity will be less for local authorities. Obviously we would expect to make efficiencies by sharing management (through joint appointments) and accommodation. We are also considering how the range of ‘support services’ required by health and social services would be best delivered. At this stage it is not possible to say if this will lead to efficiencies or if in fact some may require additional investment ‘Support services’ include; Finance; Human Resources; Legal Services; IT and Property; Facilities Management.
6. *What effect do you anticipate integration plans will have on our outcomes for those receiving services?*

It is our expectation that integration plans will focus on the removal of barriers between agencies and redesigning services based on delivery improved outcomes for clients/patients/carers. This will put those who use the service at the heart of the redesign. Services should be easier to access and appear seamless at the point of delivery.

North Ayrshire Council  
2 August 2013
Introduction

NSPCC Scotland welcomes the opportunity to provide written evidence to the Health and Sport Committee, to inform its consideration of the Public Bodies (Joint Working) (Scotland) Bill.

While we support the aims of the Bill to improve service provision and achieve better outcomes for service users, we have general concerns regarding the apparent lack of detailed consideration about the how the Bill will affect children’s services or how it relates to the wider legislative agenda for children and families.

About NSPCC Scotland

The NSPCC aims to end cruelty to children. Our vision is of a society where all children are loved, valued and able to fulfil their potential. We are working with partners to introduce new child protection programmes to help some of the most vulnerable and at-risk children in Scotland. We are testing the very best intervention models from around the world, alongside our universal services such as ChildLine, the ChildLine Schools Service and our adult Helpline. Based on the learning from all of our services we seek to achieve cultural, social and political change – influencing legislation, policy, practice, attitudes and behaviours so that all children in Scotland have the best protection from cruelty.

NSPCC Scotland response

NSPCC Scotland does not have specific comments to make on particular provisions in the Public Bodies (Joint Working) (Scotland) Bill; rather our response seeks to highlight concerns about how the Bill links with the other legislative developments. We feel it imperative that the Committee considers the Bill in relation to the wider context.

We recognise that the primary aim of the legislation is the integration of adult services, with a particular focus on improving older people’s services. In so doing, the Bill affords relevant authorities discretion as to whether other functions – such as children’s services – are included in the new integrated arrangements. However, we are concerned that the potential impact of the Bill on children’s services has not been thoroughly thought through and merits further consideration.

The Bill and supporting documents make very few connections with other pieces of recent and proposed legislation that will impact on children, young people and...
their families. In particular, there is no mention at all of the Children and Young People (Scotland) Bill which is also currently before the Scottish Parliament.

The latter Bill makes provision for a duty on Scottish Ministers and public bodies to take steps “to secure better or further effect” of the United Nations 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).

In legislating for service planning and provision, there is certain crossover between both Bills; this raises questions about how they are intended to ‘fit’ together. There appears to be no consideration of children’s rights in the Public Bodies Bill and no apparent consultation with children and young people. We are 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.

Similarly, the recent Social Care (Self Directed Support)(Scotland) Act 2012\(^1\) and the planned Community Empowerment and Renewal Bill\(^2\) will also have implications for the planning and delivery of children’s services, and the involvement of service users.

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.

The impact of this broader legislative landscape on children’s lived experiences must be a central consideration for the Committee when considering the Public Bodies (Joint Working) (Scotland) Bill.

Where children’s services are not integrated into the proposed new structures, we have concerns that the proposals could potentially have a negative impact on ‘whole family’ approaches. While the initial aim is to achieve better integration between adult services, this could, at the same time, widen divisions between adult and children’s services, and/or split functions. This could create or exacerbate communication and practice issues from a family perspective.

---

\(^1\) 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](http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Self-Directed-Support/Bill)

\(^2\) This Bill will seek to strengthen community participation and development. See [http://www.scotland.gov.uk/Topics/People/engage/cer](http://www.scotland.gov.uk/Topics/People/engage/cer)
Similarly, thought would need to be given as to how social work services can deliver integrated support, particularly where outcomes are tied to complex family circumstances, such as substance or alcohol misuse. It is also unclear how education and community justice services will link in with the new arrangements, particularly given that the structures for the latter are likewise under review\(^3\).

The discretion the Bill permits in relation to integrating children’s services may lead to greater inconsistency and variation in policy and practice around the country.

In order to gain a fuller picture of developments and enable a more thorough consideration of proposals, we suggest that the Health and Sport Committee considers holding a joint evidence session with the Education and Culture Committee to consider the interaction of relevant provisions contained in both the Children and Young People and the Public Bodies Bills, and their implications for services for children and families. We have made a similar suggestion to the Education and Culture Committee which is considering the former Bill.

**Conclusion**

NSPCC Scotland welcomes the aims of the Public Bodies (Joint Working) (Scotland) Bill but we have concerns about what the impact will be on children’s services and how the Bill fits with the wider legislative landscape, particularly the Children and Young People (Scotland) Bill. We urge the Committee to give consideration to these issues during Stage One.

**NSPCC Scotland**

**2 August 2013**

---

\(^3\) See [http://www.scotland.gov.uk/Publications/2012/12/7292](http://www.scotland.gov.uk/Publications/2012/12/7292)
Public Bodies (Joint Working) (Scotland) Bill

British Heart Foundation (BHF) Scotland

About BHF Scotland

Coronary heart disease is Scotland’s single biggest killer. For over 50 years BHF Scotland has pioneered research that has transformed the lives of people living with heart and circulatory conditions. Our work has been central to the discoveries of vital treatments that are changing the fight against heart disease.

BHF Scotland welcomes the opportunity to respond to this consultation.

General remarks

BHF Scotland fully supports the intentions of this Bill.

It order to see the practical implications of the intentions, is particularly with regard to heart failure that we make this response. See the Appendix for further information on this condition.

Specific remarks

Do you agree with the general principles of the Bill and its provisions?

The Bill’s stated ambitions of ‘integrating health and social care services… to improve the quality and consistency of services for patients, carers, service users and their families…. to ensure resources are used effectively and efficiently to deliver services ‘….are extremely welcome.

Effective coordination between health and social care systems is a vital component of achieving high-quality, cost-effective and integrated care for heart failure patients amongst others, providing a coherent patient and carer experience.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

BHF Scotland’s focus is on the outcomes of any proposed approach.

The merging of health and social care systems could, if implemented effectively, help address many important issues, by improving the transition between health and social care services, management of physical and mental co-morbidities in community and residential care settings, and medicines management in care and home-based settings, and by ensuring that the needs of carers are addressed within the system.
Additionally, this approach should lead to better use of health and social care resources, which is important given the need to make best use of limited funds.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

With reference to people with heart failure in particular, we see the commitment to ‘joined up quality health and social care services in order to care for people in their homes or a homely setting where it safe to do so…and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older’ as its key strengths.

Patients need care in the most appropriate setting - home, care home or hospital. At present, too many patients end up in hospital due to poorly co-ordinated service and lack of integration of health and social care

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

BHF Scotland believes that the following areas should be regarded as particular priorities:

- Improved service user experience
- Continuing care: this is a key area where coordination between health and social care is particularly vital
- Reduced social isolation: this should cover the broad range of emotional, psychological and practical support that an individual may need to avoid social isolation, and include consideration of the needs of carers
- Services should be regarded as seamless, both across service provision and across time – available round the clock, 7 days and 24 hours.

The letter of the Bill focuses on the new challenge of integration of two key services at a strategic level and on the statutory responsibilities of integration authorities. The Policy Memorandum recognises the existing challenge of the lack of integration within the health service, e.g. between primary and secondary care. Authorities must not lose sight of this challenge in the work ahead.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

As a charity which has committed millions of pounds over many years to pioneering health services and driving up standards in the health service, BHF Scotland welcomes the commitment to treating third sector organisations as key partners in the planning and assessing of services.
As the champion of the needs and interests of people with heart disease, we also welcome the commitment to services being planned and delivered seamlessly from the perspective of the patient, service user or carer.

**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

People with heart failure would enjoy a better quality of life if services were effectively integrated.

Not only do they require health services but they need support with housing; transport; personal care; benefits and social isolation.

Overall, the symptoms associated with progressive heart failure make it difficult for the person to continue with normal daily activities. Many people have to give up work and may get into financial difficulties at a time when they feel too ill to cope with their problems. Housework, cooking and gardening become difficult and washing, dressing and going to the toilet can be problematic. With so many disabling and distressing symptoms it is hardly surprising patients get depressed.

Social care needed for many of these patients includes help with shopping, housework, preparing meals and personal hygiene. Many will live alone and be housebound and will be socially isolated and may also benefit from a purely social visit from someone calling round for a cup of tea and a chat.

Caring for the people affected can become problematic as many of these patients are elderly with significant other co-morbidities and in many cases, their spouses are elderly and frail and find it hard to cope alone without additional support. Many carers would benefit from some respite from their carer role, however there is very little available for carers to access at present.

**Concluding remarks**

BHF Scotland supports the intentions of this Bill as, when successfully implemented, the result should be joined-up care that delivers better outcomes for patients and carers. The 71,000 people in Scotland living with heart failure stand to benefit.

**British Heart Foundation (BHF) Scotland**

2 August 2013

**APPENDIX**

**About heart failure**

Heart failure is a disabling and life-limiting condition for which there is no cure. It is usually, but not always, the result of damage to the heart from a heart attack. As heart failure progresses, many patients appear breathless even at rest. Breathlessness resulting from pulmonary oedema (fluid in the lungs) is a distressing symptom, which has been described as ‘feeling as if I’m drowning.’
It restricts physical activity and may occur in acute paroxysms (spasms), especially during the night (paroxysmal nocturnal dyspnoea) disturbing sleep and patients need to sleep propped up with a number of pillows or in a chair (orthopnoea). It is often accompanied by a persistent, dry, irritating cough. Oedema (fluid retention) may be apparent, initially in the feet, legs and ankles but in severe cases may be found anywhere, including the abdomen, causing the patient significant discomfort. Oedema can also increase the risk of pressure sores.

Many patients complain of tiredness which may be due to lack of sleep, breathlessness, loss of appetite and also muscle weakness resulting from poor perfusion of organs and muscles and can be exacerbated by abnormalities of serum electrolytes (especially increasing urea and hyponatraemia (low sodium). As further deterioration occurs, patients often report loss of appetite, nausea, itchiness of the skin, abdominal discomfort or pain, and delays in their blood clotting time increasing the risk of bruising and bleeding.

Prevalence of heart failure

Across Europe there has been a general decline in mortality from heart conditions, with death rates in Scotland falling by around 40% since 2000 (General Registrar for Scotland 2011). The prevalence of heart failure however is the one cardiac condition which continues to rise. This is due to changing demographics (e.g. ageing population) and improved survival from cardiac conditions in earlier life (European Society of Cardiology 2011a). Additionally people are living longer with heart failure due to improved management of existing cardiac conditions and specialist heart failure care including Specialist Heart Failure Nurses. Information and Statistics Division (ISD) Scotland estimate that there are around 100,000 people in Scotland living with heart failure.

Patients are reviewed by specialist nurses in a variety of settings: hospital wards, outpatient clinics, satellite clinics and in their homes. Their social care needs are therefore also an important part of their wider care and treatment package.
Do you agree with the general principles of the Bill and its provisions?

The general principles of the bill to make an integration plan to make provision in relation to the carrying out of the functions when integration is in place is extremely useful. To forward think with a formulized focus for the functions of the local authority and health boards will make for ease of transition.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objective?

Agree in principle, but need to make sure that all administrative tasks that may be easily overlooked (i.e. IT, laptops, expenses, log in details) are all thought through in the integration plans and not just the wider organisational issues (i.e. payroll).

Please indicate which, if any aspects of the Bills policy objectives you would consider as key strengths

The integration planning principles of the bill are a key strength, along with acknowledging the need to take into account the particular needs of recipients. Geographical issues are important, particularly within an older population, therefore utilising the integration planning principles when addressing wider determinants of health and wellbeing in consideration of integration is useful.

Another key strength is that these plans are being set out and led locally which will utilise the knowledge of the population from general practitioners and community led professions, as well as information from secondary care. In line with this, making the best use of available facilities, people and other resources, again linking into the voluntary sector will be an important and key point to the principles and objectives. Increased engagement from voluntary sectors, who normally work within community settings, and on limited funding, allows for gathering of experiences and learning from the development and working of these sectors.

Another key strength will be the establishment of consultation group to focus and manoeuvre the integration plan, allowing for key communication and discussions between groups, and focussed planning in terms of the agenda.

Please provide details of any areas in which you feel the Bills provisions could be strengthened.

Wider understanding and considerations of locality boundaries, payments and broader professional and organisational agenda setting that may occur. Wider consideration of the frontline workforce in integration plan, they come with information and knowledge that can be utilized and acknowledged within the
plan. Again as stated above, a wider consideration of voluntary sector and primary care (i.e. GP’s).

Another aspect which could be strengthened or further informed would be the publishing of the integration plans. Where and how will this be published, also will this be well publicized to all the workforce and wider population along with voluntary sector. Many of health and social care staff are not aware of the integration; thus are unable to comment on it. Co-operation section again did not seem to take into consideration of other partners and sectors out with health board and local authority.

In line with the national health and wellbeing outcomes, staff and population level need to be made aware of these, to ensure the integration functions are being followed. Therefore these must be well publicized within all sectors.

**What are the efficiencies and benefits that you will anticipate will arise for your organisation from the delivery of the integration plans**

Better joint working. Community partnerships will grow and develop, primary secondary, community and voluntary sector will hopefully be made more aware of each other and the services and provisions that they can offer. Wider understanding and considerations of preventative and anticipatory care, utilizing information sharing in a more positive form to develop better services and provisions for the population and staff.

**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

Information sharing between local authority and health board in determining the integration plan, will have positive effects on those receiving the service, as information sharing and sharing of best practice will benefit the whole system.

Heather Locke and Catherine Murray
2 August 2013
Voluntary Health Scotland

Introduction

Voluntary Health Scotland is the national voice of the voluntary health sector with around 400 members. We welcome the opportunity to submit a response to the Health and Sport Committee’s call for written views and evidence on the Public Bodies (Joint Working) (Scotland) Bill. Our comments below reflect consultation with the sector through attendance at events and through individual discussions with members. We have also shared this response and sought feedback from members.

Questions

1. Do you agree with the general principles of the Bill and its provisions?

The policy memorandum sets out the policy ambition and overarching principles of the Bill. Voluntary Health Scotland agrees with these principles, which describe a framework for joined up care that delivers better outcomes for patients, services users and carers, focusing on a person-centred approach to effectively address the needs of individuals. This person-centred approach should build upon current legislation and initiatives and embrace principles highlighted as part of the Christie Commission. We would further stress the importance of a focus on human rights as a guiding principle to the Bill to protect dignity and quality of life, ensure individual needs are taken into account and ensure service users are effectively involved in the planning process.

However, while the Bill details integration planning and delivery principles, it does not adequately reflect the overarching policy ambition and principles of person-centred approaches, collaboration and co-production. We appreciate the rationale behind this approach, and the legal difficulties in defining principles in legislation. However, we and our members, agree that people-focused principles should be set out at the start of the Bill to demonstrate that the aim of structural reorganisation is to provide more integrated, consistent and quality care. We highlight the approach taken in the Social Care (Self-directed Support) (Scotland) Act 2013 as good practice, and support a similar approach with the Public Bodies (Joint Working) (Scotland) Bill with the inclusion of general objective/principles into the main body of the Bill.

The provisions of the Bill centre on integration at a strategic level and statutory responsibilities of integration authorities. However, successful health and social care integration is contingent on a range of factors, of which structural reorganisation is only one. Northern Ireland has had a structurally integrated system of health and social care since 1972. However, evidence

---

from Northern Ireland\(^3\) has shown that there can be difficulties with integrated systems, notably through inequitable resource allocation, priorities, identification of need and performance targeting. The Northern Ireland integrated health and social care system has not realised its full potential and the opportunities provided by the structural organisation have not been fully capitalised upon. The Audit Scotland 2011 Review of Community Health Partnerships\(^4\) also highlights a number of challenges in the integration of health and social care and concludes that effective local leadership and a commitment to develop partnership working over a sustained period is also needed. We would welcome further consideration of incorporating a ‘route map’ to integration in the Bill, incorporating people-focused principles and partnership working, which would accompany and complement structural reorganisation.

The policy memorandum also highlights a disconnect between primary and secondary care, and, acute and community care within the NHS. However, the provisions of the Bill do not address this disconnect and this will impact upon the effectiveness of integration plans. We would welcome further consideration of this reflected in the Bill.

2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The approach proposed in the Bill places significant focus on the structural reorganisation of public bodies as the route to integrated services. However, there is a disconnect between this and the policy objectives to; improve the quality and consistency of services for patients, carers, service users and their families; provide seamless, joined up quality health and social care services; and effectively and efficiently deliver services that meet people’s needs.

Structural reorganisation will not automatically lead to these outcomes and further work is necessary to ensure the Bill results in effective services for individuals. The Bill does not effectively address unintended consequences of integration, such as the short-term division of resources and focus, and issues surrounding transitions between services and atypical scenarios that can ‘fall through the gaps’. Here lies an intrinsic tension between person-centred approaches, collaboration and co-production and the realisation of a joint bureaucracy and the budgetary, structural and cultural tensions that accompany this.

We would advocate a holistic approach to the integration of health and social care, which draws on learning from the rest of the UK, and seeks to integrate structural reorganisation with effective partnership working and person-centred principles. Evidence submitted to the Christie Commission demonstrated that effective collaboration and partnerships with people and communities makes a real difference. It recommended that the government


should use these models to ensure legislation benefits individuals and communities. We would welcome further consideration of incorporating a ‘route map’ to integration in the Bill, incorporating people-focused principles and partnership working, which would accompany and complement structural reorganisation.

The third sector contribution to achieving the stated policy objectives is significant, and while this contribution is recognised within the policy memorandum, it is missing from the proposed legislation. The third sector brings a range of resources and expertise to integration in terms of:

- providing valuable support and services, both in collaboration and independent of the statutory sector
- adding insight and intelligence in the strategic commissioning process
- maintaining close links to service users and communities, which enables their voices to be heard, and
- accessing hard to reach groups.

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.

3. Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

Voluntary Health Scotland agrees with the Bill’s policy objectives, subject to considerations detailed in question 1 above. We welcome the emphasis on integration of health and social care and the legislative duty on local authorities and health boards to integrate their services.

The development of national health and wellbeing outcomes will be critical to this process and we, the third sector, welcome the opportunity to contribute to the development of these shared objectives as detailed in Part 1: Section 5 (4) to ensure the vision of better outcomes for patients, services users and carers is achieved. We anticipate that the integration of health and social care will have a positive impact on openness of strategic commissioning, timely decision making and funding agreements and accountability.

4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

We do not believe that the proposed legislation effectively acknowledges or utilises the knowledge, resources and skills of the third sector. Partnership working with the third sector is crucial to ensuring the suitability and sustainability of services within an area. We believe that the legislation, omitting engagement with the third sector in the development of both integration and strategic plans, is flawed. We would recommend strengthening these provisions to ensure third sector involvement, especially if integration planning and delivery principles are to be achieved.
As previously outlined, the third sector has significant experience in delivering services that suit the needs of individuals and communities and have access to people that local authorities and health boards do not. As such, we believe that the involvement of the third sector should be strengthened in primary legislation to ensure involvement in designing and delivering services. Evidence from the JIT Health and Social Care Integration Enquiry\(^5\) shows that many areas have processes in place for planning shadow arrangements; within these, there has been variable engagement of key stakeholders. We believe that omission on a duty for integration authorities to consult and engage with the third sector will directly impact on the consistency of services across Scotland.

We acknowledge the inclusion of third sector organisations in the Bill in relation to the development of the national health and wellbeing outcomes. However, would recommend the inclusion of third sector organisations in the following sections of the Bill:

- Part 1: Section 6 – Consultation
- Part 1: Section 12 - Integration joint boards: further provision
- Part 1: Section 26 - Establishment of consultation group

We note from the policy memorandum that the remit of the Bill is to provide a framework to integrate adult health and social care services as a minimum, and for statutory partners to decide locally whether to include other functions in their integrated arrangements. The JIT Enquiry highlights that again in planning shadow arrangements, there are inconsistencies across Scotland as to what is included in integration arrangements. For example:

- 4 partnerships intend including aspects of children’s services and 6 are also actively considering this.
- 4 partnerships intend including criminal justice and 5 partnerships are also actively considering this.
- No partnership had intentions to include their housing departments in formal integration arrangements. Housing support is already integrated within social work for a number of partnerships and 3 partnerships are also actively considering this.

This creates a confusing landscape across Scotland for members of the public, service users and carers and impinges on the consistency of care across Scotland. It also creates questions for national third sector organisations and their ability to seek to influence nationally in future and engage with third sector interfaces. Similarly, transitional services are not included in legislation and we as a sector are concerned that transitions between services and atypical scenarios can ‘fall through the gaps’. We would recommend further strengthening of provisions for including other

functions in integrated arrangements and clarification is required on how these elements connect with community planning partnerships.

The Policy memorandum notes the importance of ensuring the effectiveness, quality and safety of services. However, third sector providers have noted the absence of ‘ensuring quality’ in the Bill itself. Accountability, assurance and ensuring that vital services continue to be provided to a high standard remains high on the third sector agenda. National standards could be referenced in the Bill, along with clear guidelines for independent scrutiny of quality, performance and the achievement of national outcomes.

We are also concerned around how the Bill links to existing legislation, for example, the Self Directed Support Act, and the complexities the integration of health and social care will introduce for service users, carers and families. We are also concerned about the provisions in the Bill for public involvement in the scrutiny of integrated services and how patients, service users, carers and their families can influence, feedback and complain about services in accordance with the Charter of Patient Rights & Responsibilities⁶.

5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

As the national voice of the voluntary health sector, we believe that if the third sector is involved in the design and delivery of integration plans, this will lead to improved engagement between third sector organisations and statutory bodies. However, in order to do that, the provisions within the Bill need to be strengthened as described in our response above, to identify the third sector as equal partners in planning and decision making processes, including full membership of joint integration boards. This would recognise the equal input of the third sector into the partnership.

There needs to be a strengthened focus on integrated care and focusing on a framework for joined up care that delivers better outcomes for patients, services users and carers. This does not just include statutory bodies and as we have demonstrated, the third sector is a key partner in the delivery of services and can bring a number of advantages to the framework, including:

- Providing valuable support and services that complement and collaborate with, or those that are missing from statutory services
- Accessing hard to reach/isolated individuals that can be reluctant to engage with statutory bodies
- Tackling health inequalities through holistic approaches that take the social determinants of health into consideration, and
- The ability to move quickly and flexibly, to respond to patient and service user need without bureaucratic constraints.

⁶ http://www.scotland.gov.uk/Publications/2012/04/6273
6. **What effect do you anticipate integration plans will have on outcomes for those receiving services?**

Both integrated health and social care, and integration plans have the potential to positively impact on patients, service users, carers and their families. In line with the policy objectives of the Bill, this if developed effectively can lead to significant outcomes for people. However, this depends on the suitability of the framework adopted in each integration and strategic plan and the development of national health and wellbeing outcomes. This is not only dependent on the structural reorganisation of statutory bodies, but also includes the following:

- principles of person-centred approaches, partnership working, collaboration and co-production are realised and key stakeholders are engaged in the process
- lessons are learned from the rest of the UK, and former initiatives e.g. the review of CHPs, and
- recommendations from enquiries such as the Christie Commission are taken into account.

Voluntary Health Scotland
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

British Psychological Society

About the Society

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Do you agree with the general principles of the Bill and its provisions?

The Society strongly supports the principle of service integration, which recognises the links between health and social care needs and that well-being can best be achieved by providing a more holistic approach to people’s care. We also welcome the focus on prevention and on efforts to make better use of local resources. This focus fits with an assets based approach, which is consistent with psychological models of well-being and which we believe is the most efficient and effective way to addressing Scotland’s health inequalities and to meeting the future mental health needs of its population.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The Society is concerned that the proposed arrangements may not lead to improved well-being amongst the population of Scotland. The joint working arrangements may simply lead to the continued emphasis on current methods of tackling people’s health and social care needs, albeit in an integrated fashion. It is our view that a more radical shift is required that moves away from traditional models of care, and more towards services react to problems with treatments and interventions, towards an assets-based approach, which focuses on prevention by helping people build resilience and develop the skills and resources to solve their own problems and by involving families and communities. We would like to see a stronger commitment to increased investment in assets-based approaches (Division of Clinical Psychology Scotland, 2013). We would also like to see greater efforts to make use of the expertise of practitioner psychologists to contribute a psychological perspective to inform this shift in approach. Currently, practitioner
psychologists are under-represented in the decision-making structures of health boards and social care services and it does not seem as if the proposals in this Bill will help to overcome this.

We are also concerned that the proposed arrangements do not allow sufficient involvement of users, carers and the third sector. It is the Society’s view that the involvement of these parties should be extended beyond the requirement for them to be consulted, to being included as equal partners in the strategic planning and governance arrangements.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

The Society supports the emphasis on older people’s health and care and the efforts to reduce hospital admissions amongst this population.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

As detailed above, it is our view that the planning and governance arrangements must be expanded to include users, carers and the third sector. We would also like to see greater efforts to bring about a fundamental shift towards an assets-based approach. To achieve this end, we believe that there must be greater financial investment in this approach at the expense of traditional methods. Furthermore, strategic planning must involve a broader range of professionals than is generally the case, including in particular, practitioner psychologists.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

Psychological services will benefit from closer working arrangements with social care services in allowing a more holistic approach to care. Stronger governance arrangements which recognise the important role of psychological services and applied psychology in improving health and care outcomes will also be of benefit. Further, national outcomes for health and well-being should lead to improvements in the consistency of care for people across Scotland.

What effect do you anticipate integration plans will have on outcomes for those receiving services?

Integration plans should allow recipients to experience a more co-ordinated, coherent approach to their care. It should allow them and their carers to be more actively involved in their care planning and to have access to services in the community which are better suited to their particular needs. However, unless there is a shift in commissioning practice from the acute care sector to the community, the Society is not confident that the proposals will ensure that older people are provided with services that support them to live for as long as they can in the community. Integration may help to deliver improved outcomes for older people and lead to reduced costs, the evidence base for this is not
yet fully established (Weatherly, H., Mason, A., Goddard, M., and Wright, K, 2010) and the process could lead to increased costs in the short to medium term which might undermine service quality.

British Psychological Society
2 August 2013

Reference:


About this Response

This response was led for the British Psychological Society by:

Dr Ruth Stocks CPsychol, Division of Clinical Psychology Scotland and Division of Forensic Psychology Scotland

With contributions from:
Dr Belinda Hacking, CPsychol AFBPsS, Division of Clinical Psychology Scotland and Division of Health Psychology Scotland
Do you agree with the general principles of the Bill and its provisions?

In our response to the Consultation on the Bill, NHS Lanarkshire affirmed our commitment to putting in place a system of Health and Social Care that is robust, effective and efficient and which reliably and sustainably ensures the highest possible quality of support and care to the communities we serve. In working towards these goals we fully acknowledge the need for services to be designed around the service users and their carers in a way that is as seamless and integrated as possible.

Together with our community planning partners we also recognise the importance of being jointly accountable for the delivery of national outcomes and for improving service delivery. In summary we therefore agree with the general principles of the Bill and strongly support the stated policy objectives.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

Again, within our response to the Consultation on Adult Health and Social Care Integration, NHS Lanarkshire and its Local Authority partners highlighted our shared concerns that where partnerships were already assessed as performing to a high standard in meeting the conjoint objectives of A Joint Future, that plans for integration that included structural changes could detract from the existing focus on delivering effective and efficient services to people in local communities and shift focus on to the reform process itself. Whilst recognising that the approaches set out in the Bill will require a significant level of leadership and organisational development time and energy, the proposed approaches are never the less very likely to support the achievement of the policy objectives. Local Authority and NHS leaders will be required to ensure that implementation plans and change management processes do not detract from frontline service delivery during the transition period.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

Within the response to the Consultation NHS Lanarkshire and its partners requested that any plans took account of the necessary balance between national expectations and targets and the local priorities that emerge through local community planning systems. In this way services can be designed to meet varying local circumstances whilst still achieving prescribed national outcomes. It is considered that the approaches set out in the Bill around Joint Strategic Planning afford the opportunity to strike the right balance and flexibility to meet specific local priorities. For this reason this is considered to be a key strength.
• Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

Overall the Bill’s provisions are considered to provide a clear framework to enable NHS Boards and Local Authorities to develop robust integration plans and to strengthen professional inputs to the community planning process.

• What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

Since the publication of the Royal Charter for Older People and the subsequent introduction of “A Joint Future” service users and carers have sought more streamlined assessments, service plans and delivery mechanisms. The Bill presents an opportunity to build on the existing strong foundations of partnership working in Lanarkshire which in turn will see less duplication of effort and more effective use of assets be they Buildings, Equipment or Staff. Over time there will be opportunities to bring Corporate Services such as Finance, Human Resources, Estates and Capital Planning and IM&T together as single services. There will also be opportunities to streamline operational management structures and governance systems.

There will also be opportunities to begin to develop the roles of staff to enable individuals to deliver a broader spectrum of health and social care inputs by blurring professional boundaries. This will improve decision making especially where people have complex needs.

• What effect do you anticipate integration plans will have on outcomes for those receiving services?

From a service user perspective receiving comprehensive health and social care services based on a single shared assessment should speed up service delivery and reduce information exchanges and ‘hand offs’ between services. The integration plans should therefore support achievement of the overall policy objectives which are designed around improved access to more consistent, efficient and effective range of services.

NHS North Lanarkshire
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Carers Scotland

Carers Scotland is a charity set up to support the thousands of people who care for an elderly partner, sick friend or disabled family member. Carers Scotland is the Scottish nation office of Carers UK. Caring is part of life. Three in five of us will provide unpaid care for someone at some point in our lives. However, without the right support the personal cost of caring can be high with many carers experiencing poor health, poverty and disadvantage. Carers Scotland helps carers and campaigns to make their lives better.

Facts about carers

- There are almost 660,000 carers in Scotland
- 110,000 people provide over 50 hours of care per week
- People from lower socio-economic backgrounds\(^1\) and in areas of multiple deprivation\(^2\) are more likely to need and to provide care.
- Unpaid carers and young carers are more likely to suffer poor physical and mental health, particularly those who are providing intensive levels of care. This affects their ability to care.\(^3\)
- The role of carers is significant in the delivery of care and support. Currently the cost to replace the care provided by carers would be more than £10 billion each year\(^4\). Carers are critical in enabling older and disabled people to live safely in their own homes and communities.
- With a growing ageing population, the need for unpaid care will also increase. It is estimated that by 2037, there will be 1 million carers in Scotland\(^5\).

Introduction

Carers Scotland welcomes the opportunity to comment on proposals for the Public Bodies (Joint Working) (Scotland) Bill. Our comments aim to provide suggestions to strengthen the Bill and any supporting guidance and to highlight areas of concern.

1. General Principles & Policy Objectives

Carers Scotland welcomes the commitment to integration of health and social care and its intention to improve outcomes for individuals and carers. It is

\(^1\) EHRC, How Fair is Britain (2010)
\(^3\) Carers Scotland & Carers UK: Carers in Crisis (2008)
\(^4\) Carers UK: Value of Caring (2011)
\(^5\) Carers UK: It Could Be You (2001)
clear that, done well, this has the potential to break down artificial barriers between health and social care and enable people to receive consistent support that addresses their needs more holistically. We believe this will begin to address current problems where often carers report that they and the person they care for fall through the gaps between health and social care, causing unnecessary readmission to hospital and subsequent strain on carers.

For example, in recent research by Carers Scotland, four in 10 carers caring for someone discharged from hospital in the last year felt that the person they cared for was not ready to come out or they did not have the right support to be at home. Almost two thirds had either not been consulted about their discharge or had only been consulted at the last minute.

“She was discharged too early, without proper medication which resulted in her being re-admitted to hospital within three days.”

“The impact of a rapid discharge back home with me, even when I said I couldn’t manage, has been one of the most highly stressful things that I’ve had to deal with.”

This applies equally in the delivery of social care services in isolation from carers’ needs. Of those who cared for someone who had been admitted to hospital as an emergency in the last three years, more than one in five (22%) felt that this emergency admission to hospital could have been prevented if they had received replacement care to look after their own health or been given more respite and support.

We welcome the commitment to underpin these reforms with those outlined in the Christie Commission in that “effective services must be designed with and for people and communities.”

However, this should be clear that individuals and carers should be involved as equal partners alongside statutory, third and independent sector providers in strategic commissioning and planning for the delivery of services and support at all levels.

This means ensuring that legislation and supporting guidance for the Bill ensures that partnerships build a consistent approach to involving carers and carers’ organisations in strategic planning for support across the authority and in planning and delivery in localities.
We believe that the Bill as it stands does not sufficiently translate the stated policy of designing services with people and communities. We agree\(^6\) that “services should be planned and led locally” and that a consultation group to involve stakeholders should be established as an integral part of the development of strategic plans. However, we believe Bill itself should specify more than “engagement” and “consultation” and instead should specify that such planning is grounded in “co-production” with carers, individuals and communities who are fully involved from the outset. A mechanism for formal agreement of the integration plans by these representatives at both strategic and local level should be in place alongside that of the local authorities and health boards with statutory responsibility.

To deliver real change, the principles of good co-production should apply at all levels of planning – strategic, locality and individual. For example:

“Good co-production can ensure that services are shaped according to need, that the benefits of re-configuration are clear to all, that real challenges including financial ones are transparent and understood and that real involvement and control are given to communities.”\(^7\)

2. Strengths

Carers Scotland welcomes that the Bill places a duty on local authorities and health boards to integrate their services rather than previous, often inconsistent, approaches to joint working that have often failed to deliver for carers and those they care for. However, as outlined above, it is vital to fully engage with people and communities to deliver the most effective outcomes.

We further welcome the Scottish Government commitment to prescribe national outcomes. National outcomes have the potential to achieve consistency across Scotland in the delivery of holistic health and social care services. Changing and improving systems to improve delivery of health and social care is important but what is most important, and warmly welcomed, is the outcomes focus of the Bill which is firmly based upon making people’s lives better. We believe this holistic approach can make a difference to carers’ whole lives, focusing not only on their caring role but instead on sustaining and improving their health, wellbeing, quality of life and achieving aspirations.

At present there is a significant disconnect between social care and both primary and acute care. This can affect carers negatively and has impacts far

\(^6\) S4 1 (iv) & 25 1b (iv)
\(^7\) A Controlled Earthquake - A think piece on where Joint Commissioning Strategies need to go: Joint Improvement Team (2011)
beyond their ability to sustain caring. Carers can experience poor health, isolation, poverty and loss of employment simply because they care for a loved one. In our recent research\(^8\) 84% of carers said that caring had a negative effect on their health yet two thirds said their GP was aware of their caring role but gave them no extra help. This illustrates just one example of the lack of joined up approaches to providing effective support to carers.

Despite long term policy to better recognise and value carers as equal partners in care and to provide support to sustain caring, less than half were involved or consulted in discussions about the care of the person they look after, only half knew about technology such as telecare and telehealth that could help them in caring and almost a third of those caring for 35 hours or more receive no practical support with caring.\(^9\)

With effective leadership, the Bill and national outcomes have the potential to address these problems more consistently and deliver the seamless services that carers should be able to expect. Moreover, we welcome the intention to consult with carers in the process to regulate for national health and wellbeing outcomes that affect them and those they care for. Carers and organisations representing cares must have meaningful opportunities to make clear what will improve the lives of carers and those they care for.

3. Issues that require further strengthening

**Section 2: Integration plans: two or more local authorities**

Carers Scotland has some concerns over the lack of information in relation to this section of the Bill. There is a need for greater information on plans for the delivery of strategic planning over multiple local authorities. Carers Scotland would welcome more in-depth analysis and guidance to explain what this will mean in practice, ways in which people will be fully involved in the co-production of such plans and how they intend to deliver effective outcomes for people and carers.

**Consultation**

Whilst Carers Scotland welcomes the Government’s recognition\(^10\) that additional resources will be needed to support capacity and the recognition of co-production as key, we have some concerns over the lack of detail within the Bill on consulting and involving carers, people who use services and representative organisations such as carers’ centres. As noted earlier, we believe the provisions of the Bill itself should specify more than “engagement” and “consultation” and instead should specify that all integration planning is

---

\(^8\) State of Caring 2013: Carers UK
\(^9\) State of Caring 2013: Carers UK
\(^10\) Explanatory notes: 62-64
grounded in “co-production” with carers, individuals and communities who are fully involved from the outset. As noted, a mechanism for formal agreement of the integration plans by these representatives at both strategic and local level should be in place alongside that of the local authorities and health boards with statutory responsibility.

Statutory guidance and the specified secondary legislation should aim to ensure that there is a consistent approach across all partnerships and localities. This should build current standards for the involvement of carers and patients.\textsuperscript{11}

**Approval**

It is unclear in what circumstances approval for an integration plan may be refused by Ministers. This requires more clarity. However, we would suggest that in order to achieve approval, integration plans must include a formal agreement by carers and people who use services (and representative third sector organisations) alongside that of the local authorities and health boards with statutory responsibility.

**Complaints Procedures**

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 introduced for integrated partnerships to avoid confusion for people who use services and carers.

**Principles**

Carers Scotland welcomes the inclusion of integration planning principles\textsuperscript{12}. However, we believe that the Bill would be enhanced through underpinning and aligning principles with other relevant legislation and for these to be on the face of the Bill. This would ensure that the focus of integration in improving people’s lives is “centre stage” (as intended through the national outcomes) rather than structural change.

For example the Social Care (Self-Directed Support) Scotland Act 2013 principles include collaboration, involvement and the provision of information and to take “reasonable steps to facilitate” and respect individual’s right to


\textsuperscript{12} S4
dignity and to participate in the life of the community in which the person lives. The Patients’ Rights (Scotland) Act 2011 focuses on encouraging participation in decisions, providing information and support and the right to give feedback or raise concerns.

**Achieving Savings and Reinvestment**

The intention of integration is clear, to move from disjointed systems that can cause expensive unplanned and unnecessary admissions and delayed discharges towards coordinated support built around communities that will improve outcomes.

What is not clear however is how these “savings” made to acute care will be identified and reinvested into the new integrated services. Whilst we recognise that it may take time for these changes to actually deliver savings, it is 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 is critical to success.

4. **Efficiencies and benefits for organisations**

As an organisation involving and representing carers, we hope that integration will improve opportunities for active, equal and full engagement with carers and with those organisations representing and supporting them at both strategic and locality level. However, at its heart, integration must recognise and value the knowledge and expertise of communities, third sector organisations, carers and people who use services in identifying and delivering the best solutions that bring about real change and improvement. Again, we welcome the Government’s recognition \(^{13}\) that additional resources will be need to support capacity and co-production.

5. **Anticipated effects on outcomes for those receiving services?**

Integration has the potential to deliver better support for carers and those they care for. It is vital however that, as intended, it delivers support holistically; understanding that in order to reduce the negative effects of caring, support is needed not only to make caring sustainable but also to improve carers’ health, wellbeing and quality of life. This includes ensuring that they have the same opportunities to remain in paid employment and take part in learning, leisure and social activities as all citizens. We also hope that integrated plans will also recognise the linkages between good support for carers and for those

---

\(^{13}\) Explanatory notes: 62-64
they provide care, recognising the importance of delivering good outcomes for both.

It is critical however that integration retains its clear intention on improving outcomes and that this does not become lost in the process of changing systems, structures and workforce.

Carers Scotland
2 August 2013
1. **Introduction**

1.1 YouthLink Scotland is the national agency for youth work. It is a membership organisation and is in the unique position of representing the interests and aspirations of the whole of the sector, both voluntary and statutory.

1.2 This evidence does not claim to be the position of any one individual member organisation, or of all member organisations. Individual organisations may hold views which differ from the opinions presented here. We have consulted with our membership on this evidence, in line with our consultation response protocol, and this submission incorporates the views of those members who responded to the request for feedback.

1.3 In this submission, we are mostly concerned with the implications of the Bill for children and young people’s services. As the Bill’s provisions are focused on adult services, and have little to say on children’s services other than making it possible for them to be integrated, we are unable to answer some of the Committee’s questions directly, but rather have provided comments and questions for consideration and further exploration.

2. **General principles**

2.1 We welcome the overall policy aim of the Bill, which is to improve outcomes for service users, carers and their families. The general principles which are on the face of the Bill are the integration planning and delivery principles. These aim to improve the wellbeing of service recipients by providing services which: are integrated from the point of view of recipients; take account of their needs; are locally planned and led; anticipate needs and prevent them arising; and make the best use of facilities, people etc.

2.2 We support the general principles, but believe that there should be a greater emphasis on the rights of service users, as well as their needs. The need to tackle health inequalities, and the importance of preventative approaches and early intervention, should also be emphasised.

2.3 With regards to the Bill’s provisions, this is a more complex question. We deal with some of the issues, from the perspective of the children’s and young people’s sectors, below.

3. **Children and young people in the Bill**

3.1 The Bill seems to have been originally conceived as a ‘services for older people’ Bill, as it refers to them throughout. As a consequence, children and young people are largely invisible in the legislation. The potential to integrate children’s services and other functions such as housing seems to be something of an
afterthought and the implications of integrating (or not integrating) these other services is not adequately explored.

4. **Areas in which the Bill’s provisions could be strengthened**

4.1 There is a lack of clarity over how this Bill links to the shared children’s services planning duties in the Children and Young People (Scotland) Bill, and to the assessment of needs and planning requirements in the Regulations for Community Learning and Development 2013. These regulations require education authorities to undertake an assessment of community learning and development needs in their area, and to publish three year plans accordingly. It is imperative that these assessments and plans take full account of children and young people’s needs, and that, in turn, children’s services planning takes full cognisance of the role and contribution of community learning and development. How is it envisaged that these planning processes will link to the integration of children’s services, as enabled by this Bill?

4.2 We are unclear as to how the provisions will impact on the transition from children’s to adult services, especially given that there may be a proliferation of different integration approaches across Scotland. This is a highly significant issue, as transitions are crucial in helping children and young people achieve positive outcomes. Transition is an important issue for all young people, but it is particularly significant for vulnerable and disadvantaged young people, and those who have disabilities and long-term conditions. The guidance accompanying the Social Care (Self-directed Support) (Scotland) Act 201 refers to transitions and the importance of early planning, which we would reiterate. We would like to see a greater connection between the Self-Directed Support provisions and this Bill.

4.3 We would like further clarity over where children’s social work and education (including community learning and development) will sit within, or in relation to, these new structures, and where management responsibility will lie.

4.4 As the provisions will result in a range of different approaches to integrating children’s services being taken across the country, this could result in increased complexity, especially when dealing with cases that cover more than one area, and could lead to confusion among the public.

4.5 In many cases, areas will choose to create new integration bodies. If these bodies are to operate as trusts, this could present some specific difficulties. In our evidence to the Education and Culture Committee on the role of children’s charities in June 2012, we reported the views of some of our member organisations, whose experience is that “the trend towards creating local authority trusts is problematic, as trusts spend a disproportionate amount of time on income generation as opposed to direct delivery of services for young people and their communities.”

4.6 There is a lack of detail on the requirement to involve service users in the governance arrangements. If children’s services are integrated then it will be

---

1 http://www.youthlinkscotland.org/webs/245/documents/EducationandCultureCommittee-Written evidencefromYLS.doc
necessary to include children and young people in these processes. As we stated in our response to the consultation on the Community Empowerment and Renewal (Scotland) Bill\(^2\), the involvement of young people must be meaningful and not tokenistic. Methods of engagement are more successful when they are creative and sustained, and where there is a positive attitude towards young people’s involvement. There needs to be awareness that structures can exclude young people – for example, the times that meetings are held at may be unsuitable as they clash with school or college timetables. These issues could be developed and clarified through statutory guidance and regulations.

4.7 The Bill also needs to demonstrate how integrated services will connect to community planning processes and the provisions in the Community Empowerment and Renewal Bill, which, as mentioned above, requires community engagement (including the participation of young people) in planning processes.

4.8 The integration of services will also presumably lead to the merging of three different complaints mechanisms (for health, social care and social work). Whatever mechanisms are decided upon, it is important that means of complaint and redress are accessible, local, and young-person friendly, so that problems can be resolved quickly and easily.

5. **The third sector**

5.1 The third sector must be fully involved in the planning and decision-making processes. However there are a number of questions regarding how this would work in practice. The third sector is diverse, with a range of sometimes competing views. Who will ‘the third sector’ representatives be, and how will this be decided on? There will be practical difficulties for national voluntary organisations in engaging in these diverse models of integration across Scotland. It may be the case that umbrella bodies, such as voluntary organisations’ councils, will represent the sector, but this requires further discussion.

5.2 The Policy Memorandum suggests that the third sector will not have voting rights on the governance bodies. If this is the case, it could lead the third sector being perceived as a ‘second tier’ member with less influence.

6. **Other issues**

6.1 The Bill requires integration between local authority functions, which are ultimately accountable to elected officials, and NHS functions, where the officials are appointed rather than elected. This raises some questions over accountability and representation, particularly in instances where the health board becomes the lead body, or where a new body is created.

6.2 Another issue which the Bill does not address is the discrepancy between social care services and NHS services in terms of cost. There is a charge for social care services, but NHS services are free at the point of delivery. This creates a

discrepancy which members of the public may find difficult to understand, especially if they are receiving services from one integrated body.

6.3 The Bill raises questions about the future direction of public services more generally, as the Scottish Government has now introduced a considerable amount of legislation in relation to joint planning and delivery. What is the overarching picture the Government has in mind?

YouthLink Scotland
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Dumfries and Galloway Council

Introduction

The Council’s response to the Health and Sport Committee is based on the joint submission in September 2012 by Dumfries and Galloway Strategic Partnership (our Community Planning Partnership) to the Scottish Government’s consultation on the Integration of Adult Health and Social Care and public service reform generally. It also reflects recent discussions and considerations by the Dumfries and Galloway Community Health and Social Care Partnership Board (CHSCPB) in its role as shadow Health and Social Care Partnership (HSCP).

Given that the Public Bodies (Joint Working) (Scotland) Bill was published relatively recently, our Elected Members will continue to consider the detail of it as it progresses through Parliament and as we develop, in equal partnership with our Health and Third and Independent Sector colleagues, our local current preferred model - body corporate - for consideration at future meetings of Dumfries and Galloway Council post political recess and Dumfries and Galloway NHS Board.

On 4 July 2013, the CHSCPB considered a detailed report on the contents of the Bill and an initial comparison of the integration models possible against our local principles for integration with the conclusion that our local principles can be accommodated and progressed through the Bill as it currently stands.

The integration model for Dumfries and Galloway - being informed and developed through our Health and Social Care Integration Programme Board - will meet legislative requirements and our local integration principles, focussing on bespoke services provided at local area level to meet the specific needs of individuals, communities and partner organisations.

Call for written evidence on the following 6 questions

1. Do you agree with the general principles of the Bill and its provisions?

The intent of the Bill is to provide “the framework which will support improvement of the quality and consistency of health and social care services through the integration of health and social care in Scotland”. As indicated in the Introduction above, the CHSCPB has considered the direction in the Bill and has concluded that there is alignment with the Dumfries and Galloway local principles for integration which focus on:

- improved health and wellbeing outcomes and addressing health inequalities
- prevention and early intervention
- quality of care
• a commitment to a person-centred approach
• services provided at community or locality level wherever possible
• full and meaningful engagement with communities and participation of all partners
• clear and robust decision-making structures; local accountability; integrated budgets; and professional leadership

The considerations of the CHSCPB confirm that our local principles are accommodated and will be progressed through the Bill as it currently stands.

2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The CHSCPB has noted that much of the detail of the Bill is to come through guidance and regulations; however, the Board expects to see an improvement in service design, quality and delivery through application of our local principles for integration which are broadly in line with the direction in the Bill and accompanying Policy Memorandum. An emphasis in the Bill and in our local principles on developing local decision-making and community involvement is a positive and necessary step to realise the policy objectives. Putting people at the centre of all decisions about their health and care and ensuring that services are planned and delivered to support this seamlessly for patients, carers, service users and their families is fundamental.

3. Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

The policy ambition within the Bill for integrating health and social care services is to “improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older”. The work of the CHSCPB to date confirms that our local principles for integration are consistent with this ambition.

Our demographics highlight that the biggest single factor influencing social care and health needs in the future is expected to be the substantial rise in the number of older people, particularly the projected increase in those over the age of 75, and this is recognised in the Bill.

4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

More detailed information through early guidance and regulations is anticipated and there will be continuing discussions between COSLA, local government and other interests. Early notification of the timescale for submission of a final integration plan would be helpful although it is
acknowledged both that this is dictated by the pace of the legislative process, and that there may be changes to some of the detail in the final Bill.

5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

If integration plans fully reflect the integration planning principles currently outlined in the Bill and the proposed national health and wellbeing outcomes (which we have seen in draft), then the anticipated efficiencies and benefits for our Council should closely resonate with the outcomes we wish to see delivered through our local principles for integration i.e.

- clear and robust decision-making structures fully reflecting the unique and different roles of the Council and the NHS, retaining the respective accountability for resources, outcomes and performance and quality of services through a continuing commissioning approach
- clear and robust structures providing for full delegation and empowered decision-making
- professional leadership and oversight and practice development should remain with senior professional officers in each organisation
- an integrated budget to respond to all situations
- valuing staff and ensuring professional leadership and appropriate supervision, supporting them in their roles within integrated services
- existing change or improvement activity in adult health and social care refocused to support and underpin the delivery of integrated services

There are already programmes locally, including Putting You First, that are addressing aspects of the health and social care agenda for certain groups of adults. The efficiencies and benefits we anticipate through delivery of integration plans would be across health and social care for all adults in a consistent manner.

6. What effect do you anticipate integration plans will have on outcomes for those receiving services?

If integration plans fully reflect the integration planning principles currently outlined in the Bill and the proposed national health and wellbeing outcomes (which we have seen in draft), then the anticipated outcomes for those receiving services should closely resonate with the outcomes we wish to see delivered through our local principles for integration i.e.

- improved health and wellbeing outcomes for local people, quality of care and the needs of the individual being central in all our considerations and decisions - “a person-centred approach to care”
- services delivered at a local level recognising that the shape of services may be different in each local area to meet specific and unique characteristics
- ensuring that people have the right support in the right place with timely and appropriate access to specialist services, minimising harmful delays in care and support
• involvement of people, communities and professionals from the outset and as equal partners in determining service design and delivery and support in their local area

• promotion of early intervention and prevention

• encouragement of self-care and self-management; and addressing health inequalities

Dumfries and Galloway Council
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Children in Scotland

1. Do you agree with the general principles of the Bill and its provisions?

Children in Scotland welcomes the opportunity to submit evidence to the Committee on this Bill which provides the framework to integrate health and social care services. The intention to provide a legal underpinning for integration and working together is welcomed, and has the potential to create more accessible services and clarity for service users.

The Bill itself does not refer to the principles which are detailed in the policy memorandum - it is very much a technical document setting out how arrangements for integration can be made. This is understandable but it should be possible to include more of the spirit and intentions at the start of the Bill, as has been achieved with the general principles at the start of the recent Social Care (Self-directed Support) (Scotland) Act.

Structural reorganisation is not the only element of ensuring successful health and social care integration – we would welcome further information on a ‘route map’ to integration incorporating partnership working to accompany the structural reorganisation provisions.

2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The Bill is largely focused on structural reorganisation which will not automatically lead to the stated policy objectives - this needs to be combined with partnership working (including the third sector) and person centered principles. Successful integration will also require culture change for health and social care services, effective engagement with children, young people and families and also sound communication of information in accessible formats throughout the planning, implementation and evaluation stages.

3. Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

The intent and legislative provisions for integrating health and social care services are welcomed, but as noted above and below could be strengthened. The development of the national health and wellbeing outcomes will be key in this process, and the third sector and service users should have a voice where possible in shaping these.

4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

The people who use health and social care services, where they wish to, should have a recognised voice in the process. There is a concern that the Bill currently states that third sector providers of health and social care services,
should be consulted and engaged with, but they may not have a role in eg signing off integration plans, or voting on proposals. This might include those who may not consider themselves ‘providers’ but who contribute considerably to meeting individual and community needs and towards achieving positive health and wellbeing outcomes.

This Bill makes no mention of the processes that will apply for those who access health and social care services – and this will hopefully be addressed in guidance/secondary legislation. There is, for example, no equivalent of the ‘named person’ (as contained in Getting it Right for Every Child and the Children and Young People Bill) – or a central point of contact for service users. The Bill mentions scrutiny of new bodies and arrangements but there is no mention of how service users will be able to raise concerns or provide feedback under new arrangements.

We would also welcome clarity on how this Bill will link to existing legislation such as the Social Care (Self-directed Support) (Scotland) Act and the possible complexities integrated social care services may introduce for service users, carers and families, particularly with regard to transitioning from children’s to adult services.

The policy memorandum to the Bill states that integration should include adult health and social care services at a minimum, and that local partners should decide whether other functions should also be integrated. It is our understanding that a number of areas will choose to integrate children’s health and social care services. An enquiry by the Joint Improvement Team (2013)¹ found that 4 partnerships intend including aspects of children’s services and 6 are actively considering this. A survey of Children in Scotland members showed mixed knowledge as to whether this was being planned in their area or whether some children’s services were already integrated. There was enthusiasm for more information on this topic.

This has the potential to create a mixed, and potentially confusing picture across the country where some services are integrated in one area but not in another. More emphasis on integration beyond adult health and social care is required in the Bill or accompanying documents.

We would also encourage the Health and Sport Committee to communicate with the Parliaments Education and Culture Committee who will be considering the Children and Young People Bill, which will likely work its way through Parliament at the same time as the Public Bodies Bill.

The Children and Young People Bill makes a number of provisions in relation to Getting it Right for Every Child and joint working which may have implications for any integrated health and social care services. These include:

- Requiring local authorities and health boards to develop joint children’s services plans
- Require a ‘child’s plan’ where targeted intervention is necessary
- Creating a statutory definition of wellbeing
- The requirement for each child to have a ‘named person’ (for under 5’s this will likely be a health visitor and for school aged children a teacher or head teacher).

The Bill will also require Scottish Ministers and public bodies (including local authorities and health boards) to issue reports showing how they have taken the UNCRC into account.

5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

Children in Scotland has members from both statutory and non-statutory services and we believe both have a key role to play in the successful integration of health and social care services. The third sector is a key partner in service delivery and its involvement in the design and delivery of integration plans could lead to improved integration beyond just greater partnership working between health boards and local authorities.

It may be beneficial to the Committee to consider taking oral evidence from representatives from non-statutory or voluntary services (local and national) during stage 1 consideration of the Bill to discuss issues such as the involvement of the third sector in design and delivery, and the implications where services (eg children’s) are integrated in one area but not another. Children in Scotland is a member of Voluntary Health Scotland who have held a number of events to consider these issues.

6. What effect do you anticipate integration plans will have on outcomes for those receiving services?

Children in Scotland welcomes the intent to extend integration of health and social care services beyond older people’s services as the original intention seemed to be. The responses received to the initial consultation suggested that an arbitrary point or age at which integration begins to apply (eg age 65) would not be helpful. We 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. Transitions are a key concern in many policy areas affecting children and young people including education, health and social care. There may also be implications if some parts of Scotland choose to integrate these children’s services and others do not. Transitions need to be more overtly addressed in the Bill and accompanying documents. The policy memorandum also states that other services such as housing could be integrated in future – it would be useful to have some sort of estimate of what the proposed timescale or intention for future integration is.

Stakeholders in the integration process will require effective information, communications and guidance to ensure good outcomes for service users –
particularly those with additional support needs using health and social care services.

Children in Scotland is the national umbrella agency for organisations and professionals working with and for children, young people and their families. It exists to identify and promote the interests of children and their families and to ensure that policies and services and other provisions are of the highest possible quality and are able to meet the needs of a diverse society. Children in Scotland represents more than 400 members, including most of Scottish local authorities, all major voluntary, statutory and private children’s agencies, professional organisations, as well as many other smaller community groups and children’s services. It is linked with similar agencies in other parts of the UK and Europe.

The work of Children in Scotland encompasses extensive information, policy, research and practice development programmes. The agency works closely with MSPs, the Scottish Government, local authorities and practitioners. It also services groups such as the Cross Party Parliamentary Group on Children and Young People (with YouthLink Scotland). In addition, Children in Scotland hosts Enquire - the national advice service for additional support for learning, and Resolve: ASL, Scotland’s largest independent education mediation service.
General Comments
There are many things that Scotland has done to support the improvement of the quality and consistency of health and social care services through integration; the coherent policy across government, maintaining a commitment to integration, giving it time to work and relative organisational stability. A robust legal framework would help progress integration but focus needs to be on leadership development of public sector agencies and their key partners to improve collaborative working.

Community pharmacy should be central to keeping people safe, improving outcomes for patients, reducing health inequalities and improving the wellbeing of local communities. The public would be better served if community pharmacy were fully involved in the development and implementation of health policy.

Translating the government’s policy and achieving the key ambition of integrated care based around the person on a sustainable basis will rely on the involvement of multiple agencies, systems, commissioners, providers and government at national and local levels. Community pharmacy is not only a major provider of health services within Scotland but also a vital part of the wellbeing of communities in terms of investment, employment, training and sustainability.

What people really want – personalised, high-quality, seamless care focused on their needs. The public sector agencies of health and social care as well as private, independent and third sector agencies do not collaborate well enough and as a result people, especially those living with long terms conditions, are poorly served.

We support Dr Harry Burns, Chief Medical Officer, when he proposed ‘that asset based approaches may provide the necessary step change in health creation which Scotland needs to accelerate gains in healthy life expectancy across the population’. We would like propose some forms of integration where pharmacy can make a significant contribution:

- Vertical integration (secondary and primary care). There are opportunities for community pharmacy to help people even more to get the right medicines by integrating community pharmacy services with hospital admissions and discharge planning, palliative care and end of life services.

  We are keen to see greater involvement of community pharmacy in Managed Clinical Networks (MCNs) which have been constant feature of the health care system in Scotland for the last 15 years. The universal coverage across all Health Boards in the following areas; coronary heart disease, stroke, diabetes, respiratory and cancer would deliver even
greater benefits to patients from the intervention of community pharmacy teams.

- **Horizontal integration (primary, community and social care).** Community pharmacy supports independent living as well as providing these services as part of the national contract; Minor Aliment Schemes (MAS), Chronic Medication Service (CMS), Public Health Services (PHS), Advice to Residential Homes, Dispensing of Methadone for Drug Users, Domiciliary Oxygen Service, Needle Exchange Services and Disposal of Patients’ Unwanted Medicines.

There are many people who are disempowered living isolated lives in their communities. Community Pharmacies are often a focal point, the place where people go and we can help to address this type of issue by signposting to social care services.

- **Virtual integration (systems and processes).** Community pharmacy provides Acute Medication Service, (AMS); electronic transmission of prescription information (ETP) between GP prescribers and community pharmacy. However we are keen to see the ambition for information sharing as set out by Professor Lewis Ritchie - Chairman of the CMS Advisory Group (2009), progress with a greater sense of urgency and integrated across health and social care.

‘**CMS will need to be underpinned by robust information flows in both directions linking community pharmacies and general practices, supported by explicit and informed patient consent.**’

The Scottish Government said in ‘Renewing Scotland’s Public Services, priorities for reform in response to the Christie Commission, 2011’

‘**Community is at the heart of our approach and Community Planning Partnerships will continue to play a significant role in identifying priority local outcomes and leading service integration in their areas through the further development of Single Outcome Agreements.**

**Our priorities for improving partnership during this Parliament include:**

- continuing closer joint working between GPs, pharmacists and other community services to improve the service on offer to patients’

We are keen to understand the planned work streams that are in place to achieve this priority and how we can contribute during this parliament.

**Response to specific questions**

**Do you agree with the general principles of the Bill and its provisions?**

Yes, the Bill provides a supportive framework. Integration of health and social care requires long-term sustained effort. Integration has been facilitated by relative organisational stability, political consensus, a willingness of health and social care professionals and all parties committed to collaborative working.
To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

A key policy objective of this Bill is to enable and require appropriate, local responses to changing patterns of need, within a national context of accountability for clearly articulate, joint outcomes.

- Aligned performance management. The National Performance Framework and the Single Outcome Agreements (SOAs) clearly demonstrate the coherent policy across government. SOAs are the means by which Community Planning Partnerships (CPPs) agree the strategic priorities for their local area and express them as outcomes to be delivered by the partners.

We are keen to understand how community pharmacy contributes and aligns with this performance management system. The Scottish Ministers required to involve a range of key stakeholders in the development of outcomes and performance indicators; as a key stakeholder we are keen to offer our support.

- The proposed reform programme. The focus on governance, accountability and management arrangements will establish integration joint boards and integration joint monitoring committees. These boards and committees will need to demonstrate effectiveness in this cluttered landscape of integration of health and social care.

If the Community Health Partnerships (34) are to be replaced by an optimum number of new integration joint boards, how will that be achieved without rationalising the current number of Health Boards (14) and Local Authorities (32)? Other public services such as Fire and Rescue Services and Police have reformed significantly in April 2013 and could be a model for health and social care in the future.

- Full integration of health and social care. This requires managing the tensions and differences in the NHS and LAs i.e. the NHS has not gone down the purchaser, provider model of care whereas LAs increasingly commission services from other providers such as the independent and third sectors. There is a sense of mistrust between Local Authority Councillors and Health Board members; councillors are elected whereas Health Board members are not. The implicit pooled budgets for health and social would be a key success factor for effective integration.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

We are delighted that after the consultation on the proposals for the integration of adult health and social care, May 2012, the government strengthened the wording as proposed from “engage” to “involve”. ‘The integration authority will be required to involve a range of partners in the development of the plan (strategic) and consult widely.’ Community pharmacy is a key partner and would make a significant contribution to the development of strategic plans.
We support the proposal in the consultation that integration authorities will need to ensure professionals have time to participate in the process. This is of particular relevance to community pharmacy because under the regulations, pharmacists would have to pay for locum cover in order to attend meetings during working hours. This additional cost burden could prevent community pharmacy from fully participating in the process and would be seen to be unfair.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

Pharmacies are in the heart of the community, making easy access for people who are well, those who are unwell, families and carers, and those who are disempowered living isolated lives in their communities. Community pharmacy is not only a valuable health asset but also an important social care asset. We believe that there should be more explicit recognition of the need for pharmacists to be represented on new bodies and fully involved in the planning of health and social care services.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

a) Focusing on Safety. Around 2 million people in Scotland have at least one long-term condition, and one in four adults over 16 report some form of long-term illness, health problem or disability. By the age of 75, nearly two-thirds of people will have developed a long-term condition. Recent research has also demonstrated that most people with a long-term condition have more than one and that the prevalence of multi-morbidity increases with age and is associated with deprivation (Barnett et al 2012).

Drug wastage represents a significant lost resource within the NHS. It is estimated that around 50% of medicines are not taken as prescribed by patients with long term medical conditions (Establishing Effective Therapeutic Partnerships, report 2009). There is general agreement of the benefits to integrating the management of people living with long term conditions. However there is no evidence of the integration of medicines across the patient pathway.

Community pharmacy is best placed with local team of experts in medicines to help people get the best out of their medicines (and reduce preventable harm). We expect to see CMS integrated across MCNs.

b) Effective community pharmacy engagement in developing and implementing strategic plans. Pharmacy leaders need to be in the same room with key partners discussing, sharing, listening and thinking differently as to how we can make real change and deliver measurable benefits. We expect to see representatives of community pharmacy working closely in partnership with integration authorities and making a significant contribution to the development of strategic plans.
What effect do you anticipate integration plans will have on outcomes for those receiving services?
We would anticipate a positive effect on outcomes for those receiving services.

Company Chemists Association Ltd
2 August 2013
Public Bodies (Joint Working) Bill

Community Pharmacy Scotland

Introduction
Community Pharmacy Scotland represents the owners of Scotland’s 1247 community pharmacies. Services are provided for patients throughout Scotland through the contract under the terms negotiated with Scottish Government for pharmaceutical care services.

Community Pharmacy Scotland is supportive of the Government’s 20:20 Vision for health.

Our response to the 6 questions posed follow.

Do you agree with the general principles of the Bill and its provisions?
Yes. We note that there is scope for different NHS Boards/Local Authorities to develop their own plan in their own way. However as pharmacy contractors may operate pharmacies in more than one NHS Board or local authority we see potential for confusion and complexity in terms of our ability to deliver.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
We would like to say we are confident that it will, but given the lack of detail at this stage on how what is proposed will be delivered on the ground, we are not in a position to predict how successful it will be.

Please indicate which if any aspects of the Bill’s policy objectives you would consider as key strengths?
We consider the introduction of nationally agreed outcomes could be a key strength. We’d like to know how these proposed outcomes are being developed to improve on current outcomes. We see that work on outcomes will be taken forward as regulations are prepared and we look forward to having the opportunity to engage with that work.

We are also pleased to see a focus being placed on involvement and engagement with all local professionals.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened?
Based on our previous experience with locally negotiated services we would prefer to see more direction being given nationally. Nationally agreed outcomes with local flexibility to deliver should encourage innovation and have previously in our experience, improved service experience for patients. The trick will be to ensure that innovation can successfully become mainstream rather than reliant on particular individuals.

It is not clear to us how success in meeting objectives will be determined and if objectives are not immediately met how long SG will give the new structures to bed in.
What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?
We hope to see greater involvement of the pharmacy profession. Unfortunately to date we have not had the opportunity to participate in any work of the bill preparatory groups.

We’d like to see a holistic approach to care delivery with both health and social care in agreement on what would most benefit the patient. The prime example for us is the provision of compliance aids where social care services can often insist upon their use and healthcare can see that they bring problems as well as benefits. Our hope is integration can help drive focus on patient need rather than shifting responsibility to meet skill deficiencies at particular points.

What effect do you anticipate integration plans will have on outcomes for those receiving services?
We hope to see a focus on anticipatory care, in whatever form that might take, and that where a change in the care pathway is required it can be delivered in a speedy and efficient fashion.

We all, including patients and/or their carers, need to be prepared to be realistic about what can be delivered in the current financial circumstances.

We think the most important point here is that there has to successful delivery of integration plans. The plan in itself delivers nothing.

Community Pharmacy Scotland
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

The Scottish Independent Advocacy Alliance

Do you agree with the general principles of the Bill and its provisions?

1. We feel it is useful for the Bill to outline general principles; however we feel that these principles need to be consistent with other Scottish Government policies, for example regarding user involvement and co-production in the design, delivery, monitoring and review of services. The principles should be clearly stated and positioned at the beginning of the bill to ensure clarity, e.g. like the Mental Health Act.

2. The Bill should include a right of access to independent advocacy in the same way as identified in the Mental Health (Care & Treatment)(Scotland) Act 2003. Individuals and groups should have the appropriate levels of support to be able to engage effectively in the form of individual and collective independent advocacy. There also needs to be a strong statement about the importance of proper and effective engagement between the statutory sector and the third sector. Alongside other Scottish legislation, this Bill should be based on the principles of human rights. The language used in the Bill appears to be orientated towards the medical model of disability and does not have an emphasis on empowering or fully involving individuals. The use of the word ‘recipient’ does not reflect principles of empowerment or inclusion. Rather it feels like people using services will have things ‘done to them’ rather than being actively involved in making decisions. We feel that the Bill would better reflect the principles if the approach reflected Human Rights, user involvement and the social model of disability. This would also help with the change in culture that is required within both the NHS and LA in order for this legislation to succeed. The Bill should also identify principles and outcomes around engagement and participation.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

3. We are concerned that the stated policy objectives of the Bill and the actual Bill are not clearly aligned. We feel that the Bill appears to concentrate on structural and financial aspects of integrating the NHS and LA and does not give enough regard to the cultural shift that is required. It also does not appear to consider the implications of statutory duties that currently lie with specific professions and what the impact of this legislation would have on these duties, e.g. the importance of the independence of the Mental Health Officer (usually LA) from the clinical team (usually NHS) when making decisions about an individuals’ care and treatment.
4. We are concerned that the Bill currently does not give enough recognition to the role of the third sector. The third sector can play an important role in helping to ensure that the objectives outlined in the Bill are fulfilled and we believe that the third sector should have voting rights as should people who use services. The third sector, namely independent advocacy organisations can support individuals and groups to effectively participate in the design, delivery and review of services. They can also support individuals and groups voice their opinions, needs, aspirations and wishes effectively.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths.

5. We welcome the ideology of integrating health and social care but we think that there needs to be a greater emphasis on outcomes for individuals and groups. We think there needs to more attention given to quality assurance so that there is greater clarity and transparency about when principles are being adhered to and when they are not and when outcomes are achieved or not.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

6. The Bill should give users the right to access independent advocacy in the same way as the Mental Health Act. There needs to be clarity and transparency about what is effective involvement of service users in all aspects of health and social care, whether that is as individuals or collectively.

7. There also needs to be a clear understanding of the role of the third sector and recognition that the third sector is not a homogenous group but has varying agendas and priorities. We feel that the involvement of people who use services needs to be given proper consideration separately from the third sector.

8. There needs to be further thought given to the role of Public Partnership Forums. The locality groups identified in the Bill need to have a clearly defined role and remit. The Bill needs to address how the locality groups are going to operate without undue party political influence.

9. We also believe that the responsibility for ‘signing off’ strategic plans should lie with the Scottish Parliament Health & Sport Committee rather than the Minister.

10. There needs to be clarity around how people can raise concerns about the service they receive. There are different systems currently between health
and social care. For example how will the Patient Rights Act apply across service provision?

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

11. If the right to access independent advocacy is added to the Bill then we would anticipate the demand for independent advocacy both individual and collective to increase. We would also hope that engagement between advocacy organisations and statutory bodies would be enhanced and strengthened.

What effect do you anticipate integration plans will have on outcomes for those receiving services?

12. We hope that service provision will improve and that it will help to improve the lives of people and facilitate independent living.

The Scottish Independent Advocacy Alliance
2 August 2013

The Scottish Independent Advocacy Alliance (SIAA) is Scotland’s national membership body for advocacy organisations. The SIAA promotes, supports and defends independent advocacy in Scotland. It aims to ensure that independent advocacy is available to any person who needs it in Scotland.

www.siaa.org.uk
Melrose House, 69a George Street, Edinburgh EH2 2JG. Tel: 0131 260 5380
SIAA is a Scottish Charitable Incorporated Organisation. Charity number SC033576
Public Bodies (Joint Working) (Scotland) Bill

Falkirk Council

Background

Falkirk Council fully supports the aspirations of improving outcomes for people who use Health and Social Care Services in Scotland. People who depend on our services should have seamless care no matter who delivers, manages or pays for that care.

We welcomed the opportunity to comment on the Government’s earlier consultation on Health and Social Care Integration and view the current Bill as the most significant piece of legislation to affect Social Work Services and the people who depend on them for decades. As such it is important that the provisions in this Bill are shaped to give confidence that improved outcomes will follow. There is a balance to be struck between detailed prescription and the creation of a general legal framework which facilitates local responses to local circumstances. The Bill undoubtedly strives to achieve that balance, however, we would not always agree with the areas where detailed prescription is applied.

In relation to the specific questions posed by the Committee:

1. Do you agree with the general principles of the Bill and its provisions?

Falkirk Council agrees with the general principles of the Bill and its provisions. However we have some concerns about the powers which Ministers would be granted to intervene in the management of services if they perceive that services are not delivering well enough. This function was not part of the consultation and it is not clear the circumstances in which it would be used. It is also not clear how such powers fit with the role of inspection and regulatory bodies.

It is also of concern that the Bill provides Ministers with the power to extend the scope of integration authorities by regulation (Section 1(6)). This is a very far reaching power which could see the delegation of a much wider range of Local Authority without recourse to further legislation. This provision is not in keeping with the policy intention of the Bill and we would advocate it’s removal from the Bill.
2. **To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**

Much of the detail of the Bill is being left to regulation and guidance. We will await those parts of the legislation before reaching conclusions on how the provisions can be implemented and before offering a view on the likely impact.

There are parts of the Bill that we still require further clarification, for example what proportion of the acute budget from the NHS will be put into the partnership arrangements. There is also some uncertainty around the details of the governance arrangements as outlined in the Bill.

3. **Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths**

The Bill’s policy objective of improving the wellbeing of people who require adult health and social care services is one which we would consider to be a key strength.

4. **Please provide details of any areas in which you feel the Bill’s provisions could be strengthened**

- The Bill leaves lots of detail to regulation which we are unable to comment on at this stage.

- The Bill makes no reference to the role of the Chief Social Work Officer in new partnership arrangements and no consideration is given to how, irrespective of structural considerations, the integrity of this role should be ensured. This is particularly important in view of the potential downside of the integration of adult services which could be the fragmentation of Children’s services and Criminal Justice Services.

- The Bill does not address how the voice of service users can consistently be heard across health and social care services and how the move towards citizens directing their own support can be promoted not just in respect of social care services but also in respect of health provision.

5. **What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

It is difficult at this point in time to identify what efficiencies will be achievable and the financial memorandum associated with the Bill provides very limited evidence of how these could be achieved. The Council has responded separately to the Finance Committee’s call for evidence in this regard.
6. **What effect do you anticipate integration plans will have on outcomes for those receiving services?**

Integration plans should have, at their heart, a shared commitment to improved outcomes. However, their success will be dependent on there being a commitment to a well-planned and well-managed change process. For this reason we would urge the committee to take into account the time that will be required to bring about this change while at the same time maintaining strong operational management of services to some of society's most vulnerable adults.

Falkirk Council
2 August 2013
WHO WE ARE

HIV Scotland is the national HIV policy charity for Scotland. We want a society which is well-informed about HIV and devoid of HIV-related stigma and discrimination. Our mission is to ensure that all HIV relevant policy and practice in Scotland is grounded in evidence and in the experience of people living with and affected by HIV. We maintain meaningful engagement with people living with HIV and demonstrate how their involvement makes a difference.

SUMMARY

This Bill is of particular relevance to people living with HIV, given its implications for health and social care and initial emphasis on the needs of the aging population. Since the introduction of antiretroviral therapy, people living with HIV are enjoying healthier longer lives; 1 in 5 people with HIV in the UK is now over 50\(^1\) and a 2011 study\(^2\) found that the prevalence of certain conditions typical of aging (e.g. cardiovascular disease, liver disease, hypertension) in people living with HIV was more typical of HIV negative people aged 10-15 years older. The same study also points to the need for earlier detection of non-infectious comorbidities, which this Bill could play a vital role in addressing. Furthermore, people living with HIV may be more likely to access multiple services across a range of settings e.g. health, social care, social work, welfare, housing and criminal justice.

The Bill also has the potential to ensure that individuals, communities and the third sector are meaningfully involved in the planning, design and delivery of public services. However, HIV Scotland believes that the provisions in the Bill require to be strengthened if this potential is to be realised and to ensure a genuine focus on the needs and rights of individual patients and service users.

QUESTIONS

- Do you agree with the general principles of the Bill and its provisions?

HIV Scotland fully supports the policy ambitions and principles outlined within the Policy Memorandum, such as the delivery of joined up and person-centred care. However, within the Bill itself the overarching ‘general principles’ are unclear; instead there are a set of ‘integration planning principles’ and


‘integration delivery principles’ set out within different sections. It is also unclear which principles are to be seen as driving this legislation, whether it be the “the underlying principle… that Health Boards and local authorities must take joint and equal responsibility for the delivery of nationally agreed outcomes…” or “the desire to embed a person-centred approach to public service delivery of health and social care.”

HIV Scotland firmly believes that any reform to public services must be driven by the need to place the person at the heart of the services they receive, however the principles contained within the Bill at present do not go far enough to ensure that the focus will truly be on the individual patient or service user. A far better approach would be to explicitly set out guiding principles at the start of the Bill, placing a duty on the relevant public bodies to adhere to principles such as involvement, collaboration and the fulfilment of individual’s rights (e.g. independent living and access to quality and effective services) when acting on their functions under the Bill. We would refer to the Social Care (Self-directed Support) (Scotland) Act 2013 as an example of good practice in this regard. This Act established a legal framework for people to have greater choice and control over the support they receive, with principles such as independent living being set out on the face of the legislation.

- To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The Bill appears largely focused on the technical aspects of integration, placing a strong emphasis on the desired structural change. However, the integration of health and social care is a means to an end and not an end in itself. The integration of services alone will not be enough to better deliver outcomes for individuals and produce better quality services equipped to meet their needs. In order to achieve these ends, it will be absolutely essential that the people accessing services are meaningfully involved in their design and delivery but the provisions in the Bill relating to the involvement of service users and communities are currently weak.

The significant contribution of the voluntary sector towards meeting the policy objectives must also be recognised, with the voluntary sector being included as a full and equal partner. The voluntary sector has a key role to play, both in supporting commissioners to procure services that are responsive to peoples’ needs and provide value for money, and in the delivery of effective and innovative health and social care provision. The voluntary sector is also well placed to engage people and communities and give them a voice in decisions which affect them. Unless the Bill is strengthened in this regard, the potential for it to achieve the stated policy objectives will be greatly lessened.

One of the stated policy objectives is to “improve the quality and consistency of services”. The fact that the Bill allows for integration authorities to progress integration using several different models may result in significant inconsistencies between localities. This could have implications for the consistency of support for people living with HIV who may travel beyond their
local service(s) to access care. Furthermore, depending on the delegation model adopted and the effectiveness of its implementation, there could remain serious disconnects. For example, disconnects could be widened between child and adult services where a ‘delegation between partners’ model is employed in relation to these services.

- Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

HIV Scotland welcomes attempts to deliver joined up care which delivers better outcomes for patients, service users and carers. The fact that the Bill introduces a requirement for health and social care partners to integrate their services and budgets, prepare and publish strategic plans and engage in strategic commissioning certainly goes further than previous attempts to foster integration.

We also greatly welcome the introduction of nationally agreed outcomes for health and social care, which if properly developed and implemented could go far to ensure that all partners are working together towards the delivery of better outcomes for individuals and communities.

- Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

As stated above, the development of national health and wellbeing outcomes and published integration plans could help to bring about improvements in the delivery of public services. However, this will only be the case if the people accessing these services and the third sector are meaningfully involved in their development. The term ‘consultation’ used throughout the Bill is not strong enough to ensure that this will happen; a much greater emphasis must be placed on involvement and collaboration, with the voluntary sector being positioned as an equal partner in strategic planning and the design/delivery of services. Unless the provisions of the Bill are strengthened in this regard, there is a real danger that the national health and wellbeing outcomes will not reflect the needs people accessing services and that voluntary sector involvement will become tokenistic within the new arrangements. This is especially so given that the third sector will be a non-voting member of the HSCP Committees.

In relation to integration plans, the Bill could be greatly strengthened by placing a duty on Health Boards and local authorities to evidence/report how they have involved communities and the third sector in their development. Furthermore, there is little detail in the Bill about how or whether integration authorities will be held accountable for progress against the agreed national outcomes and strategic plans, or how poor performance will be identified and addressed in a timeous manner.

The plans to integrate adult health and social care services are not limited to older people’s services but are intended to extend to all adult health and social care services. HIV Scotland believes that the proposals would greatly

3
benefit from clarity as to when and where the proposals for integration are intended to be progressed.

HIV Scotland would also like to see human rights and a rights-based approach being given more prominence within the Bill. This could be achieved by setting out clear overarching rights-based principles as described earlier in this response.

- **What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

  This Bill presents an opportunity to ensure that services across all sectors can be better aligned to joint outcomes, focused on the needs of individuals and communities. HIV Scotland is aware of a number of examples of good practice in this regard, where effective joint working has delivered significant efficiencies for all partners and, critically, better outcomes for individuals.

  Waverley Care is a national charity that works with people living with HIV and hepatitis C. One of their projects is the running of Milestone House, a short term residential support unit. This service is currently being comprehensively redesigned and reshaped in collaboration with the local authority and the NHS to focus more on ‘step-up’ and ‘step-down’ care. Multi agency referral pathways are being designed, with funding being allocated to the new service by both the local authority and health board. Waverley Care also runs an African Health Project that provides a variety of holistic support services ranging from housing and immigration to health. An important aspect of this is work with Africans, both living with HIV and not, is support to access health services and navigate a sometimes complex NHS system. This is particularly vital for recent migrants who are completely unfamiliar with the system and often have low levels of treatment-literacy. This is an ‘at risk’ population that is often only able to access services because of the support of the third sector. This delivers clear benefits, not only in ensuring the best use of NHS resources, but also in terms of the preventative approach put forward by the Christie Commission; taking demand out of the system over the longer term.

  Positive Help is a charity which offers volunteer led practical help to those affected by HIV and hepatitis C in Edinburgh and the Lothians. Positive Help’s befriending service offers a life line to children and young people who are either living with HIV or hepatitis, or whose parent/s have HIV or hepatitis C. By establishing trust and relationships with young people and their families, Positive Help not only provides a vital support which better enables people to live in their local communities and enjoy an improved quality of life, but any problems can be identified at an early stage and the families linked to the appropriate support. This again demonstrates the way in which the voluntary sector can engage people and communities who may not normally come to the attention of statutory services, ensuring that their needs are identified and addressed at the earliest possible opportunity.

  Another example of good practice is Gay Men’s Health (GMH), the only Scottish organisation that delivers community based services run by and for gay and bisexual men. To steer the work it does, GMH consults widely and
frequently with its volunteer base and the whole community, enabling new trends and health needs to be quickly identified and addressed. GMH also works with NHS Boards to increase the choice and variety of sexual health services that gay and bisexual men can access, offering HIV testing within community settings to increase awareness, and early identification, of HIV in a risk group.

However, building on this type of success will require that joint strategic commissioning is taken forward in such a way that it prioritises preventive support and recognises the third sector as a key partner. If this is not the case, there is a very real risk that existing areas of good practice could be undermined by the integration proposals.

- **What effect do you anticipate integration plans will have on outcomes for those receiving services?**

The answer to this question depends heavily on the extent to which the outcomes of people receiving health and social care services come to be reflected in the national health and wellbeing outcomes. At present, HIV appears to be largely missing from national and local outcomes and performance monitoring mechanisms. HIV Scotland is hopeful that the integration plans will provide an opportunity to address this oversight and ensure the inclusion of people living with or at risk of HIV in the design and delivery of services.

The development of shared outcomes and better integrated services may present new opportunities to better promote and evaluate public health and prevention efforts to reduce HIV transmission. For example, it could help to align efforts to increase the proportion of people with HIV being identified at an early stage of infection. The overall proportion of late diagnoses remains high in the UK, in 2011 this comprised 47% of people newly diagnosed with HIV.³ People diagnosed late have a tenfold increased risk of dying within a year of diagnosis. The findings of a recent Scottish study support more routine HIV testing outside of a specialist setting, particularly for patients in high-risk populations.⁴

The integration plans could also serve to ensure that people working across sectors and settings have a greater awareness and understanding of HIV and related issues. This could be achieved, for example, through developing joint training packages and co-locating staff and services.

**HIV Scotland**

2 AUGUST 2013

---


⁴ L Goodall and C Leen, *Scott Med J* (2011) ‘Late diagnosis of HIV: could this be avoided?’
Public Bodies (Joint Working) (Scotland) Bill

Alex Stobart (the Alliance)

“to improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.”

Comments to Health Committee – Alex Stobart

Do you agree with the general principles of the Bill and its provisions?

In general, the direction of travel to take Christie and build is very sound. However, I think the Bill is mis-named and not accurate. The focus should be on outcomes and citizens, not Public Bodies alone as they do not work or act together unless there is a sustainable common purpose.

It requires individuals, their behaviours and cultural attitudes to change in order for Organisations e.g. State Bodies; Delivery Organisations to change. By only emphasising the role of Public Bodies, the Bill does not convey all the messages or chances for truly person-centred approaches.

The Bill does not address the principles enshrined in the observation by the Christie Commission that —effective services must be designed with and for people and communities

While I agree with the general principles, I do not feel that they offer the individual citizen a comprehensive and effective role in their Health & Care. The Bill appears to attempt to correct Organisational defects.

Organisations in 2013 that accept that data belongs to the individual, and that the future of an “Information Society” can be built by Scottish citizens, will benefit from the co-production opportunities and the greater trust that flows.

In practice, citizens can interact with porous boundaries and nuanced identities, while Organisations are still grappling to manage the new digital economy. Person centred services that enable information to flow from the individual to multiple organisations will empower citizens.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

I do not believe that changing functions and titles among the participating Organisations will be enough. The Bill should include much more information about, and statutory rights for, the individual to be involved in the system. Users of services could provide invaluable sources for service improvement – often innovation and new thinking comes from outside the system.

Nor does the Bill contain any reference to the uses of technology, aligned with the needs of the citizen. The Bill should aim to empower citizens in Scotland
to live longer and healthier lives through the use of personalised digital channels for their health and care needs, and also aim to work with citizens and clinicians to reduce pressure on more expensive services.

This can involve digital participation with citizens, the Third Sector, user communities, public sector and other businesses.

- Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

The willingness to attempt something new and the emphasis on a person centred approach at Para 13 of Policy Memorandum (PM).
The procurement corrections appear sensible to allow Lead partners.

- Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

Para 6 of PM – “integrated health and social care “ is wrongly defined as it is Organisation-centric and does not understand Christie.

In the Bill, it should read that –
“the individual is the point of integration of health and social care. The individual should have a central role, able to exercise choice and control over their health and care arrangements.”

Organisational re-arranging on its own will not achieve any lasting change, or improvement in quality or outcomes. Much more of the Bill must focus on the citizen, and how they participate in the service.

As is recognised, cultures and behaviours have to change inside the NHS and Local Authority systems; the citizen can assist with this by having a much greater role, and being treated as the same person all the time, and whenever they touch the system. At the moment, people have to re-start their story time after time with different parts of the system.

- What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

As currently drafted and envisaged, I would suggest there will be no benefits or efficiencies for Organisations outside the State sector. It will not be possible to advocate and support the individual if the system is not moved to change.

Community Planning Partnerships were created by the Parliament, but they have not directly or knowingly improved the lives of citizens. They remain relatively distant and opaque bodies, and ordinary people do not know what they are.

Without involving citizens, and communities, this Bill will risk the same end – apparently very little in terms of better outcomes.
Because there is no place for ordinary citizens in the Governance arrangements, it is likely that people in Scotland will not relate to, or understand these new organisations. This will be a shame.

- What effect do you anticipate integration plans will have on outcomes for those receiving services?

The effect will be sub-optimal as it does not involve the individual, or give them a statutory duty to be consulted, included and involved.

The governance is not completely democratic, and it is closed. Citizens cannot influence this process of governance in the Bill, so outcomes will not be measured by the people receiving them. Where this situation arises elsewhere in the Health system, the evidence is that outcomes are not identified when issues arise.

Integration Joint Boards are at risk of being lost in existing, alternative, prevailing governance arrangements. There are too many competing arrangements it would appear, and few include the citizen.

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

Alex Stobart (the Alliance)
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

College of Occupational Therapists

What is occupational therapy?
Occupational therapy promotes health, wellbeing and independence through participation in activities or occupation. These are the things that make us who we are and give our life meaning, from daily tasks such as washing and dressing, to working, socialising or taking part in a hobby. Occupational therapy gives people the tools and skills to do the things they need or want to do, removing obstacles to disability, injury, illness or other conditions. “Occupational therapy enables people to achieve health, wellbeing and life satisfaction through participation in occupation.” (COT Definition 2004)

- Do you agree with the general principles of the Bill and its provisions?

The College of Occupational Therapists (COT) welcomes the general principles of the Bill and its provisions but has comment to make in both regards.

The principles fail to indicate an asset based approach taking a “needs” led and one could argue a medical model approach instead. This implies services that are done to rather than shared with the people and communities and do not reflect the Christie Commission Report that “…effective services must be designed with and for people and communities-not delivered ‘top-down’ for administrative convenience.”

The word ‘need’ itself is difficult here as it implies neediness rather than holistic wellbeing. It is also difficult in relation to prevention and anticipatory services as this is about retaining health and wellbeing rather than specific needs. The word “recipient” also implies a passive rather than an active role.

There is no inclusion within the principles of the knowledge base. The term ‘takes account’ is used without reference to any kind of standard, quality assurance or intelligence framework.

The addition of a principle that stated that services must have regard to any relevant guidance, knowledge or intelligence would be welcomed and would ensure some kind of quality within the principles.

COT has concern in relation to the different terms and conditions of employment of OTs at the point of integration where staff are moved from one employer to another. OTs within local authority and NHS are on different pay scales and terms and conditions. When integrating teams, there can be tensions especially when more experienced staff are being paid less than their less experienced counterparts. Careful consideration is required in this regard especially if they are to perform
the same function within the team and can be a real barrier to full integration.

- **To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**

Occupational therapists (OTs) are one of the professions working within health, social care and the third sector. They already work across these boundaries and the disconnect is often one of culture, communication systems and systems within services.

A good example would be someone who has experienced a stroke and have become wheelchair dependent. They see an OT with a specialism in neurology whilst in hospital for intensive rehabilitation. This OT will liaise with an OT within the community with a specialism in complex adaptation to ensure that the person is able to return home to live as independently as possible.

As they have different computer systems information is often shared as a paper copy and requires inputting into the other services system—often in a different format. The referral process within the local authority may mean that there are waiting lists and also a need to assess eligibility for services as well as means testing and assessment around self directed support or packages of care.

The joined up working is already happening between the occupational therapists and there is no duplication within their roles, one is providing intensive inpatient neurological rehab the other is assessing the person in relation to the home environment, arranging ramping and level access living. COT is not confident that the approach being proposed in the Bill will achieve the objective in regard to -integrated from the point of view of the recipient, unless there is a clear commitment to ensure that integration is not just about funding and commissioning but also about ensuring that the systems they are working with are not barriers within themselves.

COT is concerned that without statutory inclusion of Allied Health Professionals (AHPs) on the integration joint boards, they will not have the intricate knowledge required to commission services. The right people need to be at the table. This harps back to the previous point that without a knowledge base there is a risk that services will be commissioned without a clear understanding of the intricacies and potential roles of practitioners. This applies to all AHP services. If lead AHPs are not positioned within the integrated boards there is a real risk that their potential will not be realised. AHPs and indeed OTs are key to supporting people with long term conditions and people requiring rehabilitation to remain at home in the community living as independently as possible, as well as supporting the prevention agenda.
An example of the effectiveness of OTs working within preventative services below indicates a cost saving that the Board without AHP representation may not be aware of.

A randomized controlled trial in independent-living older adults (the Well-Elderly Study) found significant health, functional and quality of life benefits attributable to a 9-month preventative occupational therapy programme. The study aimed to evaluate the cost-effectiveness of this preventative programme. It was found that post-intervention healthcare costs for the occupational therapy intervention groups were reduced by 50% compared to the control group. The research concluded that preventative occupational therapy for this client group demonstrated cost effectiveness and a trend towards decreased medical expenditures. (Hay J et al, 2002)

- **Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths**
  COT is very supportive of the objective to embed a person-centred approach to public service delivery of health and social care.

- **Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.**
  COT understands the intention to enable local decision making in regard to other services that may be included outside of the minimum adult health and social care services within the integrated arrangements.

  This does raise some concerns though in regard to true integration.
  - Children’s services at the point of transition.
  - Mental health services—People cannot be siloed into mental and physical. People experiencing a long term condition may also be depressed.
  - Learning Disabilities—the same applies as to mental health and this group often require support in relation to physical health.
  - Criminal Justice, We know that this population experiences some of the greatest health inequalities.
  - Housing—adaptations, housing support, healthy communities and community support—essential for well being and independence.

  COT would welcome a stronger message within the Bill for truly integrated services. Once again a reference to the Christie Commission report is appropriate “…effective services must be designed with and for people and communities—not delivered ‘top-down’ for administrative convenience.”

- **What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**
  Greater collaboration between specialist OTs providing a seamless service without administrative barriers (this is an aspiration).
A focus on prevention and wellbeing

OTs will be able to focus more holistically on individuals rather than a narrow service led interventions.

- **What effect do you anticipate integration plans will have on outcomes for those receiving services?**
  Decisions made with a focus on the individual rather than between organisations with a focus on funding and systems.

  Hopefully in time with clear national outcomes and a focus on prevention, individual assets and co-production; there will be a true shift in the balance of care with the individual at the centre of decision making and service design.

The College of Occupational Therapists is the professional body for occupational therapists and represents over 29,000 occupational therapists, support workers and students from across the United Kingdom. There are approximately 3,500 Occupational Therapists working in Scotland. Occupational therapists work in local authority social services, the NHS, housing, schools, prisons, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapists are regulated by the Health and Care Professions Council, and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties.

**College of Occupational Therapists**

2 August 2013

Reference

Chartered Society of Physiotherapy Scotland

Introduction and comment
The Chartered Society of Physiotherapy (CSP) welcomes the introduction of the Public Bodies Joint Working (Scotland) Bill. CSP Scotland strongly supports the initiative to better integrate health and social care provision and particularly welcomes the emphasis on preventative and anticipatory care as being in the best interests of patients and service users and the most effective use of resources.

Physiotherapists, along with other Allied Health Professionals (AHPs), work across all healthcare settings and in both health and social care services. They are ideally placed to understand the interface between health and social care provision and routinely support service users and their carers to access appropriate services. Physiotherapists, and other allied health professionals, are the ‘glue’ that holds complex health and social care pathways together, especially for older people and those with long-term conditions. Better integration between the community and acute setting is needed to put an end to fragmented transitions which can potentially slow or limit an individual’s recovery.

It is in this context that CSP Scotland seeks to ensure that future decision making over the planning and provision of health and social care is focussed on the needs of patients and service users.

Q1. Do you agree with the general principles of the Bill and its provisions?
CSP Scotland fully supports moves to better integrate care between settings (both community, primary and secondary) and also in improving integration between NHS funded healthcare services and local government funded social services. The bill as introduced is welcomed as a recognition of the need to provide the necessary framework to enable more integrated provision.

The current Bill has been titled ‘joint working’ but the principle of integration remains in the clauses. It is recognised that it is an enabling measure which does not create a single health and social care body, but will encourage integration without creating or requiring structural upheaval. CSP Scotland supports this approach, as large scale reorganisation can be costly and distract from the business of providing quality services.

CSP Scotland notes the provision in the Bill to empower new corporate structures to employ staff. Whilst this may be necessary for its administrative function, CSP Scotland would strongly assert that this must not allow for the direct employment of health and social care staff or staff groups that are employed by the NHS under nationally agreed terms and conditions.

In addition the primary legislation does not include the detail that will be essential for joint working to succeed. In particular, the success of the policy
will depend on good decision making in the planning and delivery of integrated services, and a patient centred approach to health and social care provision. Much of this will be determined by the secondary legislation. CSP Scotland would urge the Scottish Government to publish the regulations as soon as possible in order that they can be considered alongside the Bill.

Q2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
The integration of health care and social care provision requires collaboration at the interface of planning and delivery at all levels, including strategic management, professional relationships, and joint working across multiple settings and services areas. The success of the approach will be dependent on the practice of integration, not merely the legal and financial framework. CSP Scotland has consistently recognised the importance of supporting a cultural shift, in order to better integrate health and social care, from all involved. Facilitating this will require local opportunities to exploit joint working networks, events and professional development initiatives to support the creation of a culture of mutual accountability for delivering agreed national outcomes.

The policy objectives must therefore be driven by closer working relationships and pathways of care, which will be determined by the practical changes and involvement of all stakeholders. This should include partnership working with staff side representatives in transforming services. The principles of sharing best practice to drive up standards of care will also be essential to the success of the policy.

Q3. Please indicate what, if any, aspects of the Bill's policy objectives you would consider as key strengths.
CSP Scotland welcomes the focus on joint accountability for national outcomes, as a driver for change within the new framework. This will ensure accountability at senior levels to support and encourage integrated working arrangements.

Following initial consultation, it is also a key strength that the integration agenda is not imposing structural changes involving the transfer of staff or workforce upheaval that would detract from the aims of the legislation. The Society particularly welcomes the avoidance of compulsory transfer of staff to new employers and the focus on better working relationships between the various organisations involved.

The Society also welcomes the intention to consult on and introduce national outcomes for health and social care, and the emphasis on the involvement of professional groups and service users.

Q4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.
CSP Scotland would wish to see a statutory requirement to involve the relevant health and social care professionals (as currently specified in community health partnerships) and particularly the inclusion of allied health
professionals. Essentially, in the same way as currently exists for the Community Health Partnerships (CHPs) a ‘statutory governance framework’ must be put in place to ensure that joint arrangements and new corporate bodies operate consistently and effectively across Scotland.

There must be a degree of flexibility to allow for local circumstances to be reflected in the delivery of integrated care. However, it must be clear from the outset what extensions or modifications to CHP functions are proposed, and these must be set out as additional functions within the terms and remit of the new arrangements.

For effective strategic planning across health and social care, the professions at the interface of the sectors, such as physiotherapists and other allied health professionals, must be included in the decision-making structures that are developed.

The role of allied health professions in rehabilitation and preventative care make them an essential component whose role is not always recognised or understood by policy makers or other professionals. The inclusion of an AHP member at a strategic level in the Community Health Partnership Committees has been invaluable in transforming rehabilitation provision in primary care in Scotland. We would strongly urge the Scottish Government to ensure the same contribution from AHPs is a requirement of any reformed structures in primary/social care.

**Q5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

As the professional education and trade union body for the physiotherapy workforce in Scotland, the CSP is interested in those benefits that assist physiotherapists to ensure that people have the right access to appropriate services, and derives no ‘organisational benefit’ as such from the proposals. Nevertheless there are opportunities for physiotherapy practice that in turn will benefit patient care. This includes the more efficient use of resources that emerge with more integrated working and the capability of services to respond more flexibly to patient need. Great involvement of physiotherapists in the wider delivery of related services would deliver benefits, for example in the more joined up use of resources to promote greater independence for older people’s services.

Reablement services present an opportunity for health and social care to work in an integrated way; successful services assist older people to maximise their capability on discharge from a hospital admission or following an acute event. CSP Scotland promotes the value of services to support people to stay in their own home, and this is critical to the sustainability of residential care provision. The reablement agenda is a vital element to supporting older people to remain in their own home for as long as possible and reduce avoidable hospital admissions. Physiotherapists, and other allied health professionals, have a unique role, working across care pathways, and often providing a ‘bridge’ between hospital, primary, community and social care, helping patients navigate their way through their treatment. This gives them unique expertise.
in patient wellbeing that complements and enhances professional healthcare in community settings. They are ideally placed to support closer integration around the needs of patients.

Community-based healthcare professionals must have access to the same standard of IT infrastructure that colleagues in secondary care settings use, but many staff still have to use a variety of different systems when communicating with different agencies. The recent experience is that this has not been prioritised and physiotherapy data is still not collected electronically in many cases, creating difficulties in sharing information about a patient’s journey across different care settings. CSP Scotland would identify the Scottish Government aims to improve integrated IT system support as an essential benefit.

Q6. What effect do you anticipate integration plans will have on outcomes for those receiving services?

CSP Scotland is primarily concerned with improving pathways and outcomes for service users. Integrated planning of services is needed to deliver quality care which is more cost effective in the long term.

One of the essential aspects of the agenda to better integrate health and social care provision is the potential to better target joint resources toward preventative care, in particular, reducing unscheduled hospital admissions and GP referrals. There are numerous examples of good practice in supporting older people to remain in their own home, in supporting effective self-management of long term conditions and health promotion for various patient groups, all of which are of considerable benefit to patients and service users while also reducing the burden on health services and avoiding the need for more intensive social care.

CSP Scotland would highlight improved outcomes for the following conditions and patient groups (further information is available on request):

- **Falls prevention**: by reducing hospital admissions and keeping people independent. The physiotherapy led Glasgow falls Prevention Programme sees 175 patients per month to reduce risk factors, reducing admissions due to falls between 27% and 40%.
- **Chronic Obstructive Pulmonary Disorder (COPD)**: supporting self-management and reducing avoidable hospital admissions. The Edinburgh Community Respiratory team, led by physiotherapists, where around a fifth of the 570 referrals each year are made with the explicit aim of preventing hospital admission.
- **Chronic Pain**: improving quality of life, greater independence and employability, programmes such as the Fife Integrated pain Management Service, provides pain management in community settings, with increased referrals from 1260 referrals in 2009/10 to 1451 in 2011/12.
- **People with learning disabilities**: Physiotherapists can act as a conduit between service users and health and social care providers, such as at Perth and Kinross multidisciplinary learning disability service.
for NHS Tayside, supporting access to services, increasing quality of life, and reducing reliance on health and social care support.

- **Older people’s services, stroke care, and dementia:** early access to physiotherapy can prevent the need for greater social care support, through targeted community provision.

Chartered Society of Physiotherapy Scotland
2 August 2013
Macmillan Cancer Support welcome the opportunity to respond to your consultation. In previous responses on health & social care integration we have expressed strong support for this proposal – and indeed have suggested that without integration of health & social care services, preventive spending on improving the co-ordination of care would not achieve the proposed outcomes.

Do you agree with the general principles of the Bill and its provisions?
The central aim of an integrated health and social care system should be to improve the patient experience by providing person-centred care that is based on assessment of individual needs, including emotional, financial and practical needs. People should, where possible be supported to self manage their condition in their own homes and should be provided with rehabilitation support and help to stay in or return to work. An effective health and social care system would also support end of life care at home rather than in hospital, an important issue for many older people. The General Principles of the Bill do seem to want to achieve these aims.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
The Scottish Government has stated its aim of a person-centred health service that shifts the balance of care away from acute and secondary care, to the community, supported self-management and supportive care.

We believe better use of Cancer Clinical Nurse Specialists to deliver and co-ordinate care more effectively, including assessment and care planning for all cancer patients – linking to information provision and benefits advice – is the key.

Improving the coordination of cancer care through more integrated Health & Social Care service is vital not only to improve the patient experience but also to increase quality and cost effectiveness. People whose care is unplanned and uncoordinated are more likely to be high users of health and social care services, including emergency care. Research led by Macmillan and Monitor Group shows that improving supportive care such as co-ordination, communication and information can deliver improved productivity and is cost effective, having the potential to release about 10 per cent of cancer expenditure. This is achieved by addressing some of the problems that result in high costs for cancer services including:

- Reducing avoidable emergency admissions to hospital
- Reducing length of stay in hospital
- Improving follow-up
- Supporting patients to return to or stay in work
Supporting patients to die at home rather than in hospital

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
Macmillan were involved in the shaping of the responses from Health and Social Care Alliance Scotland and Voluntary Health Scotland – their submissions raise several issues including around third sector involvement that we are concerned about.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?
Macmillan together with the Scottish Government launched the ‘Transforming Your Care After Treatment (TCAT)’ programme earlier this year – and we hope this model of follow-up care will prove to be a successful model for integrating health and social care services. Successful delivery of integration should mean projects like TCAT are deliverable across the sector.

What effect do you anticipate integration plans will have on outcomes for those receiving services?
Macmillan’s experience suggests that the improved coordination of care that would be a result of integration of health and social care can significantly improve the quality of care received by cancer patients, including:

- Reduced stress
- Reduced confusion
- Increased involvement of carers and patients in their treatment
- Improved health outcomes for survivors
- Better palliative care support

Macmillan Cancer
2 August 2013
The Society of Chiropodists and Podiatrists (SCP), the professional body and trade union which represents over 10,000 Chiropodists and Podiatrists throughout the UK, wishes to respond to the invitation to submit written evidence to the Health Committee regarding the Public Bodies (Joint Working) (Scotland) Bill. In responding to the various questions to which the Committee seeks an answer, where necessary, distinction will be drawn between the two functions of the Society.

1. **Do you agree with the general principles of the Bill and its provisions?**

The SCP supports the objectives of the Bill and many, but not all, provisions.

2. **To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**

The SCP believes with the right people around the right tables at national, local and locality levels the Bill (and subsequent early regulation) *could* make a step change to health and well being outcomes in Scotland.

The SCP, along with other AHP professional bodies, would wish the Bill – or subsequent early regulation – to secure statutory AHP representation on integration joint boards, local authority committees, health boards or joint integration monitoring committees. Integration authorities, of whichever form, need ongoing and direct access to well informed intelligence on the full professional capacity potentially available to them (particularly in relation to those services which enable people with long term conditions to live independently) in order that they can make evidence based decisions about efficient and effective use of that potential capacity in pursuit of optimum outcomes for local populations.

If AHPs are not directly and powerfully positioned to influence decisions about effective and efficient use of resources; the implementation of the Bill is in danger of continuing the current pattern of variable quality of services and poor outcomes for many adults with long term conditions in Scotland.

The SCP is well placed to comment on long term care as it is, or should be an integral part of the care pathway relating to the treatment of a number of long term conditions. These range from Diabetes to Peripheral Arterial Disease and Rheumatoid Arthritis. In addition our members, whether employed by the NHS or in private practice, work in a range of settings including home visits, community based clinics, care homes and acute hospitals.

As health professions who work to a large extent in the community, Podiatrists and other AHPs could bring a positive new perspective to the “old” argument of medical versus social in health & wellbeing delivery for the population. AHP leaders can also draw on their long experience and knowledge of best practice to demonstrate and provide leadership on providing services in
people’s home or homely settings in integrated, multi-disciplinary, multi-agency and multi-sector ways.

AHPs are already fully focussed on delivering the health and well being outcomes described in the consultation paper preceding the Bill.

AHP representation as described above could also help facilitate the Bill’s overarching objective to significantly change how and to what ends services are delivered. The above benefits may be deliverable at little extra cost as many boards already have AHP Directors or Associate Directors in post and efficiently one AHP representative could cover up to 12 professional groups, assuming the appropriate uni-disciplinary leadership is in place to support this representative.

3. Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths
The Bill’s stated policy ambition “to improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.” is perhaps its greatest strength. The Christie Commission report of 2011 established that demographic and economic realities meant that the status quo was not an option. The policy ambition articulated above is surely one which health professionals and the public at large can overwhelmingly support. However as with all legislation, “the devil is in the detail”.

4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.
The Allied Health Professions are currently represented on CHPs. The removal of CHPs reduces greatly the ability of AHPs to influence resource use and service planning locally. Securing AHP representation on CHPs was an advance which helped to address the usual imbalance towards other health professionals (Doctors, Nurses) at this strategic level.

The SCP, as a trade union, had three areas of concern regarding the original consultation on the integration of health and social care.

- an AHP role at the strategic heart of any reorganisation,
- workforce issues, including partnership working and staff governance,
- and, closely related to workforce issues, the allocation of resources between integrated budgets and non-integrated parts of the system.

Of these three concerns the question of a strategic leadership role for AHPs has been adequately covered. This leaves workforce and budgetary issues to be addressed.

The SCP sees no evidence in any part of this Bill that the various proposals simplify rather than complicate existing bodies and structures. We have
some concerns around potentially fracturing service delivery. NHS podiatrists typically have a mixed caseload of elderly/adult and children. It would be very unfortunate if the reality of integration actually led to a fragmenting of budgets and services leading to unnecessary confusion.

This leads to a major concern regarding workforce, namely the lack of clarity over the transfer of staff. We will resist detrimental changes to our members Terms and Conditions of service. There needs to be clear unequivocal direction from the Scottish Government on maintaining the NHS Staff Governance Standard and Partnership working. On this subject, the SCP would stress the need for clarity around the term partnership. Partnership working, as defined within NHS Scotland, by NHS MEL (1999), is a very specific term with a very specific application. Members have expressed grave concern that the fact that there is no mention of partnership working or of trade union representation on integrated joint boards (for example) will mean an end to arrangements as they currently exist within NHS Scotland.

The partnership model of industrial relations in NHS Scotland is regarded as a leading edge example of the extent to which innovative industrial relations arrangements may contribute towards improving public service delivery. There should, therefore, be a firm commitment to ensure that these exemplary partnership working structures and practices will be part of the integrated system. Ideally, this should be guaranteed by legislative underpinning i.e. a statutory requirement for Health and Social Care Partnerships to have a Staff Governance framework in place.

We would wish to see integration plans include details of the planned method of ensuring quality services relevant to the delegated functions. This method might include how boards are going to take account of Health and Care Professions Council regulations, AHP clinical standards of practice and other clinical governance duties.

The SCP would also wish planned methods of ensuring quality (or changes to these) to be subject to Ministerial approval along with methods of calculating payments.

5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

The SCP has a significant proportion of members in private practice. We hope that in the delivery of integration plans the potential for “integrating” this significant element of the workforce into health & social care provision is fully recognised. Early work on this has already been undertaken by the recognition in the Scottish Government’s Personal Footcare working group, that referral to a private practitioner for personal footcare is one of a number of possible models. However private practitioners, along with colleagues in the NHS, are fully qualified HCPC registered professionals and as such it would be good to see government recognition that the “independent sector” is not just about care and care home providers.
Other benefits that will arise specifically for the organisation (i.e. The Society) are less easy to identify at this early stage in delivery, however a properly and fully integrated pathway for the delivery of podiatry which saw the service fully recognised and funded for the important role it has to play in keeping people mobile, active and living in their own homes or the community, would benefit both the foot health of the nation and members of the Society in carrying out their profession.

5. **What effect do you anticipate integration plans will have on outcomes for those receiving services?**

It is easy to lose sight of the priority of an improved patient experience of health and social care services when addressing specific concerns. It is important therefore to state that with suitable protection for members, and with AHPs, including Podiatrists, placed firmly at the centre of reform, the SCP believes that the stated policy objectives of the Bill can be achieved. Mention has already been made of Diabetes and of Rheumatoid Arthritis.

Podiatry has a crucial role to play in both of these conditions and both conditions are best managed within a multi-disciplinary team. A diabetes annual review will involve the following professionals- doctor (diabetes consultant or GP), specialist nurse, Podiatrist, Dietician, and Orthoptist - for retinopathy (diabetic eye screening). So typically three AHPS, doctors, nurses and the patient (self – management in the community) are all involved in the team. It is not alarmist to describe the increase in diabetes in the population as a “time bomb”. For up to date statistics and related information on diabetes, Diabetes UK Scotland’s “State of the Nation” report is comprehensive.

Similarly Rheumatoid Arthritis is best managed in a multi disciplinary team, with sign guideline 123 explicitly stating in Key message 2.1 “The multidisciplinary team has been shown to be effective in optimising management of patients with RA. All patients should have access to such a range of professionals including general practitioner, rheumatologist, nurse specialist, physiotherapist, occupational therapist, dietician, podiatrist, pharmacist and social worker.” The guideline also states explicitly that all patients should be offered podiatry referral.

If integration plans are successful in achieving the desired outcomes patients receiving treatment for these and other conditions should experience a fully integrated “seamless” patient pathway.

The Society of Chiropodists & Podiatrists
2 August 2013

---

2. Scotland State of the Nation, 2013, Diabetes UK Scotland
http://www.sign.ac.uk/pdf/sign123.pdf
Public Bodies (Joint Working) (Scotland) Bill

MS Society

Do you agree with the general principles of the Bill and its provisions?

The MS Society welcomes the Scottish Government’s commitment in this Bill to integrating health and social care to improve outcomes. We believe that greater coordination between health and social care services could significantly improve the lives of people affected by Multiple Sclerosis (MS).

MS is a progressive and incurable long-term condition, most commonly diagnosed between the ages of 20 and 40. Over 10,500 people are living with MS in Scotland – one of the highest rates anywhere in the world. Along with medical implications, MS has a social impact. A person experiencing a relapse, for example, may require medical treatment from a MS nurse but their relapse may have caused mobility problems meaning they also require support to get dressed or need adaptations to their home. It is a condition that does not adhere to department boundaries.

MS can also be a fluctuating and unpredictable condition. People living with MS may need to access health and social care services throughout the course of their condition sporadically but perhaps quite suddenly. Coordinated action and a shared knowledge of an individual’s condition are crucial if people with MS are to receive timely and responsive services. The right support at the right time can help people with MS remain in work for longer or live independently for as long as possible.

While we welcome the general principles of the Bill, we would question whether its provisions go far enough to enable the transformation required to deliver improved outcomes on the ground.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

We welcome the legislative duty placed on local authorities and health boards to integrate their services, rather than the non-statutory approach to date which has not led to the common vision and joint working required to improve services.

However, we are concerned that the Bill is in danger of focusing too heavily on structural change and how to achieve this - at the expense of the primary focus on improving outcomes for people. Delivering coordinated and effective care requires more than structural change and integrated budgets. Strong leadership and a radical change in culture will be key to improving services, and we hope to see the Scottish Government’s plans on delivering these critical changes, without which legislation can not achieve its policy objectives.

Our experience shows that where health and social care work best together there is a tangible desire to coordinate action and an understanding that coordinated services provide the best outcome for individuals (see case study below). Greater professional respect is also needed across departments, along with an understanding of the different professional and legal boundaries of each professional. In addition, practical barriers like different IT systems, different terms and conditions for staff and training will all need to be considered for services to improve on the ground.
Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

As noted above we welcome the legislative duty placed on local authorities and health boards to integrate their services, rather than the non-statutory approach to date which has not led to the common vision and joint working required to improve services.

We also consider that the inclusion of a framework for National Outcomes for Health and Social Care within the legislation offers an important basis for monitoring outcomes and improving the quality and consistency of health and social care services across Scotland.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

(a) Consistency and charging

We believe that the Bill needs to be strengthened with regard to measures to improve the consistency of services provided to people by Health and Social Care Partnerships.

People with MS have often told us of their frustration at a ‘postcode lottery’ of care. Many feel that this inconsistency stems from the different charging policies and eligibility criteria across local authorities. This local variation is a real concern for people with MS. At present, for instance, transferring a care package across local authority areas can be very difficult, which can affect where a person decides to live and work.

As free of charge health and contribution-based social care services integrate there is a risk of creating additional confusion and inconsistent practices around charging policies and eligibility for different services. This Bill offers an opportunity to improve consistency, however this critical issue of charging needs to be addressed head on.

The MS Society would also welcome greater clarity about how integration fits with the roll out of Self Directed Support. As services become more integrated it is unclear whether service users will be able to use their SDS options for housing or health needs, for example.

(b) Scope of integrated budgets

The impact of MS of is far-reaching. It can affect an individual’s physical and mental health, housing requirements, educational needs, employment prospects and financial security, family responsibilities, mobility and social inclusion.

It is important then that other budgets are considered when thinking about an individual’s health and social care needs; and the MS Society supports the intention of the Bill to enable Health Boards and local authorities to include other budgets within the scope of the HSCP.

However, we are concerned that without guidance in the policy memorandum to support this provision in the Bill, the current challenges caused by inconsistency in approach will be exacerbated.
(c) Third sector and service user involvement

The MS Society believes that a stronger voice for people who use health and social care support and services is required. Service user participation is essential to improving services. It is important that the third sector – as an advocate and conduit for the voices of service users – is able to participate meaningfully at a strategic level within HSCPs. We welcome that consultation with the third sector is enshrined in the Bill, however we believe that the third sector should also have a role in signing off the local strategic plans.

What effect do you anticipate integration plans will have on outcomes for those receiving services?

We hope that the delivery of integration plans will have the following outcomes for people living with MS:

- Care that is more person-centred and holistic
- Better information-sharing between professionals involved with an individual and their family
- Faster access to the health and social care services that an individual needs at the time they need them
- Improved information and clarity on entitlements to services
- Equality of access to high quality health and social care services across Scotland
- People with MS feel more supported to live independent and active lives

Mixed outcomes to date

People living with MS in areas that have started to integrate report mixed experiences of how it has made a difference to them. Some examples are provided below:

1. “Since integration of health and social care, one individual, whose husband is her carer but also not in the best of health, has been very glad to have now had help allocated to them through their social worker, whereas before they were simply unable to access any help and had to make private arrangements for which they paid.”

2. “The service is seriously overloaded for the number of staff employed. Staff are frequently off sick with stress and there is no continuity, and a tendency to “pass the buck”. The provision is simply not there. Whereas a few years ago before integration, members knew their social worker/care manager/key worker (the name keeps changing), now most of them do not have a person dedicated to them individually.”

3. “I feel that Social work - NHS integration is not working as it should be for adults. There is no clear guidance on what they can provide or who to ask. Most people including ourselves have been told by friends about who to ask. The last time I was on the Council web site, the Social Work part was not easy to understand by myself. There is no clear guidance on where to ask for advice. I know that in our area they have moved some services to different offices but not told anybody. One example-the contact for the Help Call has been moved but we, the users were not informed.”
Integration project case study

A good example of a very simple but effective integration project can be seen within Lanarkshire. A number of ‘managed care networks’ have been set up, which bring together personnel from health, social work and third sector support organisations in a single community venue, providing a ‘clinic’ for people affected by MS.

The benefits of these clinics are diverse; fundamentally, they offer a one-stop-shop service for people affected by MS, allowing issues and needs to be explored and addressed in a co-ordinated manner across services. A visitor to the clinic can meet with professionals from health services, social work services, and third sector services all in one short visit. Clinics are held in community settings, typically in health or local authority buildings, thus tackling the challenge of equity of access to services / postcode lottery problems.

There are additional benefits for professionals, and these include:
- a reduction in referral time and paperwork;
- improved networking and development of contacts across services and sectors;
- a collaborative approach to case management and problem-solving;
- the development of a greater understanding of cross-sector standards and objectives and a joint commitment to shared outcomes.

The managed care networks have been developed without the need for extensive or lengthy planning, and with minimal or no cost impact on operational budgets.

In conclusion

It is clear that integration has the potential to make a positive difference for all health and social care users, especially those with complex needs or long-term conditions. The Bill is a welcome step forward, however for the reasons outline above it is important not to lose focus on the non-structural aspects that are essential to the delivery of what it sets out to achieve.

MS Society
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Citizens Advice Scotland

While Citizens Advice Scotland (CAS) are not submitting a detailed response to the questions raised in the call for written evidence about the Public Bodies (Joint Working) (Scotland) Bill, we have a general concern about the lack of reference to public feedback mechanisms, including complaints, within the proposals.

The Scottish Government Patient Safety and Improvement agenda has a clear aim of being responsive to the needs of the public. The Healthcare Quality Strategy for NHS Scotland states that “…people in Scotland will have the opportunity to comment systematically on their experience of healthcare and its impact on their quality of life”\(^1\). It goes on to say that it “…is about putting people at the heart of our NHS. It will mean that our NHS will listen to peoples’ views, gather information about their perceptions and personal experience of care and use that information to further improve care.” The 2020 Vision for Health and Social Care also discusses giving the public “…a voice on their experiences to drive up the quality of care” and to ensure that “…they become more involved and engaged in their healthcare.”\(^2\)

These aims cannot be achieved without clear and effective mechanisms for feedback, comments, concerns or complaints. This is clearly acknowledged in the Patient Rights (Scotland) Act 2011, but the Public Bodies (Joint Working) Scotland Bill currently fails to recognise this.

CAS feels that it is vital that this forms a core principle of the Bill.

A clear framework for handling feedback will be necessary to enable responsiveness to public feedback and to facilitate joint working, particularly as health is integrated with social care. It will be particularly important to have a statutory mechanism for addressing and acting on complaints regarding social care and social work, including where complaints may fall between geographical or services boundaries, that is where these are not coterminous.

This is an issue which cuts across a number of Scottish Government agendas and policies. While NHS Education for Scotland, regional Health Boards and the Patient Advice and Support Service have been helping to raise staff’s awareness of patients’ rights, this will now need to be extended across the whole social care field. This will involve changes within a wide range of organisations both internally and externally as well as a change in culture which will have to be introduced consistently at all levels of each organisation.

\(^1\) The Healthcare Quality Strategy for NHS Scotland
\(^2\) A Route Map to the 2020 Vision for Health and Social Care
Failure to make provision for complaint handling could have serious implications for user safety. There are potentially serious risks to individuals if complaints are not raised to and with the correct area/member of staff and action cannot be taken to change practices identified as being detrimental. With experience of delivering the Patient Advice and Support Service and therefore a thorough knowledge of the structured NHS complaints system, CAS are particularly concerned about clients moving from NHS to Council-provided services and how they would be affected by a lack of clarity about who would deal with the issues they have raised.

CAS are concerned that there is a potential for vulnerable clients to fall between the lines during a time of transition. There is a need for consistency of approach in the handling and providing of feedback, comments, concerns or complaints in both health and social care. It is vital that information, training and awareness-raising is carried out for staff working in both the NHS and social care to enable this to happen smoothly and to ensure that no patients or service users are adversely affected by this. CAS believe that failure to include provision for handling of feedback, comments, concerns and complaints in the Public Bodies (Joint Working) (Scotland) Bill would be a missed opportunity to protect vulnerable people.

CAS are involved in the Social Work Complaints short life working group. However this group hasn’t yet resolved the issues around social work complaints. CAS feel it is vital that this is dealt with on a statutory basis within the Public Bodies (Joint Working) (Scotland) Bill.

Citizens Advice Scotland
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

The Scottish Health Council

The Scottish Health Council is part of Healthcare Improvement Scotland. Our written evidence focuses on the aspects of the Bill which relate specifically to involving service users and communities, and should be read alongside the Healthcare Improvement Scotland response, which addresses other relevant aspects of the Bill.

Do you agree with the general principles of the Bill and its provisions?
The Scottish Health Council supports the policy ambition underpinning the Bill and welcomes the focus on improving the quality and consistency of services for patients, carers, service users and their families, subject to our comments below.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
Whilst the general approach and ambition for the Bill are sound, there is a significant danger that these will be undermined if the statutory agencies focus disproportionately on the ‘mechanics’ of integration, including in particular the structural and financial aspects. Much of the Bill appears to be skewed towards these aspects. It is essential that this balance is redressed as work progresses to develop how integration will work in practice, particularly in relation to ensuring that people and communities using integrated services are empowered to shape their design and delivery, working in partnership with the statutory agencies and the third sector.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths
The Scottish Health Council recognises the “two key disconnects” described in the Policy Memorandum i.e. between primary and acute care in the NHS, and between health and social care. We agree this makes it difficult to address people’s needs holistically. It also results in missed opportunities and inconsistency in terms of how people are involved and engaged in these services. Integration offers the chance to do things differently in future – to review experience of involving people to date across these sectors, to learn from what has worked well and to develop a refreshed approach to engagement, which is shaped and designed with the people and communities whom the services exist to support. The recognition of the importance of this involvement in the Policy Memorandum is welcomed but the Bill itself needs to go further to ensure this aspiration is enshrined effectively in the primary legislation.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
In 2012-13, the Scottish Health Council commissioned research to explore future possibilities for public involvement in health and social care in
Scotland. The research gathered views from members of the public, and health and social care practitioners through discussion groups, telephone interviews, an online survey and a workshop. This was followed up in June and July 2013, with three events in Edinburgh, Glasgow and Perth to discuss the ideas raised by the research and a related ‘think piece’. A report on these events will be published shortly. We have drawn on the themes and issues explored through this research and stakeholder discussions in reaching many of our views outlined below.

Both the ‘integration planning principles’ in section 4 and ‘integration delivery principles’ in section 25 of the Bill are welcome. However, it is disappointing that they do not appear to go as far as suggested in the Scottish Government’s response to the 2012 consultation exercise, which says: “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 would like to see the Bill strengthened accordingly.

In other legislation, such as the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003, there is a statement of guiding principles at the beginning of the legislation. This helps to set the tone of legislation and guide overall interpretation. The Scottish Health Council would advocate adopting the same approach to outlining the overarching principles in section 1 of the Public Bodies (Joint Working) (Scotland) Bill.

The principles should also explicitly acknowledge the vital role played by carers.

Section 5 of the Bill says that Scottish Ministers may set out in regulations, national outcomes in relation to health and wellbeing. Our research and work with stakeholders (see above) explored the issue of national outcomes and in particular, the suggestion that there could be a national outcome related to service user and community participation. One option would be an overarching principle or outcome on participation which underpins the other national outcomes as a way of working, and this could be developed and supported by co-producing a vision and plan for public involvement in health and social care nationally.

Consultation requirements in relation to the preparation of integration plans are set out in section 6. It is essential that service users and communities are able to shape and influence the development of these plans and that the statutory agencies are able to demonstrate how they have listened to input gathered from local people. This is equally important in relation to the

---

development of strategic plans (sections 23-27) particularly as the strategic plans will clearly lead to changes in service delivery. Currently NHS Boards are required to follow Scottish Government guidance on *Informing, Engaging and Consulting People in Developing Health and Community Care Services, CEL 4 (2010)* when planning changes to services. The Scottish Health Council believes that the principles and approach outlined in this guidance in terms of involving service users and communities should be adapted in relation to integrated services, and any lessening of expectations in this regard would be a retrograde step.

The ‘consultation group’ (section 26) will have an important role to play in the preparation of a strategic plan and its membership must include representation of service users and communities, and also the third and independent sectors which play a vital role in health and social care.

Section 30 of the Bill relates to a situation where an integration authority proposes to take a decision that might significantly affect the provision of a service, and which is intended to take effect other than in its next strategic plan. The authority must take “such action as it thinks fit” to involve and consult users of the service which is or may be provided in relation to the decision. The Scottish Health Council is concerned that the term “such action as it thinks fit” is not appropriate in this context. It is vague and likely to lead to inconsistent interpretation in practice. We would suggest that the Bill includes reference to guidance which should be developed to set out clear expectations about how this provision should operate, drawing on the principles and approach set out in existing guidance *CEL 4 (2010)* referred to above.

Section 34 outlines that any variation to the integration plan must be made jointly by the local authority and the Health Board and is to be achieved by the preparation of a revised integration plan. A revised integration plan must be jointly submitted by the local authority and the Health Board to the Scottish Ministers for approval, who will set the date on which the revised integration plan will take effect. It is of concern that there is no requirement that revisions to the plan should be subject to any consultation or engagement, and the Scottish Health Council believes that the Bill should be amended to address this omission.

Section 51 of the Bill repeals certain sections of the National Health Service Reform (Scotland) Act 2004, thereby removing Community Health Partnerships from statute. The Bill does not explicitly address the issue of what will happen to Public Partnership Forums, which currently have a key role in enabling Community Health Partnerships to engage with local communities. However, as Community Health Partnerships are repealed, it could be argued that Public Partnership Forums should no longer exist by default, despite the recognition in the Policy Memorandum that “they were quoted as an example of a successful means of engaging with the public”. The Scottish Health Council’s local offices have supported the development of Public Partnership Forums and have considerable knowledge and experience of what has or has not worked well in relation to their establishment and
operation, and would welcome the opportunity to use this learning to support any further development in involvement structures.

The issue of structures for involving communities, and what this might mean for Public Partnership Forums, was explored during our research and events mentioned above. Most stakeholders felt that there should be guidance on options for involvement structures and a recommended model (or models), with local areas asked to adopt this or explain why they are using a different approach. The Francis Inquiry\(^2\) highlighted the significant difficulties that can arise when communities don’t have an effective channel for local involvement. It is also worth noting that there are some people whose voices may not be heard through traditional routes and structures and it is essential that statutory agencies are proactive in adopting a flexible and proactive approach to ensure that there are a wide range of opportunities for people to participate which take account of diversity and individual preferences within communities.

Our research also highlighted support for creating a single standard for public involvement in health and social care services. Currently, local authorities and the NHS use two main standards – the National Standards for Community Engagement and the Participation Standard. There are links between the two, but they are assessed in different ways. While the National Standards for Community Engagement are voluntary, the Participation Standard is mandatory for NHS Boards. Overall, there was broad agreement that there was potential to further align the two standards and a belief that a common standard could help with building a joint ethos, culture and language around public involvement across health and social care. The Scottish Health Council has 8 years experience of reviewing the application of national guidance and standards for engagement, including the Participation Standard, and is keen to draw on this experience to help shape how the quality and consistency of participation is assured in the context of integration.

**What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

The Scottish Health Council believes that there are significant potential efficiencies and benefits in a more joined up and holistic approach to involving service users and communities in service design, development and delivery, and we believe we can play a key role in supporting implementation and sharing learning from experience to date across the new integrated services.

**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

There is significant potential for integrated services to make a positive difference to outcomes for those receiving services, but there is a long road to travel before that ambition is realised in practice. It is essential that everyone involved stays focussed on the goal of improving services for individuals and communities who use them, and the best way of ensuring that this happens is to involve individuals and communities on every step of the journey.

---

\(^2\) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC, February 2013
Further comments
Access to clear information and appropriate support services will be vital in order to support effective participation of service users and communities in integrated services. Individual and collective independent advocacy services would support the aims and the principles embedded in the Bill. Services such as the Patient Advice and Support Service (PASS) also have a key role to play. It is essential that these services are appropriately funded in order to meet any increased demand which they may face to ensure that all those affected by the Public Bodies (Joint Working) (Scotland) Bill can access the support they may require to participate fully and ensure their voices are heard.

There currently exists a raft of legislation which applies either to health services or social care services. Further work is needed to consider what changes might be required to ensure that there is a holistic and consistent approach in relation to service delivery from the perspective of service users. One example is the Patient Rights (Scotland) Act and the associated Charter of Patient Rights and Responsibilities. Might these provisions be revised where appropriate to encompass social care? How will recently introduced expectations on NHS Boards to produce annual reports on feedback, comments, concerns and complaints, analysing data and showing how this has been used to improve services, apply to integration authorities? What implications might there be for those benefiting from self-directed support? These and many other questions will require to be addressed.

The Scottish Health Council would be happy to provide any additional information that would be helpful to supplement our response and would also welcome the opportunity to discuss the issues that we have highlighted further by taking part in the oral evidence sessions on the Bill.

The Scottish Health Council
2 August 2013

About the Scottish Health Council
The Scottish Health Council was established in April 2005 to promote improvements in the quality and extent of patient and public participation in the NHS in Scotland, and has a local office in each NHS Board area. It supports and monitors work carried out by NHS Boards to involve patients and the public in the planning and development of healthcare services, and in decisions about those services.
The Scottish Health Council is part of Healthcare Improvement Scotland.

Further Information
Further information about the Scottish Health Council can be found on our website www.scottishhealthcouncil.org
Inverclyde Community Health and Care Partnership

Background
As an integrated Community Health & Care Partnership since 2010, Inverclyde CHCP is pleased to submit written evidence on the Public Bodies (Joint Working) (Scotland) Bill to the Health & Sport Committee and we are available to provide evidence orally if required.

Inverclyde CHCP embraces the integration of social care and health services to improve outcomes for the people who use our services. Our view is based on local experience of integration, and we believe that local people now have better services as a result of our joint arrangements, and that this situation continues to improve. Our integration arrangements include all social work and community health services, from antenatal; through children and families; and adult services, addressing health inequalities through health improvement programmes is a key priority of current integrated working arrangements.

Specific questions

1. *Do you agree with the general principles of the Bill and its provisions?*
Inverclyde CHCP agrees with the principles of the Bill and its provisions. We are pleased that the Bill provides flexibility for us to continue to develop our current approach, albeit that there will be a need to review some of our arrangements with regard to governance and financial structures in order to ensure that we become fully compliant with the requirements of the legislation. We are confident though that the Bill supports our aspirations for improved service-user outcomes through integrated services that support better pathways and easier access.

2. *To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?*
Some aspects of the Bill reflect our own current arrangements; however there are parts of the Bill that we still require clarification on. We would expect to pursue the body corporate model, with the integration joint board being similar to our current CHCP Sub-Committee and being led by the Chief Officer which we envisage as being similar to our current arrangement of having a jointly appointed CHCP Director.

Our jointly appointed CHCP Director is responsible for the management of the aligned budgets and the delivery of services. An important area requiring clarification is whether the CHCP Sub-Committee, in evolving to the integration joint board, would become a full joint Committee in its own right. Currently Council requirements are met by the CHCP Sub-Committee having a reporting and governance line to the Health & Social Care Committee which meets annually and delegates its powers to the Sub-Committee. The Bill would require the integration joint board membership to have Elected Members and Health Board non-Executives. This requirement needs to be
reconciled with current requirements that Council Committees are populated exclusively by Elected Members. We would wish to be supported to build on our success to date, rather than our energies being diverted to the construction of complex technical devices to meet the detail of the legislation rather than the spirit of the Bill.

3. **Please indicate which, if any, aspects of the Bill's policy objectives you would consider as key strengths**

Our experience of integration to date has been very positive and we believe that integration of health and social care services is the right way ahead for the whole of Scotland. Integration has brought some unanticipated benefits such as a stronger presence in Community Planning and closer links with colleagues in other parts of the Council such as Education and Community Safety. The Bill provides the impetus for integration where it has not already begun.

4. **Please provide details of any areas in which you feel the Bill’s provisions could be strengthened**

The Bill leaves much of the detail to regulation, so it is difficult to comment specifically at this stage. However there are some areas where we would seek clarity.

The Bill proposes that budgets will be fully integrated and that money will “lose its identity”, yet accountability to and control by both parent organisations will remain. It is not clear to us how this will work in practice. For example:

- If the joint integration board spends over or under budget, it is not clear how the judgement should be made as to which parent body will be responsible for the shortfall, or have claim on the underspend. However there is clear potential for this to be written into the integration plan.
- If either or both of the parent bodies are required to make efficiency savings, how will the integration joint board’s contribution be calculated?
- Health services are free at the point of delivery but social care services are chargeable, and each authority has discretion to set its own charges. If service users cannot discern the interface between health and social care provision, it could be difficult to explain and justify charging.
- There could be questions around how parent health boards spanning multiple local authorities will manage differential charging.
- It is not clear at this stage how financial governance will operate with accountability to the parent bodies remaining, whilst money will lose its identity.

5. **What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

We have already realised a number of efficiencies and benefits from having established our integrated CHCP. For example, we have streamlined the management function (and numbers) through merging two distinct organisational structures. Joint planning and commissioning have
been well supported through our arrangements too. We are on a continuing journey of integration of services, recognising that within the former CHP and Social Work departments, different service areas were at different stages of readiness for integration. On that basis we are still evolving, but we have come a long way so far. One of the most important aspect of our integration journey has been to proactively support the development of a new CHCP culture based on the values that underpinned the former organisations, and taking the best examples of practise from both and implementing them across the then newly formed CHCP. This helped to reinforce that we were aiming to build on established good practice so that staff felt values and involved. We would urge that new integration joint boards are encouraged to support staff with the transition in similar ways.

6. **What effect do you anticipate integration plans will have on outcomes for those receiving services?**

We believe that integration is an important means by which to improve outcomes. The draft national outcomes, although requiring further development, seem sensible and relevant. We would urge though that due consideration is taken in developing performance measures against the final outcomes, and that this be done in the context of reviewing the full range of performance returns currently required of the NHS and Social Work Departments. In the changing public sector landscape, many of the indicators could potentially be combined, streamlined or even discontinued if they are no longer relevant to policy direction.

Inverclyde Community Health and Care Partnership
2 August 2013
The Royal Pharmaceutical Society

The Royal Pharmaceutical Society (RPS) is the professional leadership body for pharmacists in Scotland, England and Wales. The RPS leads and supports the development of the pharmacy profession for public and patient benefit. This response comes from the Scottish Pharmacy Board (SPB) which is the elected body of pharmacists representing all sectors of pharmacy practice in Scotland.

The Bill is in general very enabling and the scope for tailored local arrangements is welcomed, however it will be the specific details in the forthcoming regulations and orders which will determine how well the Bill will work in practice. We would like to draw the committee’s attention to one aspect of working together which we believe needs further consideration.

The need for sharing of information is highlighted in the policy memorandum which accompanies the Bill. The SPB believes that access and input to the appropriate parts of one single patient electronic health record will be essential to facilitate this information sharing and ensure patient safety.

RPS has recently launched a report on the use of Medicines Compliance Aids highlighting the need for patient assessment and shared responsibility between social care, pharmacists and GPs when supplying patients with these aids. Sharing of information through a single patient record will be necessary for safe and efficient working practice. In addition, there are numerous examples of patients transferring from one care setting to another, particularly at weekends and out of hours when lack of information has led to inadequate patient care and contributed to hospital re-admission. We would be happy to discuss this further with the committee.

Non-medical and pharmacist prescribing is now well established and it is possible for several health professionals to be prescribing for one individual at any one time. As health and social care integration becomes established, it will be even more important that relevant information is shared both between different prescribers and with social care colleagues. The SPB would like to see more specific requirements for the sharing of information in the regulations and orders which will follow the Bill.

It is established that medicines play an important role in the treatment of long term conditions and are a major expenditure in the care of older people. We know that unplanned admissions to hospital account for almost one third of the total spend on older people’s services.\(^1\) We also know that adverse drug reactions account for at least 6.5% of unplanned hospital admissions and over 70% of these are avoidable. Minimising these incidents and reducing unplanned admissions to hospital is a major driver for successful integration of health and social care.
The SPB would like the national outcomes which will follow the Bill to recognise the importance of medicines and pharmaceutical care in contributing to improving patient health and wellbeing and for there to be a statutory requirement for pharmacist expertise wherever medicines are included in patient care. This will require pharmacy input and engagement at all levels of new and emerging health and social care structures from the strategic and governance levels at the top through to operational delivery. We would be very happy to discuss with the committee in more detail the means through which this can be achieved and any aspect of our comments on the Bill.

The Royal Pharmaceutical Society
2 August 2013

1. Public Bodies (Joint Working) (Scotland) Bill
2. http://www.bmj.com/content/329/7456/15
Public Bodies (Joint Working) (Scotland) Bill

Royal College of Speech and Language Therapists

RCSLT response to Committee Questions

This response focuses on Part 1 of the Bill only and has been generated in consultation with leaders of speech and language therapy services and with reference to the relevant policy and research base.

1. There is broad RCSLT agreement with general principles, but not all provisions

RCSLT support the objectives of the Bill and support many, but not all, provisions.

2. Extent RCSLT believe that the approach being proposed in the Bill will achieve its stated policy objectives

RCSLT members believe that with the right people around the right tables at national, local and locality levels the Bill (and subsequent early regulation) could significantly improve health and well being outcomes in Scotland.

RCSLT, along with other AHP professional bodies, would wish the Bill – or subsequent early regulation – to secure statutory representation of allied health professionals on integration joint boards, local authority committees, health boards or joint integration monitoring committees.

Integration authorities, of whichever form, need access to good intelligence on the full professional capacity potentially available to them. This is particularly true in relation to those services which rehabilitate and enable people with long term conditions to live independently. Access to good intelligence would allow integration authorities to make evidence based decisions about the best use of that potential capacity when seeking the best outcomes for local populations.

If allied health professionals are not directly and powerfully positioned to influence decisions about effective and efficient utilisation of resources, the implementation of the Bill is in danger of perpetuating the current pattern of inconsistent, poorly informed decision making. This would lead to a continuation of variable quality of services and poor outcomes for many adults with long term conditions in Scotland.

The Health and Sports Committee’s own current survey on speech and language therapy funding and provision across Scotland is testament to the consequences of variably informed health and local authority decision making on best utilisation of professional and financial resources.

Additional material on the link between speech and language therapy (SLT) and the Bill, including the Impact of speech and language therapy on health and well being outcomes can be found at the end of this submission.
Allied Health Profession (AHP) representation as described above could also help facilitate the Bill’s overarching objective to significantly change how and to what ends services are delivered.

As health professions who largely work in a social model, AHPs could challenge the medical versus social model dichotomy by bringing a new perspective to integration planning and implementation.

AHP leaders can also draw on their long experience and knowledge of best practice to demonstrate and provide leadership on providing services in people’s home or homely settings in integrated, multi-disciplinary, multi-agency and multi-sector ways.

In fact, AHPs are already fully focussed on delivering the health and well being outcomes described in the consultation paper preceding the Bill.

The above benefits are deliverable at little extra cost as many boards already have AHP Directors or Associate Directors in post and one AHP representative could cover up to 12 professional groups.

3. **Aspects of the Bill’s policy objectives RCSLT consider as key strengths**

RCSLT fully support the Bill’s objectives to improve the quality and consistency of services; to provide seamless, joined up services in people’s homes or a homely setting and to ensure resources are used effectively and efficiently.

In particular, RCSLT is pleased the Bill:

- Removes the voluntary aspect of integrated working between both statutory agencies and third sector providers and thus promotes partnership working.
- Centrally drives joint working while allowing local flexibility on agency relationships.
- Will lead to a common national health and well being outcomes for adult services thus providing a clear vision, strategic direction and focus for all concerned.
- Establishes principles of integrated planning and delivery, which, with some improvement are welcome.
- Empowers Ministers to make orders in respect of staff and members of integration joint boards and integration authority strategic planning consultation groups.
- Empowers Ministers to prescribe aspects of implementation and approve plans, thus improving potential for local government and health boards to act consistently.
4. Areas in which RCSLT feel the Bill’s provisions could be strengthened

(1) Keep what was good about Community Health Partnerships

AHPs are currently statutory members of Community Healthcare Partnerships (CHPs) committees. The removal of CHPs represents a diminution of the AHPs potential to directly influence resource use and service planning locally.

RCSLT, along with other AHP professional bodies, would wish the Bill (or subsequent early regulation) to secure statutory representation of allied health professionals on integration joint boards, local authority committees, health boards or joint integration monitoring committees.

(2) Payment formulas to reflect policy and the services people actually use, need and want (Subsections 1:3(d), 13:(2),16,17, 18)

RCSLT are concerned that local agencies will use different methods of calculating payments to be made in respect of delegated functions without good service data on the inputs required. These inputs might relate, for example, to professional groups, the quantity or the nature of provision.

For many years SLT leaders have negotiated service level agreements (SLAs) for services to children with (and sometimes without) co-ordinated support plans. SLAs involve money transferring from Local Authorities (LAs) to the NHS. The government itself has responded to the wide variability and effectiveness of partnership working by publishing “Working in Partnership” guidance. At the local level, variable approach to transfer of funds (and associated conditions) between agencies has led to inconsistencies in service levels and quality across Scotland. LAs have made cuts of up to 50% in SLT budgets over the last few years. In at least one area, contrary to Government policy, cuts have terminated preventative SLT provision to disadvantaged nursery age children.

The Health and Sports Committee is conducting its own survey into SLT funding at the local level. **RCSLT would ask that the Committee takes the findings of that survey into account when considering this aspect of the Bill.**

RCSLT would also wish to see the method of calculating payments to integration joint boards or lead agencies regulated.

(3) Ensuring quality of services is as important as calculating payments

Subsection 21: (2) means the person to whom functions are (newly) delegated has the same duties, rights and powers as those that used to be responsible for the function. Subsection 22: (2) enables integration joint boards to make directions about the manner in which a particular function is to be carried out.
RCSLT are of the strong belief that delegated functions will only deliver the desired outcomes if they are supported by well informed and experienced clinical and social care leadership.

RCSLT would wish to see – in addition to money transfer – integration plans to include details of the planned method of ensuring quality (safe, effective, person centred) services relevant to the delegated functions. This might include how boards are going to take account of Health and Care Professions Council regulations, AHP uni and multi-disciplinary clinical standards of practice and other clinical governance duties.

RCSLT also would wish planned methods of ensuring quality (or changes to these) to be subject to Ministerial approval – just like methods of calculating payments.

(4) Co-production better than “engagement”: Integration planning principles

Use of the term “engaged” (Subsection 4:1(b)(iv)) is vague and open to wide interpretation and is therefore weak in respect of ensuring communities and local professionals consistently get the opportunity to shape integration plans - even within one area over time.

RCSLT would wish the Bill to instead talk of “co-production” involving service users and carers and health, social care, adult education and justice staff (from all sectors).

(5) Who “represents” and how well do they represent? (Subsection 5: (3) (d))

The Bill empowers the Minister to determine who “appears” to be representative of health professionals, users of healthcare and carers for the purpose of consultation on national outcomes.

It would be helpful to ensure that the Minister, when determining which body or group is representative, takes cognisance of the Office of the Scottish Charity Regulator and / or Health and Care Professions Council (HCPC) registered charities and professional bodies.

The Bill has the potential to radically change the current situation, in which it is only the voices of those who can read, write and express themselves eloquently which are heard. The Bill can do this by ensuring (through guidance, direction or regulation) that representative organisations are required to demonstrably meet the communication access needs of those they represent.
(6) *Consistency only comes with consistent information, intelligence and buy in*  
(Subsection 11: (4), 12: (2), 16: (1))

RCSLT are concerned that integration joint boards could be very different in different areas of Scotland. Diversity of core board membership prompts the question of how consistency of service will be ensured if the parties engaged in decisions about the best way to allocate resource to deliver outcomes is widely varied.

RCSLT would wish the Minister to regulate for consistent core membership (at least) of integration joint boards (and in the case of lead agency models – the integration joint monitoring committees, health boards and local authority health and social care committees), across Scotland.

(7) *Equally accessible strategic planning and published plans*  
(Subsection 26 (3))

RCSLT request that integration authorities are required (by Act, regulation, direction or guidance) to ensure equal representation on strategic plan consultation groups for people with communication support needs. Strategic plans should also be required to be published in communication accessible forms.

(8) *Who is involved in deciding what’s a “significant” change or decision and how?*  
(Subsections 30, 32)

Identifying a change or decision as “significant” will depend on an integration authority’s (or locality function’s) awareness of how a change to service inputs could impact on outcomes.

For example, the reduction of one speech and language therapist in an area might seem acceptable to the board or care team. At ground level however, it could remove a key service preventing chest infections (a primary cause of aspiration pneumonia and unplanned admissions) among a hundred or more frail elderly or people with dementia who are also highly likely to have communication support needs and are therefore less able to respond to consultation on changes.

For this reason RCSLT would wish the bill to ensure the definition of “significant” was informed by the right people, around the right tables, in integrated authorities and local function teams. Further RCSLT would wish the bill to ensure public involvement and consultation was accessible to those service users (and carers) with communication support needs.
5. **Effect RCSLT anticipate integration plans will have on outcomes for those receiving services**

RCSLT members anticipate, with the changes suggested above, that the Bill and subsequent related regulation could have a considerable positive impact on health and well being outcomes for the people of Scotland.

**Royal College of Speech and Language Therapists**  
**2 August 2013**

**Link between speech and language therapy (SLT) and the Joint Working Bill – additional material**

Speech and language therapists work solely for people with communication support needs and/or eating, drinking and swallowing difficulties.

The estimated 250,000 Scots with communication support needs and those with eating, drinking and swallowing difficulties include many, if not all of the people the Bill aims to improve outcomes for. That is those with long-term conditions such as stroke, head and neck cancers, dementia, autistic spectrum disorder, motor neurone disease, MS, Parkinson's disease, learning disability and mental illness.

It is known that 349 (40%) of speech and language therapists working in Scotland work for adult care groups and, along with other AHPs, social care and third sector partners, they are key to the success of the Bill because they are part of the service the public – and the Government - need and want to deliver health and well being outcomes. For example, the Allied Health Professions National Delivery Plan notes that “[AHPs] are uniquely placed to exploit their expertise in “enabling” approaches through providing rehabilitation/reablement approaches and leadership across health and social care as well as driving integrated approaches at the point of care.”

Speech and language therapists enable people to enjoy optimum health and well being by providing a mix of individual assessment and rehabilitation. This is provided through support, training, guidance and practical communication and eating and drinking equipment to carers and colleagues throughout statutory, private and third sector health, social care, adult education and justice settings including hospitals, care homes and people’s own homes.

The impact of speech and language therapy:

- **Improving safety and effectiveness in hospitals and the community** by reducing risk of poor nutrition of older people and chest infections and thus preventing hospital admissions or delayed discharge.
• **Improving the protection of vulnerable adults** by enabling communication access to *Adult Support and Protection* and *Adult with Incapacity* provisions.

• **Improving independent living** by improving and supporting people's communication so they and their carers can better self manage long-term conditions.

• **Enabling healthier living and reducing health inequalities** by improving 24/7 communication access to all services that enhance wellbeing.

• **Enabling services to be person centred and ensure positive experiences** by improving their capacity to meet service users and carer's communication and/or eating and drinking needs.

• **Supporting carers** by equipping them with the confidence, skills and resources they need to communicate with loved ones and ensure safe and effective eating and drinking.

• **Reducing costs** - independent economic evaluation showed SLT services can deliver an annual net benefit at least £2.4 million/annum in adult stroke services alone.
NHS Education for Scotland

NHS Education for Scotland (NES) is a Special Health Board, responsible for supporting NHS services for the people of Scotland through the development and delivery of education and training for all NHSScotland staff. Everything NES does is based on eight fundamental principles:

- Be open, listen and learn
- Work together with others to benefit patients
- Look ahead and be creative
- Always aim for quality and excellence
- Promote equality and value diversity
- Understand and respond quickly and confidently
- Work to a clear common cause and
- Give people power and lead by example

NES supports the pre and post-registration education, training and continuing professional development of doctors, psychologists, nurses, allied health professionals, dentists, pharmacists, and support staff. NES works closely with other NHS boards and also maintains strong links with the Royal Colleges, UK regulatory bodies and other organisations such as the Health Foundation. The Scottish Funding Council and the Scottish Social Services Council are key partners, and we work closely with Scotland’s Colleges and Universities, Skills for Health, COSLA, and Skills Development Scotland.

Our vision is ‘Quality Education for a Healthier Scotland’. Our mission is to provide educational solutions that support excellence in healthcare for the people of Scotland.

In supporting the integration of Health and Social Care agenda NES have been working in partnership with Scottish Social Services Council (SSSC) over a number of years. This partnership is underpinned by a Memorandum of Understanding. Current partnership workstreams include supporting a number of key government policy drivers namely the Dementia Strategy, Carers Strategy, Early Years and Reshaping Care for Older People by providing educational resources for the health and social care workforce.

NES welcomes the opportunity to contribute to this important call for written evidence from the ‘Health and Sport Committee into the Public Bodies (Joint Working) (Scotland) Bill.

In response to the questions, specific responses have been noted in respect to education and workforce development.

Q1 Do you agree with the general principles of the Bill and its provisions?

NES is supportive of the general principles of the Bill and its provisions that better integration of health and social care services is required in order to meet people’s needs and expectations.
Q2 To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
The aspiration of the Bill to address the structural, professional, governance and financial issues in order to deliver more ‘joined up’, ‘person centred care’ and ultimately better outcomes for patients, carers and users of service is supported. The degree to which the stated policy objective is achieved maybe variable but in order to support the desirable a cultural shift is required. Organisational leadership is a critical success factor and should be underpinned by multi professional, interagency education across the whole system including health, social care, housing, education, independent and third sector.

Q3 Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths?
It is difficult to disaggregate any one of the policy objectives has being a key strength when they are all intrinsically linked. 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. As is the governance required in that is will be mandatory to include representation from health and social care professionals, the third sector, service users, carers and the public.

Q4 Please provide details of any areas in which you feel the Bill’s provision could be strengthened?
Whilst a strength; the legislation allows different models of integration authority across Scotland could be a challenge which may result in multiple variations and in turn present problems. 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.

Q6 What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integrated plans?
NHS Education for Scotland (NES) and the Scottish Social Service Council (SSSC) have for a number of years worked in partnership to support education and development of the health and social services staff. This partnership work is cited in several Scottish Government documents including ‘Renewing Scotland’s Public Service – Priorities for Reform in Response to the Christie Commission (September 2011) and in the Health and Social Care Adult Integration Consultation Bill (May 2012). The partnership continues to strengthen whilst maintaining recognition of each other’s unique contribution of professional reach, skills and values.

The efficiencies and benefits in our partnership work are to ensure the health and social care workforce are both prepared and supported for working much more collaboratively within an integrated model of delivery. Integrated care delivery is unlikely to happen at the necessary pace and scale unless those implementing it are provided with support. Building leadership, trust, collaboration and a common vision amongst stakeholders are key. It is essential that frontline workers, first line managers, as well as strategic managers, have the necessary skills and knowledge to deliver better
outcomes for individuals, families and communities. Written and verbal evidence was provided by NES to the Scottish Parliament Finance Committee Inquiry in to Demographic Change and Ageing Population

The NES and SSSC work programme presently centres around current policy and strategy initiatives including:-

- Scotland’s National Dementia Strategy 2010 - 2015
- Caring Together & Getting it Right for Young Carers 2010 – 2015
- Reshaping Care for Older People – A Programme of Change 2011 - 2021
- Early Years Collaborative Common Core of Skills, Knowledge & Understanding and Values for the Children’s Workforce in Scotland
- Knowledge Management for Social Services /SSKS
- Integration of Health and Social Care Bill
- National Colloquium on Public Service Workforce Development, a process during 2012 that was designed to further the recommendations of the Christie Commission on the Future Delivery of Public Services in Scotland
- NES and SSSC through the Collaborative Leadership Development Board are promoting and implementing specific collaborative leadership development initiatives across Scottish public service, recognising national, local, geographic and sectoral capabilities and delivery models.

A body of evidence has been developed from the joint NES and SSSC partnership work that supports many benefits of joint education and training as well as efficiencies of scale. Such a practical example of efficiency relates to the partnership work between NES, SSSC and Alzheimers Scotland which has seen a number of joint educational developments for the health and social services workforce.

Around 11,000 hard copies of the DVD ‘Informed about Dementia – Improving Practice ’ which was developed to support health and social services staff knowledge and skills have been distributed and is also available via the Promoting Excellence website which also provides the detail of the education framework and other education resources to support workforce development [www.knowledge.scot.nhs.uk/home/portals-and-topics/dementia-promoting-excellence](http://www.knowledge.scot.nhs.uk/home/portals-and-topics/dementia-promoting-excellence)

The NES/SSSC learning resource “Dementia Skilled – Improving Practice” has seen 2,700 hard copies being widely distributed with another 3500 people accessing the resource on line. Accompanying guidance on the use of the Skilled Resource, targeted at the social services sector has also been produced. A range of educational resources on psychological approaches for staff have been developed.

Around 1,430 health and social services staff have undertaken various national training programmes, many using training for trainers and capacity building models including cognitive stimulation therapy, stress and distress in dementia, and palliative care. A ‘Post Diagnostic Support’ training programme
based on Alzheimers Scotland’s 5 Pillar model has been developed, piloted and evaluated.

**Q7 What effect do you anticipate integration plans will have on outcomes for those receiving services?**

Hopefully integration plans will meet the Bill’s outcomes for integrated health and social care services and the problems that it is attempting to address; namely; unnecessary delays in hospital discharges, avoidable hospital admissions and insufficient preventative services. An inconsistency of quality of care for people and support for carers across Scotland will require to have a close monitoring system in place.

NHS Education for Scotland
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Scottish Association for Mental Health

Do you agree with the general principles of the Bill and its provisions?

SAMH welcomes moves to improve patient and service user care through better joint working between health and social care services. Improvements in quality and consistency for patients, service users and their families and carers are desirable.

We are pleased that there has been a shift in focus away from older peoples’ services to adult health and social care, although we note the wording of the policy memorandum remains more focused on this than other areas.

Legislation can only go so far to drive integration and the importance of the behavioural aspects of organisational change cannot be overstated; it will take time for mutual trust to develop. The experience of health and social care integration in recent years suggests that closer attention should be paid to this aspect in future policy.¹

The focus on effective and efficient use of resources goes without saying, given the current financial climate; to ensure best value, regulation and scrutiny is required, which is where some questions remain about how this will be achieved, and where the Bill could be strengthened.

- To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

This is a technical bill setting up the structures for better joint working, as well as some of the details of the requirements of statutory and non-statutory partners. As many of the details are not yet confirmed, and given the change in culture which will be required, it is impossible to predict the success of the Bill’s proposals.

There will be significant challenges to overcome in order to improve the joint working and consistent approach required by the Bill. Previous attempts to improve joint working have had limited success, but SAMH notes the Bill strengthens the requirements for joint working between statutory agencies, rather than just enabling cooperation.

While SAMH is supportive of the Bill’s commitment to local decision-making in allowing for the creation of different integration models, we are also concerned this is potentially problematic, both in terms of delivery and benchmarking success. SAMH previously raised concerns about whether the lead agency model would be able to truly deliver an integrated approach; while we understand that some local authorities and health boards might want to work in this way, we are concerned that one agency devolving responsibility to another may not lead to better joint working. As a social care service provider,

¹ Integrating health and social care: Where next? The Kings Fund, March 2011
we would be concerned that a health board acting as a lead agency could result in a more medical approach to care.

The meaningful involvement of patients, service users, carers, and the third sector is necessary – even fundamental – to achieve the policy objectives of the Bill. Without seeing the detail of how they will be involved, as these will be set out in future regulations, but recognising that these non-statutory agencies, patients, service users and their supporters will not have equal voting rights on committees or boards, SAMH is concerned that the modus operandi of former ‘partnerships’ could continue. Clarification about how non-statutory partners will be ‘engaged and involved’ is required.

As important will be the ‘buy-in’ by the institutions, both statutory and non-statutory. As so many social care services are delivered by the third sector, efforts must be made to ensure that they are truly involved in planning outcomes and delivery. Community planning partnerships and erstwhile CHPs did not adequately involve third sector organisations, and the lack of voting rights for non-statutory members will make it hard for this to be meaningful. Statutory partners must be required to demonstrate how patients, carers, service users, third sector and others have been involved.

- Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

The rhetoric and principles within the Bill and policy memorandum are sound, and hard to argue against. We know there is political will across the Scottish Parliament for better joint working between health and social care, and for the patient or service user to be at the heart of their care provision. This Bill is an attempt to realise these goals, and that should be welcomed.

SAMH hopes that the national health and wellbeing outcomes will provide real focus and meaningful partnership working, continuing on the Christie Commission’s intentions to take a preventative approach to health and social care provision. It will be important that shared health and wellbeing outcomes are neither ‘health’ or ‘social care’ focused, but should be truly joined up and shared. SAMH believes that their focus should be on health promotion, recovery, self-management and wellbeing.

Establishing these outcomes in legislation, albeit secondary legislation, will strengthen the obligation on the health boards and local authorities. Reflecting these outcomes in single outcome agreements should join up delivery plans. However, the limitations of single outcome agreements must be acknowledged and addressed, especially if these are to be seen as a vehicle for transformational change. SAMH hopes that this Bill provides an opportunity to improve the scrutiny of how well CPPs are meeting their single outcome agreements. Historically, there has not been enough independent assessment of progress towards SOAs, and there appears to be little or no sanction for failure in this regard. Audit Scotland\(^2\) have also identified that, as local partners agree their own performance indicators in relation to SOAs,

---

\(^2\) Review of Community Health Partnerships, Audit Scotland, 2011
benchmarking local performance is not always possible. They recommended that the Scottish Government should work with NHS boards and councils to streamline and improve performance information for SOA, HEAT and other performance targets to support benchmarking.

Strategic commissioning with the full involvement of the ‘key partners’, the third and independent sectors would be a step forward. Despite the Joint Statement of 2009, and as noted by Audit Scotland\(^3\), social care commissioning has not been done well. From a scrutiny point of view, SAMH believes that this could be strengthened within the Bill to require the Care Inspectorate, Health Improvement Scotland and Audit Scotland to take on this role of ensuring partnership arrangements are working well and commissioning better outcomes. SAMH supports CCPS’s call to set this down in primary legislation rather than in regulations.

The Scottish Government has powers to reject integration plans. We hope that this retained power will ensure that the plans take into account national health and social care strategies (such as the mental health strategy, the forthcoming suicide prevention strategy etc) and that these policies are carried out systematically at a local level.

- **Please provide details of any areas in which you feel the Bill’s provisions could be strengthened**

SAMH would like to see human rights embedded within the Bill. The Convention on Economic, Social and Cultural Rights promotes the highest attainable standard of physical and mental health as a right. This should be enshrined within the legislation to promote a rights-based culture as part of the new joint working, which would require a more person-centred approach. This Bill is very technical, so the focus on the patient or service user should not be lost.

The needs of people experiencing mental ill-health extend beyond the reach of social care services. Many people who use health or social services also rely on other public services in areas such as housing, employment, transport, education and welfare. The problems that people experience are often interrelated, so SAMH would welcome an integrated approach that is holistic, so that we can better acknowledge and engage with the realities of peoples’ lives.

How will non-statutory involvement be meaningful? There is necessarily a two-tier system because of the voting rights held by statutory bodies. SAMH would like to see much more information about how the third sector and other representatives will be included and involved. In terms of the proposed arrangements for the new joint Committees, there should be a specified proportion of places should be reserved for service users and a clear statement of their duties, an acceptable selection process and the support they will receive. It will be absolutely vital that partners across all sectors are fully and appropriately involved in planning and decision making within the

\(^3\) Commissioning Social Care, Audit Scotland, 2012
new partnership arrangements. Whilst the Bill’s documents state that the NHS Chair and Local Authority Leader will ensure that appropriate stakeholders are engaged in the planning and delivery of services, it is unclear how this will actually be achieved in practice.

The issue of ‘free’ health and ‘paid for’ social care has not been addressed. As more healthcare moves into the community and services become more integrated, people who were previously treated in hospital could start receiving their care in a social care setting. If this incurred a charge, people with disabilities, who are more likely to be on a lower income or benefits, could be worse off than before, which could be subject to an equality challenge.

There needs to be much more recognition of the impact of self-directed support (SDS) in terms of delivering outcomes and strategic commissioning; and an urgent need to address potential conflicts between joint working and self-directed support. This bill is progressing through Parliament at the same time as self-directed support is being prepared for social care. Despite this, the policy memorandum barely mentions SDS and how it will operate in terms of budgeting decisions, commissioning and care delivery in the wake of health and social care integration. SAMH is concerned that there could be potential for conflicts between SDS and health and social care integration. Will care managers and service users be accountable to the integration authority/committee in terms of budget and commissioning? How will individual care plans as envisioned by SDS interact with integration locality planning?

Scrutiny (through the Care Inspectorate, Health Improvement Scotland and Audit Scotland) needs to be written into the Bill rather than merely in the policy memorandum. SAMH would be keen for the actual ‘joint working’ of public bodies and their partners to be scrutinised, as well as whether or not health and wellbeing outcomes and single outcome agreements are achieved; and whether strategic commissioning is being delivered. This will help to demonstrate whether a culture has been changed, if all partners are included and respected, and ensure service delivery is improved in an effective, resource-efficient way.

SAMH is concerned about the extent to which the financial pressures facing the NHS and local government may help or hinder integration. The impact of welfare reform on plans to improve joint working is particularly concerning. Many people with disabilities or long term ill health are being adversely affected by the changes to the benefits system. Local authorities may see even greater demands on their budgets to meet increases in homelessness, rent arrears as well as meeting the needs of people with disabilities who are assessed as being no longer eligible for certain benefits. It is likely that demand for NHS services could increase as well. The impact of increased poverty and debt is detrimental to mental and physical health, and this should to be taken into account when planning and commissioning services.

Housing is a crucial component in social care service provision – to reduce delayed discharges from hospitals or care homes to the community, there
must be adequate housing stock, both in terms of quality and quantity. Consideration should be given about how housing associations and others can be involved in strategic commissioning.

The flexible approach of different models of integration could make it harder to benchmark good practice and achievement of targets across Scotland, and in the lead agency case, could result in the medicalisation of social care provision. Effective scrutiny, governance and accountability will all be crucial to ensure that locality planning arrangements are robust.

- What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans? What effect do you anticipate integration plans will have on outcomes for those receiving services?

SAMH is responding to these questions together, because our anticipations for service delivery and the outcomes for those receiving services are based on our hopes for the policy; we still need clarification on how the Bill will be augmented by regulations, and implemented.

Poor mental health and wellbeing lies at the heart of some of the most expensive problems that Scotland faces: not only in health but also in areas such as crime, unemployment and deprivation. A more joined up approach could improve consistency and delivery of national strategies such as the mental health strategy and the various commitments on crisis services, access to psychological therapies and employability services within that policy.

If partners beyond health and social care, including patients, service users and the third sector, are fully involved in transforming health and social care provision to be truly person-centred; and there is a cultural and budgetary move towards a preventative, early-interventionist approach, we hope this could truly transform peoples’ lives.

SAMH hopes that the national health and wellbeing outcomes will take an assets-based and preventative approach to health and social care service provision. Redistribution of budgets towards health promotion services, keeping people well and active within the community, and requiring less medical intervention would be welcome. Better joint working could improve the choice of treatments available at different points of the care pathway, for mental health and other conditions, including social prescribing opportunities.

SAMH hopes that making health and social care delivery more efficient and streamlined will be reflected in the patient or service user pathway. We would like to see patient or service user referrals to social care services to be much more streamlined; there is no reason why a GP, consultant or even the person themselves cannot refer directly to services in this new approach, if health and social care bodies are to truly work better together. This could reduce pressure on the NHS, and the easier routes to support could mean that interventions take place earlier, leading to fewer people in crisis or requiring acute care.
Expanding the access points for treatment could also allow for more responsive treatment for fluctuating conditions, allowing people the confidence to ‘leave’ services, knowing they can re-join the system without long delays and bureaucracy.

If there is good strategic planning and commissioning to ensure adequate housing stock and workforce planning, delayed discharges from hospitals to care homes or community housing support should be reduced. In all aspects of health and social care, if patients, service users, carers and third sector service providers are included in a meaningful way, this should improve the commissioning of services and the care pathway. We look forward to being partners in transforming the mental health of our service users and wider Scottish society.

Scottish Association for Mental Health
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

BMA Scotland

Introduction
BMA Scotland welcomes the opportunity to provide the Health Committee with written evidence on the Public Bodies (Joint Working) (Scotland) Bill which requires NHS boards and local authorities to integrate adult health and social care services.

The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 16,000 members.

Do you agree with the general principles of the Bill and its provisions?
BMA Scotland supports the key principle of integration outlined within the Bill that the main purpose is to improve the wellbeing of recipients (S4 (1) (a)). The single biggest challenge to health and social care services both now and long-term is the increasing number of elderly people with multiple physical problems, cognitive impairment and increasingly complex care needs. BMA Scotland has consistently called for greater joint working between health and social care to address these issues, and in a recent BMA survey, when asked what needs to happen to ensure the NHS survives the next 65 years, doctors agreed with the current Government policy of greater integration between health and social care as a priority issue. The financial challenge will be considerable - healthcare spending is concentrated in the last year of life, and as people live longer, they are more likely to have more complex needs for both health and social care over extended periods. An ageing population combined with a difficult public spending environment poses a very significant challenge, and we share the concern expressed in the Scottish Government’s report on “Reshaping Care for Older People” that current arrangements are simply not sustainable.

Inevitably the proposed legislative framework for the integration of health and social care puts in place overarching parameters which do not contain specific detailed information about local implementation. The primary legislation has been drafted to require NHS boards and local authorities to integrate planning and service provision arrangements for all areas of adult health and social care. There is reference throughout the Bill that the Scottish Ministers will establish via secondary legislation the detail which must underpin the Bill, for example the functions that must, may and may not be delegated. Without sight of more specific detail at this stage it is very difficult to give specific and more helpful comment, and we suggest that the Health Committee may consider asking to have sight of the regulations and secondary legislation before Stage 2 to expedite discussion about the Bill and its implications across health and social care.
To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
The Bill is very clear in its stated policy objectives, and the broad overarching primary legislative framework requires the integration of adult health and social care services through a variety of integration models and the development of integration plans and subsequent strategic plans. This is the first crucial step towards integrating health and social care services. However in order to address this in more detail and whether the approach will achieve its policy objectives will require careful scrutiny and debate around the secondary legislation and supporting guidance.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths
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.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
This is an ambitious and challenging approach by the Scottish Government, and there are still many barriers in place between the current systems of health and social care in terms of structures, professional territories, governance arrangements and financial management that may work against general aspirations of efficiency and clinical/care quality. To avoid the significant risk of another failed attempt at successful joint working in the face of such barriers, it is vital there is also detail in place about how this change will be achieved and sustained. In particular, careful consideration will be required of the measures that will be put in place to overcome the difficulties that have undermined previous unsuccessful attempts to achieve seamless delivery of care services within an integrated NHS and local authority structure.

In order to ensure that there is robust and transparent governance and accountability in place there must be robust external scrutiny in place. Audit Scotland’s review of CHPs in 2011 revealed significant failings in the governance of these organisations as well as a failure to achieve many of the organisational objectives. The Bill outlines how the integration authority requires either a Joint Integration Board or an Integration Monitoring Committee to be put in place depending on which model is chosen, and these will ensure the governance and oversight of health and social care services. The new integration authorities must be clinically driven and supported by management to avoid the failures of their predecessors. BMA Scotland would
welcome further involvement in the development of governance arrangements for the integration authorities and the opportunity to comment on more specific guidance on who will sit on the Joint Integration Boards/integration monitoring committees, who will choose them and the mechanism for electing these committees. At the moment, the Bill states that membership will be determined by the council and the Health Board, and we understand that membership will be defined in secondary legislation. In order to strengthen the role of clinicians in the strategic commissioning of services for adults we consider that GPs and senior secondary care doctors must be represented appropriately on all partnership arrangements, and must have the confidence of local clinicians.

The financial memorandum supporting the Bill describes, in Paragraph 62, the intention to fully involve the third sector as key partners in strategic commissioning, locality planning and service delivery activity. We would agree that there is a need to ensure closer working relationships between health boards, local authorities and the third and independent sector, but there should be clarity on the exact nature of this involvement, how representation would be achieved and perhaps more importantly how this nonstatutory sector would have influence over the resources in the statutory health and local authority structures.

There is also no clear information about how the public will formally be involved in the work of the integration boards or at locality level, and feedback on how well services both in the community and hospital are working would help develop suggestions for future improvement. Public involvement had been explicitly written into the primary legislation for Community Health Partnerships. We would want to see the current arrangements maintained and improved upon. A BMA survey showed that doctors believe collaborative cultures with shared values, good professional relationships and effective leadership are essential if integration is to get off the ground. These elements are also vital to securing what should be the key measures of success of efforts to integrate, confirmed by doctors in our survey – improved clinical outcomes and better patient experiences. This collaborative approach would also need to be sufficiently robust in order to ensure that shared services deliver what is most needed by the local population.

Due to the overarching nature of the Bill, the focus is on high level principles of integration at a macro level. We would welcome greater clarity on how the role of clinicians in the strategic commissioning of services for adults will be strengthened, particularly in the locality. Without this level of detail on how clinicians will influence service delivery there is a significant risk that previous mistakes will be replicated. In a national survey of GP opinion conducted by the BMA in 2007, the lack of influence of CHPs was highlighted as a key factor in doctors’ disengagement from this structure. Two-thirds of respondents considered the lack of effective communication between CHPs and general practice to be a barrier to effective GP engagement and more than half considered the lack of shared vision between GP practices and CHPs to be a barrier to effective GP engagement. 48.7 per cent (495 of 1016) of respondents considered the lack of financial support to allow effective
GP/practice staff engagement with CHPs to be a barrier to effective GP engagement. A subsequent report from Audit Scotland (referred to previously) highlighted the lack of engagement of GPs as a key factor in the failure of many of these organisations and unless this is explicitly addressed during the legislative process, then there is a risk that the failures will be repeated.

The Financial memorandum supporting the bill highlights the intention to delegate resources between partners to create an integrated budget (paragraph 65). However 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.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?
The successful delivery of integration plans must be for the benefits of those requiring the services of health and social care. Adequate funding must be made available in line with the level of health and social care that the Scottish Government wishes to provide, as it is increasingly clear that providing care to older people will require more funding in line with demographic changes, and to keep them in their community and out of hospital requires adequate resources close to the home. Due to already excessive levels of workload there is no capacity for general practice to take on any further planned (or unplanned) work without the addition of new resources, including significant investment in infrastructure. A comprehensive assessment is needed of the likely resources required to meet the needs in both primary and secondary care of a population with a higher proportion of elderly and very elderly patients and a rising prevalence of long term conditions. Without planning and investment for both sectors Scottish Government aspirations to shift the balance of care and integrate adult health and social care may ultimately be unachievable and general practice could buckle under the strain of an impossible and unsustainable workload.

We believe that putting doctors at the heart of clinical service development is crucial, we are keen to avoid generating bureaucracy and additional costs through unnecessary organisational change. The integration of adult health and social care will require sustained workforce planning across the NHS and local authorities to ensure high quality patient care can be delivered effectively. There may be conflicting priorities if there are disagreements between local and central governments. We would welcome further information/discussion about how competing priorities would be dealt with both now and in the future.

Under Section 11 of the Bill the body corporate would have the potential power to make appointments of staff other than a chief office, and we would welcome clarification whether this is intended for the appointment of officers as it could be seen as a wide-ranging power which may be open to wider use and may confer the power to set TCS which is not in line with current arrangements for negotiated TCS. The explanatory notes accompanying the
Bill make it clear that under the harmonisation of TCS transfers will be made via TUPE rather than using a public sector exemption, however this section does allow the possibility of creating jobs which are not consistent with current arrangements.

**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

From the point of view of users of health and social care and their carers, the success of health and social care integration will largely be determined by the quality of care they receive from teams of health and social care professionals. Integration is not itself a goal, but must result in better outcomes for people receiving these services, with improved clinical outcomes and better patient experiences. There are significant potential benefits in the integration of health and social care, conversely there is also potential for healthcare to be adversely impacted by these changes, as there is a gap between the demand for social care for older people and the funding available. Unmet need in social care might result in increased pressure on primary and secondary health services which may come in the form of higher hospital admissions, delays in discharge from hospital and increased pressure on A&E and GP services. Audit Scotland’s recent report noted that Councils’ social care spending increased by 46% in real terms between 2002/3 to 2010/11. The number of older people in Scotland is projected to rise by 22 per cent over ten years (from 879,000 in 2010 to 1,075,000 in 2020), and by 63 per cent over 25 years (to 1,431,000 in 2035). The number of people aged 85 and over is projected to increase by 39 per cent over ten years and by 147 per cent over 25 years. These population trends will significantly increase demand for health and social care services in future.

There is a danger that restructuring introduced by the adult health and social care agenda may damage established joint working by health and social care. Considerable care must be taken to ensure that current examples of integrated health and integrated health and social care team working are maintained and extended. For example, GP practice based teams (practice and attached staff including community and district nurses) must be supported and expanded to include social care professionals to strengthen integration at the most local of levels.

**Delegation of functions**

Section 21 of the Bill sets out the delegation of functions within an integration plan, and we recognise that this will be key to the integration of health and social care. However the scope contained within S21 (2) (a) (b) and (c) is sweeping, as the person to whom the function is delegated has the same duties, rights and powers and ‘is in all respects as if the person who delegated the function’ (S21 (2) (c). While this is clearly aimed at maximising and facilitating integration across health and social care, such scope might potentially lead to difficulties from a professional perspective and we would welcome the opportunity for more detailed scrutiny through secondary legislation with any appropriate restrictions in place as necessary in order to ensure that changes are not inadvertently applied which may damage doctors ability to provide services to patients.
**Information Sharing**

Section 37 of the Bill enables health boards and local authorities to disclose information to the other for the purpose of preparing an integration plan and while we fully recognise and support this provision in terms of developing a plan, we are concerned that subsection (6) may be overly broad in its provision: “Subsections (1) to (3) apply despite any duty of confidentiality owed to any person in respect of the information by the person disclosing the information”. Confidentiality is a core ethical principle in healthcare that is too important to be overridden by general powers and BMA Scotland maintains its fundamental objection to the concept of patients' records being accessed without knowledge or express consent. The ease with which patient information can now be shared is a positive step towards improving the patient journey, however it also challenges us to come up with new ways of protecting information they have shared with us. With the growing use of electronic patient records, it is essential that we know who has looked at which records and when, so we can ensure only appropriate access.

A proper identity and access management system must be in place for staff to give proper electronic identities and access. Staff involved in the care of a patient should only have access to records of patients they are actually looking after and they should be able to see only information they require to carry out their duties for patients in their care. We would welcome more careful language used in this section or appropriate restrictions put in place via secondary legislation.

**Consultation process and Locality Planning**

The Scottish Government had previously confirmed that “a central role for professionals in the planning and commissioning process is critical to the success of putting in place integrated pathways of care that focus in particular on preventative and anticipatory intervention”. We consider that GPs and senior clinicians must be involved in how best to put in place local arrangements for planning service provision in order to effectively strengthen the role of clinicians. The Bill outlines the consultation process regarding the development of the integration plan and the strategic plan and we welcome the provision that it is specified that the local authority and Health Board must take account of any views expressed via the consultation process in the development of both the integration plan and the strategic plan (S6 (3) and S27 (6)).

We would however welcome clarification on who must be consulted for the development of these plans. In terms of the integration plan and the strategic plan, the local authority and Health Board must consult those persons appearing to the Scottish Ministers to have an interest as may be prescribed (S (2) (a)) and “such other persons as the local authority and the Health Board think fit” (S6 (2) (b)), and similar for the strategic plan (Section 27). There must be a robust system in place to guarantee the opportunity for meaningful engagement with professionals in the planning of services.

The Bill has been designed to enable and support locally-implemented integration, and there is considerable flexibility for local variation while still
retaining central direction. However, inevitably there is a considerable lack of clarity about the structure and function of locality groups as this will be locally driven. Involvement in the development and consultation on strategic planning will therefore be vital for local arrangements, and we recognise that secondary legislation will develop and specify involvement in the planning and decision-making process in the partnership arrangements. Local arrangements are crucial to the success of the integration agenda. We believe there are two primary elements that are fundamental to creating effective locality groups: locality group leadership must be representative of the doctors in the area and must be able to effect change of service provision (see attached Appendix 1, Letter to Cabinet Secretary for Health and Wellbeing, 10 April 2013). We would welcome ongoing involvement in the development of locality planning arrangements.

Terminology
Throughout the process to date reference has been made repeatedly to Health and Social Care Partnerships, however for the purposes of the Bill partnership arrangements are described as “integration authorities” which can be established using one of the four models of integration outlined in S1(4)(a)-(d). Given the step change that is intended to take place through the integration of adult health and social care, consistency of language and terminology in future is vital to ensure familiarity and a shared understanding across all sectors.

Conclusion
There must be a long-term commitment to an evidence-based approach. Both the NHS in Scotland and local government has entered a prolonged period of financial restraint and it will be a significant challenge to maintain the focus on quality and achieve concrete benefits for elderly people in such a difficult environment. Establishing new services or reshaping existing ones requires the right resources being made available at the right time.

In our view there are two fundamental areas that must be assured on a long-term basis to promote effective integration of adult health and social care:
• GPs and senior secondary care doctors must be meaningfully involved in the decision making processes of adult health and care integration
• Doctor-led teams must be central to the provision of services to users of health and social care.

At this stage the Bill has focused on organisational philosophy and broad themes. While this is key groundwork, it is important that further detail is made available to analyse what this will potentially mean for services and patients to ensure that integration will provide high quality care that is safe, effective, based on patient experience and based on clinical evidence. More explicit examples of how integration will work in practice will be needed. At present there is a lack of information about exactly how this integrated model will work in practice at a local level, and we would welcome the opportunity to continue to be involved in contributing to this work.

BMA SCOTLAND
2 August 2013


APPENDIX ONE

Letter to Cabinet Secretary for Health and Wellbeing (10 April 2013)

Dear Mr Neil

Medical Involvement in the Integration of Adult Health and Social Care
We are writing to you regarding medical involvement in adult health and social care integration.

The Scottish Government consultation was clear that professional leadership will be essential to the success of adult health and social care integration:

Health and social care services [will be] characterised by strong clinical and care professional leadership.

The BMA Scotland consultation response strongly supported this objective, which is consistent with longstanding BMA policy on clinical leadership in NHS Scotland. The purpose of this letter is to follow up and focus on key aspects of the BMA Scotland consultation response and describe in practical terms how we believe adequate clinician leadership can be ensured in the integration of adult health and social care.

In our view there are two fundamental areas that must be assured to promote effective integration of adult health and social care:

- GPs and senior secondary care doctors must be meaningfully involved in the decision making processes of adult health and care integration
- Doctor-led teams must be central to the provision of services to users of health and social care.

Clinician involvement in decision making
To promote the Government’s aim that health and social services are characterised by strong clinical leadership it is essential that doctors are involved in decision making at national and local (Health and Social Care Partnership and locality group) levels.

At a national level we strongly recommend that BMA Scotland and the wider health profession continue to be consulted and involved in the:

- Creation of nationally agreed outcomes for adult health and social care. These must be based on established evidence and should only be adopted where they are expected to effect genuine change to improve the wellbeing of older people.
- Development of governance arrangements for Health and Social Care Partnerships and HSCP Committee constitution.
- Development of reimbursement/contractual arrangements for clinician involvement in HSCP Committees and locality group management.

Generally, we believe that there must be an explicit duty to involve doctors from primary and secondary care who have current experience and expertise in health delivery and who provide services to patients that may be affected by any decision by Health and Social Care Partnerships. Unless doctors are able
to engage in the local decision making process and genuinely effect change, there is a serious risk that adult health and social care integration, and the associated operational structures, will fail to achieve meaningful change for NHS Scotland and its patients.

To ensure adequate doctor engagement there should be clear legislative requirements for HSCPs (and locality groups where applicable) to:

• Meaningfully engage and involve medical professionals in decision making.
• Produce a clear strategy for involving GPs and senior secondary care doctors in the decision making process, especially as it relates to service delivery.
• Demonstrate how constituent GP practices and relevant senior secondary care doctors are involved in setting local healthcare priorities.
• Engage doctors who actively deliver medical services, rather than relying largely on input from clinicians who predominantly work in managerial roles.
• Ensure that doctors are at the heart of the leadership within clinical fora, with support from health and social care planners.
• While HSCPs must operate within budgetary constraints, clinical priorities must be set by clinical consensus over what is best for patients within those constraints.
• Local clinical leaders must be required to engage with and achieve the general support of their colleagues.
• Establish clear and nationally consistent commitment to value senior doctor time for involvement with HSCPs. Doctors cannot be expected to carry out adult health and social care integration related work in their spare time, or in the case of GPs, at potential personal cost. The ongoing involvement of clinicians must be valued and resourced.

We have the following specific recommendations for HSCP Committees:

• GPs and senior secondary care doctors must be represented appropriately. To ensure that doctor representatives have the confidence of local clinicians Local Medical Committees/GP Subcommittee (contractor GPs) and NHS board Area Medical Committees (employed doctors) must be involved in the appointment process.
• Doctors involved in the provision of services to older persons should be represented on Committees as professional advisers. Given the medical specialties involved this may include a general practitioner, geriatrician and psychiatrist.
• There should be a minimum requirement for primary and secondary care doctor representation on Committees, as is proposed for patient and third sector representation.

There remains a considerable lack of clarity about the structure and function of locality groups as proposed by the consultation process. We believe there are two primary elements that are fundamental to creating effective locality groups: locality group leadership must be representative of the doctors in the area and must be able to effect change of service provision.

We have the following specific recommendations relating to locality groups:

• Localities should be clustered around geographically and service provision
sensible areas of GP practices. To ensure there is sufficient flexibility for local demographics and circumstances, we do not believe that the number of practices (or the numbers of patients served by practices) should be prescribed. Locality areas should be determined in consultation with GP practices and with agreement of the GP subcommittee of the Area Medical Committee.

• Locality groups must focus on and have the ability to: effect local service provision change (in primary, secondary and social care), address problems relating to service delivery, and, where necessary to accomplish change, have devolved power to direct local budgetary spend.
• The level of devolved locality group financial and operational responsibility must be sufficient to allow service provision changes to the patients covered by the locality.
• The locality group must be led by representative local doctors and care professionals involved in the provision of services to patients and supported by management.
• All GP practices in the locality must have the ability to nominate from within their practice or from practices within the locality a GP representative(s) to the locality group.
• Local senior secondary care doctors that care for patients in the locality area must be able to nominate clinician representative(s) to the locality group.
• Medical staff employed in a management role should be engaged to effect the changes and actions from the locality groups. This would empower clinician led changes and enhance the impact of clinicians in the health and social care system.

As above, for HSCP Committees, doctor involvement in locality group activity must be resourced appropriately. Locality groups should establish a number of funded sessions per week for doctor involvement and there should be consistency across all NHS board areas/locality groups.

**Clinician led teams**
From the point of view of users of health and social care and their carers the success of health and social care integration will largely be determined by the quality of care they receive from teams of health and social care professionals. There is a danger that restructuring introduced by the adult health and social care agenda fractures established joint working by health and social care. Considerable care must be taken to ensure that current examples of integrated health and integrated health and social care team working are maintained and extended. For example, GP practice based teams (practice and attached staff including community and district nurses) must be supported and expanded to include social care professionals to strengthen integration at the most local of levels.

Senior doctors provide leadership and vision of how services can be improved by bringing together teams for the benefit of patient care. The creation of co-located integrated teams of professionals must be considered in all areas where adult health and social care integration is expected to impact patient care. Doctors must be at the heart of these teams and be empowered and
supported by locality groups and HSCPs to organise team working for the benefit of patients.

We appreciate that this is an area that will be under discussion at the Bill Advisory Group; however, we would welcome the opportunity to discuss this matter with you directly if that would be helpful.
1) Do you agree with the general principles of the Bill and its provisions?
MND Scotland agrees and supports the policy ambition for integrating health and social care services to improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs.

2) To what extent do you believe the approach being proposed in the Bill will achieve its stated policy objectives?
It appears to us that the first problem with the proposed approach achieving its objectives is the claim that it will improve consistency. The Bill provides a great deal of flexibility to health boards and local authorities in determining, for example, which of the four integration models they will use, how they will develop their integration plans, which functions will be delegated and to whom. It is hard to see how this could achieve greater consistency. It seems more likely that there will be even less consistency than there is now, with service provision varying widely across geographical areas and the inevitable postcode lottery of service provision becoming a greater problem.

Secondly, again because of this great flexibility, the degree to which integration will actually take place could potentially be very variable from area to area. If no real or meaningful integration takes place in some areas, it is possible that the Bill won’t achieve its objectives and there may be little impact on outcomes for people who use services.

From the explanatory notes, it is difficult to understand why the Scottish Government has adopted such a flexible approach, especially when it envisages that most ‘partners’ will choose the ‘integration joint board/body corporate’ model and it appears, from the evidence provided, to be the most cost effective. The potential cost of integration set out in the explanatory notes varies enormously because it depends, amongst other things, which integration model each area chooses. This leads us to question just how economically beneficial integration will end up being.

3) Please indicate which, if any, aspects of the Bill’s policy of objectives you would consider as key strengths?
We are pleased that integration plans need approval from Scottish Ministers however there needs to be clear criteria given as to what needs to be included in each plan in order for approval to be given. We would hope that this might ensure some level of consistency.

We welcome the establishment of ‘National health and wellbeing outcomes’ and the requirement for integration authorities to produce an annual performance report. We would hope that reporting will concentrate on the outcomes achieved for service users, patients and carers.
4) Please provide details of any areas in which you feel the Bill’s provisions could be strengthened?
As highlighted in response to question 2, we feel that health boards and local authorities have been allowed too much flexibility to determine how they will integrate health and social care and it is not easy to see how this flexibility will benefit our clients. More direction from the Scottish Government on integration we feel would ensure greater consistency and more consistency in service provision would make it easier to examine and compare the quality of care being provided across Scotland.

We feel that there are a number of areas within the Bill which could be strengthened through the specific inclusion and involvement of the third sector. These would include involvement in the development and signing off of development plans and membership of joint monitoring committees. In the explanatory notes, there is acknowledgement that third sector organisations provide health and social care services and a statement 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. If this is the case, we question why fully involving third sector partners was not included in this Bill and hope that this secondary legislation is not delayed.

The Bill could be strengthened if it incorporated greater person centred principles and reflected more on the outcomes of service users.

5) What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?
With so many possibilities on how to proceed with integration open to health boards and local authorities, it is difficult to effectively anticipate how this will affect our organisation, services and clients.

Because Motor Neurone Disease, along with a number of other neurological conditions, require a high level of input from both health and social care services, often intense in nature and requiring rapid input, it would be our hope that through the integration joint boards coordination and delivery of services will be enhanced for those affect by MND. It would also be our hope that referral to our own services will be improved. We would also anticipate that staff education in MND would be facilitated through the integration boards.

As the number of those affected by MND throughout Scotland is relatively low, ~400 people, MND Scotland believe that a consistent and equitable service is needed across the country. This could be facilitated by the establishment of joint integration boards but only if they are providing the same services in each area and are structured in a way that allows patients, carers and service providers easy access.

We have a number of core services which include an MND Specialist Care Team employed by the NHS but whose costs are funded predominantly by our organisation. It is possible that none, one or more of our specialist care
team staff could have their ‘function’ delegated to a local authority or joint board. We have a concern that this could potentially create a lack of consistency to those receiving the service across Scotland.

Our Equipment Loan Service provides equipment to people with MND across Scotland such as hoists, medical beds and riser/recliner chairs while they wait on this equipment being made available from statutory services. Potentially, following integration, this service could have to liaise with an increased number of providers depending on if/who this function is delegated to.

In addition, the lack of consistency across Scotland creates problems for our campaigning work on behalf of people with MND. For example, we have recently contacted the Charging Team of each local authority asking them to outline their charging policy for personal care. If this function of the local authority was to be delegated for some areas and not others, collating this helpful information would become very difficult.

6) What effect do you anticipate integration plans will have on outcomes for those receiving services?
It is difficult to assess the impact of integration plans on those receiving services when it remains unclear exactly how, and to what degree, integration will be implemented. However, we feel it is fair to expect that there will be a considerable amount of confusion for some time for those receiving services about who is providing what service. It seems possible also that people could fall through gaps in service provision as the process of integration and the delegation of particular functions take place in each area.

In addition we concur with other charities’ concerns that there is a risk that, as we suspect has happened with NHS Continuing Care in Scotland, entitlement to free healthcare could be compromised. This would seem to be a greater risk where health boards delegate functions to local authorities. Free healthcare could be at risk of being (wrongly) charged for, or eligibility criteria put in place, as it is for social care.

MND Scotland
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Voices Of eXperience Scotland (VOX)

Do you agree with the general principles of the Bill and its provisions?
Vox believes that service users will be best served by a seamless service and that the principles of the bill and its provisions should make that easier to accomplish.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
While the general approach seems to be reasonable there is a lot of emphasis on staffing realignment and administrative arrangements and not so much emphasis on ensuring improved outcomes for the individual. In our 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.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths
VOX recognises that information sharing has been difficult between differing parts of the system notably health and social care but also primary and secondary care and welcomes the provisions that make that information more readily available to all appropriate individuals. However because of the stigma involved in mental health we would want involvement of individuals and/or appropriate advocacy groups to consider the method and extent of information sharing. It is good that involvement is referred to in the Policy Memorandum but as with all legislation dealing with mental health, where there is power to restrict people’s liberties, it is important that user involvement, and the advocacy to support it, is properly recognised in primary legislation.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
VOX believe that the bill should ensure advocacy provision for all in order to ensure that mental health service users get an appropriate provision of health and social care services to meet their identified needs whether receiving these services under compulsory powers or otherwise. The Self Directed Support and personalisation agenda will only work well for mental health service users and carers where high quality independent individual and collective advocacy services are able to provide support.

There is no mention either of the role that collective advocacy groups have been playing locally in all aspects of service design delivery and evaluation, or of the work done nationally by groups such as our own. It is important that collective advocacy groups continue to play their important role within the national, regional and local planning structures and this role is fully recognised in legislation and guidance.
The ‘consultation group’ proposed in section 26 must have mental health service user representation as they as a group are well experienced in terms of working across health and social care, and have been since the first “delivering for mental health” in 2005 and indeed the Framework for Mental Health Services for Scotland (1997).

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?
Our membership in particular our local group members will benefit in terms of a reduction in hours spent at planning meetings, and our ability to contribute to strategic and organisational issues around design and delivery of services will be enhanced.

What effect do you anticipate integration plans will have on outcomes for those receiving services?
Our members are particularly concerned with these plans as there is the risk that some services currently provided as NHS services, free at the point of delivery, may be reclassified and realigned as social care services, and become chargeable.

This would be an extremely adverse development, against a background of great financial hardship due to welfare reform where our members are already among the hardest hit of all communities, due to the lack of understanding of their conditions in the agencies involved.

For these reasons it is absolutely imperative that the primary legislation reflects the need for individual and collective voices to be heard and support to be available to have that voice heard.

Further thoughts
The principles in the mental health act include reciprocity. We have a duty to certain vulnerable individuals in Scottish society and our duties in this legislation are to ensure that their voice is heard as health and social care come together. Members of VOX would be happy to give further evidence to the Committee in its oral evidence sessions, on any of the points covered in this submission.

Voices Of eXperience Scotland (VOX)
2 August 2013

VOX is a National Mental Health Service User Led charity funded by the Scottish Government and Comic Relief. We work in partnership with mental health and related services to ensure that service users get every opportunity to contribute positively to changes in the services that serve them and the wider society.

VOX supports individuals and service user led groups to ensure that their views are listened to. We have 345 Individual members, 12 Group Members
and 8 Associate Group members (we have a fairly strict criteria for this grouping, must be service user led and must be following equal opportunities policies etc.) This means that we act for approximately 3500 people. We are the only national mental health user organisation in Scotland.
Carers Trust in Scotland

Public Bodies (Joint Working) (Scotland) Bill

- Do you agree with the general principles of the Bill and its provisions?
  Yes. Carers Trust in Scotland welcomes the Scottish Government’s commitment to integrating health and social care services and is pleased to see legislation introduced that will make this a reality. Services on the ground need to work more effectively to achieve more positive outcomes for service users and carers, and the role of unpaid carers in ensuring better outcomes for the people they look after (and themselves) will be helped and supported by integrated resources and services. Integration should mean it will be easier for people to be involved in decisions relating to their own care, or that of those they care for, and there will be a smoother transition between health care and social care in situations such as hospital discharge, as well as better multi-agency support and management of long term conditions in community settings.

- To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
  It is recognised in *Caring Together: The Carers Strategy for Scotland 2010-2015* that ‘Carers play a crucial role in the delivery of health and social care provision in Scotland’; in order for carers to carry out this role they must have adequate support, and plans for integration must include a strong focus on effective, preventative carer support, with unpaid carers being recognised as equal partners in care provision. To achieve this, service users, carers and the wider third sector must be involved in the planning, development and delivery of services. Whilst the Bill contains a number of proposals that will go towards achieving this involvement of carers and service users, we believe that this could be strengthened.

  Particularly, the title of the Bill (and references in the accompanying documents) indicates the recognition that integrated working must include a wider range of services than simply health and social care, with an emphasis on joint working between all services that contribute to people’s wellbeing. However, the provisions in the Bill are very heavily focused on the public sector and there appears to be a limited role for local third and independent sector organisations, including those who provide health and care services and those who provide support to carers and service users. As well as the role as a provider of support and services, third sector organisations are also a key mechanism through which service users and carers can be involved and have their voices heard. The direct involvement of people who use support and services is vital to ensure that services are truly beneficial to the people who use them.

  Without a strong and effective voice for the third sector and for people who use support and services, there is a risk that the Bill could focus too narrowly on changes to processes and structure within the statutory services, rather
than improving people’s experiences of health and social care by increasing the quality and consistency of services.

- Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths
  We welcome the reference to the Christie Commission report in the policy overview, recognising that services which include their service users and communities in planning and delivery are most effective, and that effective joint working requires strategic coordination that is achieved by consistency of objectives (and outcomes) between the organisations that are working together. Aligning health and social care integration within wider public service reform will hopefully ensure that the plans are successful.

  Carers Trust in Scotland also supports the emphasis on a national outcomes approach; this will provide an additional focus for the local partnerships and allow local service provision to anticipate and respond to local needs whilst also ensuring strategic consistency across Scotland. An outcomes focus also complements the objective to enable and require appropriate local responses to changing patterns of need: at an individual level, focusing on outcomes for service users will make sure they have the correct support in place at the right time, which is not constrained by issues with resources or delivery.

- Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
  A key area of concern for us is the limited role for the third sector. We are pleased to see specific mention of carers and non-commercial providers of health and social care included as groups that must be consulted at various stages of integration planning and development, including development of the national outcomes. However, as carers’ centres do not always provide formal care or contracted services, they may not always consider themselves as fitting into this category and may be excluded. More explicit inclusion of carers’ services and other support organisations who do not consider themselves to be ‘health and social care providers’ would ensure that this group is included. We agree with the Health and Social Care Alliance’s position that a further, more inclusive category is added to the list of those required to be consulted on national outcome development: ‘(k) third sector organisations contributing to health and wellbeing.’ Specific organisations for inclusion, such as carers’ centres, must be specified at guidance and regulatory stage to ensure they are not overlooked.

  Another area of concern for us at the consultation stage was the lack of voting rights for the third sector, or for service users and carers, on integration partnerships. These concerns have not been addressed in the Bill, despite some alterations to the structure of integration joint boards, and we remain concerned that the third sector may not have a role in signing off the local strategic plans. The third sector’s involvement in local Change Plans has been a significant enabler of the cultural change evidenced in the Reshaping Care for Older People (RCOP) Change Fund process, and given the repeated references to the positives of the RCOP process in the Bill and consultation so far, we would have expected the good practice to be developed further in
this legislation. We are aware of the risks that the Scottish Government have identified regarding third sector voting rights, but there is a concern that overlooking third sector involvement will result in a backwards step if Health and Social Care Partnerships are only accountable to local authorities and health boards.

Whilst the integration planning principles are welcomed, we believe there is some room for improvement as they are currently open to interpretation. Particularly, it is not clear if carers and people who don’t yet use services fit into the principles, as they may not be considered under (i) as a ‘recipient’ of services.

We would also welcome further clarity about how service users and carers will be informed of the changing structures. We agree with the points made by the Health and Social Care Alliance regarding the need to clarify what will happen to Public Participation Forums (PPFs) in an integrated landscape, as these forums have been useful to engage more widely with local communities and support public involvement in planning and development of services.

- What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?
  The carers’ centres that form part of Carers Trust’s Network provide vital support, advice, information and services to carers at all stages of the caring journey. This legislation should strengthen their position as a community-based health and care resource, providing support to carers that enables them to continue their caring role in partnership with statutory and third sector health and care services. Some carers’ centres provide services on behalf of the local authority, such as carers’ assessments; this is one of the reasons why we believe a greater role for carers’ centres in integration planning structures (as part of the wider involvement of the third sector) is necessary. Situations such as hospital discharge should be improved in an integrated working environment, as carers report that lack of communication between health and social care services, or lack of involving the carer as an equal partner in care when trying to plan discharge or admission to hospital is the main cause of difficulties.

- What effect do you anticipate integration plans will have on outcomes for those receiving services?
  Carers Trust in Scotland hopes that plans for integrated services will lead to an improvement in developing outcomes for individual service users and their carers, as greater communication between services is one of the key things which will lead to better and more joined-up care and services, allowing people to live more healthily and independently and receive care and support in a way that suits them. However, to achieve this properly, the integration process is wider than just statutory health and social care. At the very minimum education, housing and wider third sector involvement will be necessary to make sure that all partners that deliver services and that are involved in developing outcomes for individuals are fully integrated.
Carers Trust
2 August

Carers Trust in Scotland (formerly the Princess Royal Trust for Carers) works to improve support, services and recognition for anyone living with the challenges of caring, unpaid, for a family member or friend who is ill, frail, disabled or has mental health or addiction problems. With our Network Partners, we aim to ensure that information, advice and practical support are available to all carers across the UK.
Barnardo's Scotland supports the general principles of the proposed Bill. We support the integration agenda and putting people at the centre of health and social care planning. In those areas that have effectively implemented GIRFEC, putting children at the centre of service design and delivery, this has proven to be very successful and is something we would like to see replicated across Scotland in health and social care settings.

Barnardo's Scotland delivers a number of children’s services in 28 local authority areas across Scotland, many of which are fully or partially funded by local authorities. These services will be directly affected by those integration bodies that choose to take on children’s services.

We currently deliver services in Highland and have direct experience of the integration work that has been carried out there by NHS Highland and the local authority. Highland has followed a delegation between partners approach with the local authority taking on responsibility for children’s services.

Since the changes in Highland we have felt that Barnardo’s Scotland has become more involved in key decisions regarding service delivery in the area. We have had a seat at the table when discussing commissioning and budgets and have been able to negotiate around the needs of the service users rather than what money is available. Barnardo’s Scotland is well represented at key local decision-making bodies, including at community planning level. The overall impression of our staff working with the council, since these changes, is that they feel they are listened to and that the opinion of the organisation and the wider third sector is taken on board for key decisions.

Barnardo’s Scotland would call on other areas to look at the work in NHS Highland as an example of good practice. We would also like to see more assessment of the lessons learnt from the Northern Ireland model of regional health and social boards.

**General Comments**

We believe that there should be a children rights based approach to the Bill and the general principles of the Bill should be amended to reflect this. The Children and Young People Bill and its commitment to wellbeing, the SHANARRI indicators, children’s rights and the United Nations Convention on the Rights of the Child (UNCRC) should be recognised in the Public Bodies Bill.

A major concern of Barnardo’s Scotland is that the intent behind the proposals is still far too adult focused. It is important for policy-makers to recognise and understand that these proposals will also affect children’s services. We are
concerned that children’s services will not be recognised as an equal priority and suffer as a result.

It is also far from clear to us where the responsibility for children’s services will lie in those areas where integration authorities do not choose to take on responsibility for them. This will create significant uncertainty.

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.

We are pleased to see that the Scottish Government has indicated that their ambitions for integration are about improving health and social care, however, we are concerned that some areas may see integration purely as an opportunity to save money, particularly in this time of financial pressure. We believe that such an approach would undermine new integration models of working and result in poorer services.

We have concerns that there will still be consistency issues with regards to the delivery of services and care and that the integration agenda may not solve this. In our experience there were at times consistency issues with Community Health Partnerships, the forerunners to these proposals. It is clear that areas will integrate in different ways and different paces. There will also be a need for a substantial cultural shift in some areas where silo working has long been entrenched. The third sector already helps bridge the gap between health and social care across Scotland and there are lots of examples of good practice. It will be crucial to ensure that the third sector plays a critical role in the integration process and this should be recognised on the face of the Bill.

The legislation focuses almost entirely on the two main statutory partners in this process, the NHS Board and the local authority. We believe that more should be done to recognise and embed the role of the third sector in the integration process, particularly with regards to service, design and delivery.

There is little in the Bill or the policy memorandum that relates it to the proposals in the Children and Young People Bill, which is currently going through Parliament. With the Public Bodies Bill having an impact on children’s services it will be crucial to explain how the two proposed Bills will work together. The Scottish Government needs to explain further how these two pieces of legislation will interact.

Barnardo's Scotland recently supported the Social Care (Self Directed Support) (Scotland) Act and believe that the new self-directed support regime it will create will give many families and children much more control over their care packages. We are not clear about how the Public Bodies Bill will interact with self directed support. Will those eligible for self-directed support be
entitled to direct any health and social care services they need through the integration authority? There may also be issues relating to shared budgets between local authorities and NHS Boards, if a significant element of the social care budget has to be earmarked for those managing their own budgets or choosing to place their budget with another provider, this might mean healthcare has to provide a bigger share of the integrated budgets.

The proposals set out in the Public Bodies Bill must not be seen purely as a way for local authorities and NHS Boards to save money. In the context of increased budgetary pressure, evidence of return on investment is crucial if the integration of health and social care is to be a success. Measurement and evaluation of integrated health and social care should be based around outcomes for patients/service users and not process or inputs such as hospital admissions.

The Scottish Government needs to ensure there is adequate transition money to allow for integration of health and social care.

The move towards integration, which was set out in the Christie Commission, must also see a continued commitment to preventative spending and preventative services, which is also at the heart of the Christie Commission.

Specific proposals within the Bill

Barnardo's Scotland has a number of concerns about specific elements of the Bill, which we would like to see addressed by the Scottish Parliament as it progresses.

It is still far from clear to us how children’s services will work in the vast majority of integration set-ups and how this will impact on commissioning and procurement practices in these areas. From our understanding we believe that many local authorities and NHS Board’s plan to include children’s services in the work of their integration bodies. This makes these proposals very pertinent to Barnardo's Scotland and other organisations and it will be crucial that the legislation and subsequent guidelines ensure that children’s services are at the very heart of these proposals and not an add-on at the expense of adult services.

The legislation states that each area must prepare a strategic plan that explains how the delegated functions will be delivered and how they will meet national health and wellbeing outcomes. It is not clear from the face of the Bill/Policy Memorandum how and if the third sector will be involved in preparing these plans. It would appear under section 6 of the Bill that there is scope for third sector consultation and a requirement to consider this, but we are worried that this is not sufficient. We believe that the third sector should be consulted at the earliest possible point on what model of integration is considered by each NHS Board and local authority.

Barnardo's Scotland has a number of concerns regarding how the proposed national health and social care outcomes, set out in Section 5 of the Bill, will
relate to the outcomes for Community Planning Partnerships (CPPs) and Single Outcome Agreements (SOAs). This relationship will be particularly important to understand for those integration areas that choose to take responsibility for children’s services.

We are very supportive of strategic commissioning and the requirement of each integration authority under section 23 to prepare a strategic plan. We believe that decisions about commissioning services must be informed by a full analysis of the ability of different providers (public, private and voluntary) to meet the individual needs of the child/person and to achieve good outcomes most cost effectively. In our experience, commissioners rarely approach service users, including Barnardo’s Scotland, before a tender opportunity is published. We have found that a collaborative approach to service design, when it happens, can be a very effective means of improving service quality. We believe that strategic commissioning needs to be at the heart of the integration agenda and we support the proposals set out in the Bill.

Children have a right to participate in decisions made about their care. This must go beyond a simple tick box approach. Co-production must be at the heart of this Bill and its implementation. Integration authorities that take on the responsibility for children’s services must follow the GIRFEC principles and embed a co-production approach to the planning and delivery of individual services for children. Such a co-production approach should also explore how the skills and knowledge of relevant third sector organisations can also make the most effective contribution, not just as delivery agents but also as full participants in planning and development processes.

Barnardo's Scotland
2 August 2013
Leonard Cheshire Disability (LCD) is the UK’s leading pan-disability charity. Founded in 1948 in reaction to the lack of care and support available for disabled people, today we provide a wide range of services, including social care and employment support as well as working to improve the rights of disabled people around the world. Campaigning is at the heart of what we do and our policy and campaigns team works with disabled people across the UK to lobby for positive change.

Introduction

Leonard Cheshire Disability welcomes this opportunity to provide input at Stage 1 of the Scottish Government’s Public Bodies (Joint Working) (Scotland) Bill, which addresses plans to integrate aspects of health and social care. We are particularly interested in the impact that these reforms could have on disabled people living in Scotland.

We support around 450 people with disabilities across Scotland – 60% with a physical/sensory disability, 40% with learning disabilities. They are supported by around 800 staff and volunteers across Scotland and our total contract value across Scotland is just over £13m.

Our Scottish services are broadly made up of:

- Support at home 30%
- Supported living services 25%
- Day services 24%
- Residential 21%

Do you agree with the general principles of the Bill and its provisions?

We agree that there is potential, through the integration of services, to improve the design and delivery of care and support for individuals, and see that their health and care needs can be met as seamlessly as possible. We also welcome the principles contained within Section 25 of the Bill stating that services should be provided in a way that is integrated from the point of view of recipients and that takes account of the particular needs of different people. However, we share the concern of some partner organisations, such as the Coalition of Care and Support Providers, over the omission or quality of care and support in the principles of the Bill.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

While the Bill offers an opportunity to improve the way that health and social care providers work together, we believe that an emphasis on the quality of care and support is missing from the Bill and that an apparent lack of involvement from individuals in the design and delivery of their care could present a missed opportunity. We believe that there is also a lack of clarity
about how the Bill will work in relation to Self-Directed Support, and that clarity is required on this matter.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

- The intention to develop National Outcomes is a strength of the Bill as it stands. We hope that these will be used to ensure that there is a consistency across Scotland in the development of integration and the delivery of health and social care services. We hope that the Scottish Government and the Scottish Parliament will hold the joint boards to the National Standards and that a report and review mechanism will be developed to ensure that Standards are being met.

- We welcome the principle that services “should be planned and delivered seamlessly from the perspective of the patient, service user or carer, and that systems for managing services should actively support such seamlessness,” as outlined in the Policy Memorandum accompanying the publication of the Bill.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

- While we welcome the principles of the Bill as outlined in Section 25 of the Bill and are glad that the Bill envisages services that are integrated from the point of view of recipients, we believe that person-centred planning is vital if integration is to meet the needs of people in a way that allows them to live life their way. Additionally, we urge committee members to consider the need for advocacy in the design and delivery of care and support. Primary research carried out by Leonard Cheshire Disability last year found that people with learning disabilities often felt misunderstood or not listened to when accessing services while, in some cases, people’s social care needs were only met when they were visited by chance in hospital by members of our support staff. We believe that a person-centred principle within the Bill, as well as a requirement for advocacy where this is needed or preferred could deliver better quality care and support that meets the individual’s needs.

- Section 5 of the Bill outlines groups that Scottish Ministers must consult in making regulations that prescribe outcomes in relation to health and wellbeing, and that these include users of healthcare and users of social care as well as their families and carers. However, there appears to be no firm requirement that in jointly consulting on the integration plan, the local authority and the Health Board must also consult these groups. While Section 5 of the Bill addresses this to an extent and requires that integration, “is planned and led locally in a way that is engaged with the community and local professionals”, we believe that there should be a firm requirement in the regulations to require consultation with disabled people, their families and carers and ensure that they play a meaningful role in the consultation process. We also feel that the Bill should contain a stronger role for the third sector in the planning and delivery of care.
Concerns have previously been raised about a lack of a values-based approach to the integration of health and social care. The emphasis of the bill is technical and primarily concerned with governance and accountability and budgets and resourcing. While these are important aspects of integration, we believe that there is scope for the Bill to explicitly place the values of human rights, dignity and equality at the heart of integration. We hope that the guidance and regulations following on from the Bill will address this issue.

What effect do you anticipate integration plans will have on outcomes for those receiving services?
We believe that the attempt to join up health and social care services is a positive step. However, the focus on older people in the policy memorandum is concerning. Services for one group may not necessarily be appropriate for other groups and we hope that this will be addressed during the scrutiny of the Bill.

Leonard Cheshire Disability
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Quarriers

Quarriers is a major Scottish charity providing practical care and support every day to thousands of people. Through more than 120 services for Adult Disability, Children and Families, Epilepsy and Young Adults in Scotland and a growing number of service in parts of England, we challenge inequality of opportunity and choice, to bring about positive change in people’s lives.

Quarriers fully support the evidence submitted by the Health and Social Care ALLIANCE Scotland on this Bill.

Consultation Questions

Do you agree with the general principals of the Bill and its provisions?
Quarriers supports the Scottish Government’s aim to integrate health and social care to improve outcomes. Quarriers believes that integrated and high quality support provided in partnership with health and social care will lead to an improved life and healthier outcomes.

Quarriers also supports the comments from the ALLIANCE that the provisions in the bill may not go far enough to achieve the transformational change advocated in the Christie Commissions report on the future of public services.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
Quarriers believe that the Bill has the potential to improve outcomes for people using health and social care services across Scotland, but is concerned that the effectiveness of this may differ across Scotland with some health boards and local authorities working together more effectively.

Quarriers would also support calls made by the ALLIANCE that the involvement of service users, unpaid carers and the third sector are key to making integration a success.

Quarriers believe that the third sector has a key role to play to ensure the aims of the Bill are a success and would like to ensure that the third sector is a key partner working with health and social care to reshape services. Quarriers is a major provider of support and services for both Health Boards and Local Authorities across Scotland.

Quarriers would also like to see this Bill being used as an effective tool for people who use the support services to be more involved in the developing of services and support and would highlight that this is already being done effectively in some local authorities across Scotland.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
Quarriers would support calls for a stronger voice for people using health and social care support and services and would like to ensure that the third sector is involved in developing integration plans to ensure that the voices of the people using support services is added.
The role of the third sector must be clearly defined in the process as an equal partner in the process. The role of the third sector within current CHPs and CHCPs is inconsistent at best and this situation has shown little change in the start of the integration process. Quarriers are concerned that the level of third sector and individual's involvement with differs drastically between authorities. Quarriers supports the position of the ALLIANCE that

The third sector and people who use support/services should be included within membership of Integration Boards at section 12 and strategic plan consultation groups at section 26 of the Bill. Quarriers would also advocate a set of human rights based principles in the Bill, or amendments to the existing principles so that the Bill is focussed on achieving outcomes, rather than a needs-based approach and co-production/asset-based approaches rather than a professional/provider-led agenda. In their content and language the principles reflect the traditional ‘deficit/needs’ based paradigm with professionals framed as holding the balance of expertise and power. This seems at odds with the Christie agenda and wider drives for personalisation, person-centred care and the desire to ‘shift the balance of power’. "We must ensure that when budgets are brought together that it is always the needs of people supported that is key and not a budget reduction exercise that some areas may see it as.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans? Quarriers believe that the Bill could significantly strengthen the working relationship between third sector organisations and statutory services and this will lead to improved services and planning across Scotland.

What effect do you anticipate integration plans will have on outcomes for those receiving services? Quarriers believe the Bill can be an effective way of improving services and support for people across Scotland, this will only be achieved if the people receiving support and services across Scotland are active partners in the developing of health and social care across Scotland.

Quarriers
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

ENABLE Scotland

Introduction and Summary: ENABLE Scotland welcomes the opportunity to submit this written evidence paper to inform the Health and Sport Committee’s stage 1 scrutiny of the Public Bodies (Joint Working) Scotland Bill (the ‘Bill’). Our key comments/recommendations are summarised below:

a. This Bill is ultimately intended to improve outcomes for people who use services or support. By focusing on Public Bodies and not engagement of individuals, this message is lost in the narrative of the Bill. It could be more aspirational in this regard.

b. Links to other current and proposed policy and legislative frameworks are not clear, and risk developing a muddled system for individuals and organisations alike.

c. Further clarity in strong Guidance supported by a wider change management programme will be required to deliver the transformational change as recommended by the Christie Commission. This Bill is just the starting point.

d. Role of the third sector, whether as commissioned service providers, providers of services and peer support delivered via charitable income, or as bodies representing the views and needs of groups of citizens, needs further consideration and clarity in terms of service planning, delivery, strategic commissioning and monitoring.

e. The focus on older people in the Policy Memorandum may present a risk that specialist services for other groups, such as people with learning disabilities and their carers, are deprioritised, at least in the first round of locality planning.

f. The focus solely on ‘consultation’ in the narrative of the Bill is wrong (s.6); we believe that co-production and engagement are separate, but complementary, principles which should be embedded in both the planning and delivery principles on the face of the Bill, and the National Outcomes to be defined by Scottish Ministers.

g. The language used to describe people who use services and support as ‘recipients’ throughout the Bill perpetuates a passive culture; we would encourage the Committee to debate this issue and take advice on alternative wording. This reflects the wider impact of the Bill in bringing the medical and social models of disability, and therefore models of support, under the same legislative framework.

h. The planning and delivery principles proposed in s.4 of the Bill should be extended to include ‘Deliver the best quality support and services for individuals’
i. More clarity is required on the impact of bringing the NHS system of services free at the point of use and delivered directly by public bodies and a social care system that charges individuals for services which are delivered by a range of providers according to market principles; there is insufficient information about the impact of this on either individuals or providers of services in the Bill or the Policy Memorandum to inform constructive comment at Stage 1.

j. As a result, current reading of the Bill leaves ambiguity for third and private sector service provider organisations operating in the social care market about the potential for a local integrated budget to purchase health services from these sectors also.

k. The change is the name of the Bill raises questions – is the intention that the scope can be widened to services outwith health and social care?

Consultation Questions

1. Do you agree with the general principles of the Bill and its provisions?
   1.1 Our vision is a society where people who have learning disabilities and their carers have the same life chances as other people. We believe in a society that is free from discrimination and values all of our citizens equally. We believe this vision is shared by public sector bodies and that this ethos could be better embedded into the general principles of the Bill to support greater transparency about achievement of quality outcomes and greater partnership between individuals, families and provider organisations across all sectors.

   1.2 As introduced at Stage 1, we believe that the Bill’s principles (Part 1, s.4) focus too heavily on needs, as opposed to actively recognising the assets that people and communities bring; focuses too much on retrospective consultation with people on plans as opposed to promoting the co-production of locality plans in a process which actively engages with people and their representatives; and does not reflect the importance of designing support and services which deliver high quality outcomes for people in terms of helping them to live independently, achieve their aspirations and live well, regardless of their age.

   1.3 ENABLE Scotland is in favour of the greater integration of health and social care with the clear purpose of achieving better outcomes for individuals, families and communities. Of equal importance, we believe that the active involvement of individuals, families and communities is critical in designing the support and services which will deliver this. The Bill in its current format is too implicit with this aim; and we would encourage the Committee to consider how better to promote the active engagement of individuals in shaping support and services, not just be consulted, and to ensure that this results in the delivery of high quality support and services.

   1.4 It is vital that people with learning disabilities and their families are at the heart of decision making about the services and support in their lives. This was central to the ethos of “The Same As You?” (2000), the Scottish
Government’s seminal policy initiative on learning disability, and is the cornerstone of the Social Care (Self Directed Support) Act 2013, due to be enacted in April 2014.

1.5 The recent updated learning disability policy, “The Keys to Life” (2013) has highlighted that people with learning disabilities are more likely to experience poor health due to poverty, inadequate housing, lack of employment, social isolation and discrimination. It stressed the importance of taking a human-rights-based approach and includes recommendations for reorienting strategic commissioning towards outcomes and that joint commissioning plans need to take account of the needs of people with learning disabilities of all ages.

1.6 Consequently, while we welcome the principles in the Bill, we believe that these do not go far enough in reflecting human rights principles nor do they align with the values and principles of care and support recently outlined in the Draft Statutory Guidance on Care and Support that accompanies the Self-directed Support (Scotland) Act.

1.7 We also feel that people with learning disabilities are a group whom the policy memorandum could usefully have specified.

1.8 The language used to describe people who use services and support as ‘recipients’ throughout the Bill perpetuates a passive culture which runs counter to the principles of co-production; we would encourage the Committee to debate this issue and take advice on alternative wording.

1.9 Finally, we make a specific suggestion that Section 4 should include a principle of ensuring that the service provided also ‘deliver quality outcomes for persons to whom the services are provided’.

1.10 A logical extension of this suggestion is that the National Outcomes to be prescribed by Scottish Ministers under Section 5 should include a focus on participation or co-production, and quality.

2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

2.1 The Bill focuses on structural and technical issues. Though it is important to get this right, especially in the early stages of integration, we are concerned that there is a lack of focus on the aspirational aims of integration. Cultural change is required to deliver on the stated policy objectives of improved quality, seamless community-based services, and effective use of resources – but there is little indication in the Bill of how this will be achieved.

2.2 ENABLE Scotland is less concerned about functions, structures and processes than we are about public services meeting the needs of people who have learning disabilities and their carers. It is important that the Bill does not simply focus on the technical arrangements required during the initial transitional phase but embeds upfront the key principles of user involvement in the shaping and delivery of services and partnership working across all
sectors including individuals, carers and providers.

2.3 Voluntary organisations play a significant role both in commissioned service delivery, community support, and in supporting individuals and families, through collective advocacy, to make their views known. However, this wider role of the voluntary sector is not acknowledged in the Bill. The third sector should be a much stronger partner in the integration process.

3. Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

3.1 We consider the general principles of the stated policy objective of the Bill itself as its key strength, but would like to see this embedded at the start of the Bill to promote the principles at the heart of the legislation.

3.2 We are pleased at the new requirement for health bodies and local authorities to work together and engage in joint commissioning and delivery of support. Our members have long expressed frustration at the lack of joined-up work between health and social care staff, and this new duty has the potential to drive real and positive change.

3.3 We welcome the focus on national outcomes as the driver for public bodies integration plans – although we feel that outcomes on participation and on quality will be required to achieve the policy objectives.

3.4 Joint Strategic Planning and commissioning also has the potential to really lead to effective local services and support which delivery high-quality integrated person-centred services. However, we believe that requirements for authorities to involve non-statutory partners needs to be strengthened further to support the effectiveness of the planning, delivery, and monitoring process.

4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

4.1 Objectives: We have some concerns about the wording of the stated objective and the description of people as “patients, carers, service users and their families”. There’s a sense that ‘patients and carers’ belong to health services and ‘service users and their families’ belong to local authorities. We would prefer a more integrated description that simply reflects that the objective is to “improve the quality and consistency of services for individuals, families and carers.”

4.2 Principles: Section 5 and 25: The principles need strengthening particularly in relation to engagement and participation. These also need supported by robust quality assurance and monitoring to ensure these become embedded in practice. We also believe there should be a clearer distinction between principles of planning and principles of delivery.

4.3 Outcomes: It is very important that the delivery of integrated health and social care services is driven by jointly agreed outcomes for which
partnerships will be jointly accountable. People who have learning disabilities and their parents and carers want to receive the best service possible from health and social care services – they are less interested in the structure by which it is provided. Reporting and scrutiny should be robustly applied, and there should be clear consequences for health and social care partnerships where health and social care outcomes are not being achieved.

4.4 Strategic planning and consultation: (ss 23-30): There needs to be a much stronger consultation and partnership process with the 3rd sector and a clearer process for user engagement. It may be helpful to require integration boards to publish a separate Consultation Strategy and to monitor how it is used.

The Bill's proposals need to more strongly reflect the move towards co-production, and for people to become equal partners alongside service providers. People who use services and unpaid carers can play an important role, alongside professionals, in planning and commissioning. People who use services and carers representatives must have the opportunity to influence decision making – including the opportunity to vote on those decisions.

4.5 Role of the third sector: The third sector also has an important role to play in driving such a transformational change and should be an equal, strategic partner. We believe that they should have a role in the approval of the strategic plan (s. 28) including voting rights. To ensure meaningful participation and an equal role for the sector, it may be helpful if the Bill created a new public duty to facilitate the capacity-building of third sector organisations to participate meaningfully in the planning process.

4.6 Revision and review (ss. 34-26): We are concerned that there is no requirement to consult before producing a revised integration plan. There could be merit in a role for the Consultation Group in approving any changes and in deciding if wider consultation is needed.

4.7 Links with other government policy: There needs to be better links with other key areas of government policy. For example, a clearer fit with the self-directed support agenda is required to ensure that integration and self-directed support are progressed together. The recent consultation on a draft Community Empowerment and Renewal Bill envisaged a strong partnership approach and communities taking responsibility for the delivery of some local services or challenging poor service delivery by public bodies.

4.8 Complaints routes: There is no mention of complaints processes and the need to integrate these or provide a clear route for complaints that ensures people can raise any concerns with the relevant bodies.

4.9 Eligibility criteria and charging: Further clarity is needed on how eligibility criteria and charging policies will be tackled in integrated provision. Healthcare is universal and free at point of contact. Social care is subject to eligibility and contributory charges. These issues are not addressed in the Bill but will pose considerable challenges and are already a concern for people
with learning disabilities and families.

5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

5.1 It is very difficult to say at the moment. ENABLE Scotland delivers services and/or has membership groups in 29 local authority areas and it will be helpful in future if health board areas and local authority areas are coterminous. However, our experience is that different areas approach commissioning, service delivery and user participation differently and this is unlikely to change.

5.2 We anticipate that there will be more opportunities to engage with partners across the statutory, and indeed voluntary sectors, at local level to engage in the locality planning processes. We believe that there is a need for the Scottish Government to a) consider developing guidance for the Voluntary Sector on engaging with the planning and delivery mechanisms proposed in the Bill; and b) for the voluntary sector to consider further how best to organise itself to effectively engage in this process.

5.3 ENABLE Scotland is very keen for the scrutiny of this Bill to generate debate around its impact on bringing the NHS system of services free at the point of use and delivered directly by public bodies and a social care system that charges individuals for services which are delivered by a range of providers according to market principles; there is insufficient information about the impact of this on either individuals or providers of services in the Bill or the Policy Memorandum to inform constructive comment at Stage 1.

5.4 As a result, current reading of the Bill leaves ambiguity for third and private sector service provider organisations operating in the social care market about the potential for a local integrated budget to purchase health services from these sectors also.

5.5 We would encourage the Committee to consider this important issue in its Stage 1 scrutiny.

6. What effect do you anticipate integration plans will have on outcomes for those receiving services?

6.1 We believe that it is more likely that outcomes for people with learning disabilities and their families will be positive if:

- people have choice and control over the design and delivery of their services – determining the outcomes they want to achieve and being supported to do so;
- there is greater recognition of the role of early intervention and preventative services – recognising that these reduce pressure on more specialist and more expensive services, reducing the demand for more costly services;
- individuals, their families, and providers organisations are seen as equal partners in the planning and delivery of care and support alongside local authorities and health services.
The Bill has the potential to deliver this but needs more focus on principles of participation and quality supported by national outcomes which focus on the same.

ENABLE Scotland
2 August 2013
The National Pharmacy Association (NPA) is the largest UK trade body of independent community pharmacy owners. The vast majority of Scottish independent pharmacies are voluntary members of the NPA. The Association provides its members with professional and commercial support as well as representing the interests of community pharmacy in dialogue with the public, NHS, Government and other pharmacy stakeholders.

Community pharmacy owners, like general practitioners, are independent contractors of NHSScotland

The National Pharmacy Association welcomes the opportunity to respond to the following questions:

**Do you agree with the general principles of the Bill and its provisions?**

The National Pharmacy Association (NPA) agrees with the principles of integrating Social Care and Adult Health. To be effective this process will require new ways of working across organisations and disciplines. For it to be cost effective contracts will need to be aligned across contractor groups to avoid duplication of payment and promote integrated service provision in the interests of improved patient care. There needs to be clear accountability of the Public Bodies involved, including NHS and Social Care agencies and independent contractors. Our understanding is that this Bill sets the initial statutory climate and detailed further guidance, consultation and asset based planning will be required to implement the integration of social care and adult health to ensure resources are used effectively and efficiently to improve quality and consistency of patient centred care.

**To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**

The NPA believes achieving the stated policy objectives is reliant on:

- The quality and measurability of the National Outcomes for Social Care and Adult Health. The outcomes must encompass measurable social and health outcomes from a collective patient perspective and include regular audit and review.
- The facilitation of effective inter-agency joint working between Health and Social Care professionals including independent contractors. This requires shared organisational understanding, common language and communication channels.
- Integration of Joint Board and Locality Planning Groups having the expertise and experience of patient care in the entirety of social and health settings including understanding of all professional disciplines and the contractual terms of all health and social care professionals.

**Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths**

The key strengths of the policy objectives we believe to be:
• The focus on anticipation and prevention of need and effective use of resources.
• The development of a strategic plan for all agencies and that widespread consultation amongst professionals will be taken integral to their implementation.
• Locality planning will be focussed on the needs of the local population.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

• The Bill discusses wide professional consultation, specifically mentioning General Practitioners, it should be a requirement that the overall planning committees include the expertise of all health and social care professions, and the inclusion of all relevant professions in local planning, rather than just by consultation.
• There is lack of clarity on how developed service provision would be signed off and how consultation would be evaluated.
• There is lack of clarity on how budgets will be governed and what will be unsuitable for integration.
• There is a lack of mention of responsibilities of the service provider, user and Third sector involvement in service development in the Bill.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?
The NPA believes community pharmacy is ideally placed at the interface of social care and health services to be vital in the achievement of the objectives of this Bill.

Medicines are the most frequently used health care intervention and pharmacists are the health care professionals who are experts in medicines.

Throughout Scotland a network of over 1200 pharmacies provide essential and much valued services in the heart of communities, including in rural communities, urban deprived areas and the larger metropolitan centres. Community pharmacies are instantly recognisable to patients, very accessible, open longer hours than other NHS sites and have confidential, suitably equipped consultation rooms. Community pharmacy owners have invested in their premises and staff to provide facilities suitable for the safe and effective supply of medicines and advice. Community pharmacists are usually available without an appointment, are frequently the first point of call for those seeking advice and with their staff see a wide spread of the population including those who are collecting prescriptions, and those buying over the counter remedies and seeking support for self care. They see people when they are well in addition to when they are in poor health. Pharmacists being the most accessible healthcare professionals with expert clinical skills and public health service experience are well placed to make opportunistic healthcare and potentially social care interventions, such as offering brief advice on topics such as alcohol use. Pharmacists provide patients and their carer’s access to health information to assist in the management of
conditions. This provision of information could be extended to provide suitable social care information.

Community pharmacists and pharmacy premises are regulated by the General Pharmaceutical Council, and community pharmacy owners are bound by the NHS terms and conditions of being an independent NHS contractor. Community pharmacy staff are part of the NHSScotland team of Primary Care health professionals and have excellent relationships with patients, carers, other local professionals and the local communities in general.

Pharmacies are the healthcare site that has the nearest match to the distribution of deprivation with more than double the numbers of pharmacies in the most deprived areas.

Community pharmacy support often means that patients are able to stay in their own homes for longer or avoid hospital readmission. The current Pharmacy Minor Ailment, Public Health and Unscheduled care services ease the burden on other Primary care services. The Chronic Medication Service provides pharmaceutical care to those with long term conditions including those patients most at risk of hospital admission. This service supports people to get the most benefit from their medicines.

Pharmacies sit where health and social care meet, supporting the frail, disabled or housebound, and carers with the administration of medicines. This frequent contact means pharmacy staff can be the first to notice when things are amiss; this informal monitoring can be transformed into a formal role when linked to other health and social care providers. For example, shared care systems for substance misusers link the pharmacy, key worker, patient and prescriber to the benefit of patient care.

Pharmacy services could be extended to include joint working with social care, or be developed to add further anticipatory care services in order to build capacity for other primary care colleagues to take on integrated services. An example of joint working could be the pharmacy led training of social carers in medicine adherence. Extension of the Pharmacy Public Health Services to include oral contraceptive supply or NHSScotland flu vaccination could build capacity in Primary Care.

Community pharmacy services impact on both patient health and social care as with the supply of compliance aids for use by carers supporting patients paid for out of the Health budget when the benefit is felt by social care. Community Pharmacy contractors drive efficiencies for NHSScotland through Margin Sharing schemes providing cost effective medicine supply.

The NPA believes that community pharmacists take a holistic interest in their patient’s wellbeing and would welcome joint working with other organisations, social and healthcare, to improve quality and consistency of care.
What effect do you anticipate integration plans will have on outcomes for those receiving services?
The NPA believes that locality planning could provide health and social care services that achieve target National Outcomes however we have concerns that some service budgets must have a National Strategy. The NPA believe taking medicine supply budgets to locality planning could trigger “postcode prescribing” and patients “border hopping” to access services not available in their locality. Equity of current services including National Pharmacy Services must be maintained to ensure equitable access to medicines. There will be service provision that has local priorities, which should have additional local funding to be developed over and above current services.

Planning groups should be wary of introducing administrative burden for providers and service users due to local service procedural variance.

Service users and providers will require integrated care pathways for people to move easily through health and social care integrated systems.

It is important that all health and social care professionals who provide support to managing a person’s needs should have access to all appropriate information about that patient. A secure electronic, standard format, person centred care record should be available for all patients and professionals making care decisions in relevant parts with read/write access.

Do you agree with the general principles of the Bill and its provisions?
The NPA agrees with the initial principles in the Bill and await more details as to how the breadth of the joint working will be facilitated, monitored and governed to achieve improved more efficient care.

National Pharmacy Association
2 August 2013
Inquiry Questions

**Do you agree with the general principles of the Bill and its provisions?**
The Red Cross agrees with the general principles of the Bill to integrate health and social care to improve outcomes for people.

However, we are uncertain that the provisions within the Bill will be able to deliver truly integrated health and social care. We would argue that without greater consultation, involvement and participation by other statutory services, the third and independent sectors and people who use services and their carers, integrating delegated functions of health boards and local authorities will not achieve the transformation of services that is required.

**To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**
The Red Cross is supportive of integrating health and social care and believes that integration has the potential to deliver the stated policy objectives of the Bill.

Nevertheless, we feel that without a more formalised role for the third sector there is a risk that the Bill will not fully achieve the policy objectives. The Red Cross would support a stronger requirement in the legislation to establish the third sector as a partner with a crucial role in the planning, development and delivery of care.

Without formalising the role of the third sector in the integration process we remain concerned that integration will be hindered by structural and budgetary issues around the two statutory bodies, rather than focussed on improving outcomes for people.

**Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths.**
The Red Cross welcomes the legislative duty on health boards and local authorities to integrate their services through one of the proposed models. We hope that this will help health boards and local authorities approach the planning, development and delivering of health and social care as one body with a common vision.

Furthermore, we welcome the intention to introduce outcomes for which both health and local authorities will be accountable. This will help to ensure that integration is more than a structural change and is ultimately about achieving better outcomes for people.

**Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.**
The Red Cross feels that the provisions on the involvement of the third sector and users of health and social care services should be made stronger.
There are provisions to consult and take account of the views of representative groups in the integration plan, Part 1 Section 6, however we do not believe this requirement is sufficiently robust. We would suggest that either:

- a third sector representative is required to agree the integration plan or
- health boards and local authorities must demonstrate how they have effectively involved and taken account of the views expressed by persons outlined in Part 1 Section 5 (4).

In case of the latter, if this is not seen to be completed effectively this should be grounds on which the plan can be refused by Scottish Ministers.

This would ensure that the third sector has effective representation in shaping the development of the integration plans.

The Red Cross would also support a formalised partnership role for the third sector in the development of the strategic plans. This would allow for a truly integrated health and social care strategic plan to be developed which encompasses the knowledge and expertise on the ground which the third sector holds.

Finally, the Red Cross believes that it is essential that the national health and wellbeing outcomes are incorporated within Single Outcomes Agreements. We strongly believe that the full potential of this policy objective can only be achieved in partnership with a number of statutory bodies including transport, housing and leisure. It will be critical that all partners are held accountable for achieving the national health and wellbeing outcomes.

**What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

The Red Cross hopes that integration plans will deliver more seamless care pathways, within which it is clear how and where the financial resources are used. This will support the third sector to demonstrate the role it plays in enabling those care pathways.

It is also hoped that this will make the transfer of resources to the community more transparent and help deliver the shift of resources that is required to achieve the policy objectives of Reshaping Care for Older People.

**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

There is potential for integration plans to have a positive impact on outcomes for people receiving services and it is for this reason that the Red Cross supports the integration agenda.

That said, it is critical that integration plans are not dominated by the interests of local authorities and health boards. This must be an inclusive process which takes in all stakeholders and partners to ensure that truly integrated health and social care services across all sectors is achieved.
The integration plans provide a way of driving forward change as long as the knowledge and expertise of users of services and carers, independent providers and the third sector are adequately utilised. This will enable integration plans to develop which are built around an outcomes based approach and able to demonstrate how best to meet the needs of people in Scotland.

British Red Cross
2 August 2013

The British Red Cross helps millions of people in the UK and around the world to prepare for, respond to and recover from emergencies, disasters and conflicts. Our volunteers and staff help people in crisis to live independently by providing support at home, mobility aids and transport. We also teach first aid skills. We are part of the global Red Cross and Red Crescent humanitarian network. We refuse to ignore people in crisis.

The British Red Cross provides the following health and social care services:

- **Support at home** - short-term practical and emotional support at home to help people regain their independence.
- **Mobility aids** – lends wheelchairs and other independent living aids
- **Transport support** – support to people affected by crisis by providing transport for medical appointments and essential daily needs
- **Hand, arm and shoulder massage** - to promote wellbeing for people who need support at home and to relieve stress in emergencies.
Capability Scotland

Capability Scotland campaigns with, and provides education, employment and care services, to disabled people across Scotland.

Summary

- Capability Scotland believes that this legislation provides a real opportunity to reinforce the social model of disability by enabling people to live independently and maintain wellbeing, rather than being forced to rely on medical intervention. This shift in the balance of care should also enable disabled people to access the services they require by removing unnecessary administrative and budgetary barriers.

- As the Scottish Government has acknowledged, the third sector is particularly skilled at early intervention and taking a preventative approach to care and support. We would therefore urge the Scottish Government to ensure that service-providing organisations, and the third sector more widely, are given a seat at the table in the development of integrated services. The duty to consult with third sector representatives should be strengthened.

- The integration of health and social care services will make it increasingly difficult to maintain the tenuous distinction between health care which is free at the point of delivery and social care which can be charged for. This distinction will become more difficult to justify as health and social care work together to achieve shared objectives from a shared budget.

- The Social Work (Self Directed Support) (Scotland) Act 2013 will give most older and disabled people the right to receive direct payments to pay for their care and support. Greater clarity is required regards the ability to integrate healthcare within a Self Directed Support package.

Do you agree with the general principles of the Bill and its provisions?

1. Capability Scotland supports the general principles of the Bill as stated in sections 4 and 25. We would, however, like the legislation to make reference to public bodies' duties to take a rights-based approach to service planning and delivery. In particular, we would like consideration to be given to how services can be arranged in such a way that leads to the realisation of individual's rights through high quality, equitable services. Incorporation of a principle on the realisation of individual rights would not create new duties but would consolidate existing duties contained in the Human Rights Act 1998, Patients’ Rights (Scotland) Act and Social Work (Self Directed Support) (Scotland) Act 2013.

2. Capability Scotland also believes that there is a need for a particular emphasis to be placed on equitable access to services. This reflects our
concern that integration will result in some individuals having to pay more to access care and support services than others. The Bill currently makes no mention of how local authority policies on charging for social care services will be affected by their integration with NHS services. Once an integrated system is in place, with a shared budget and shared outcomes, identifying services which can be charged for will become increasingly difficult. Further, while we welcome a shift away from hospitalisation and towards independent living, we are concerned about the impact this will have on the amount disabled people are asked to contribute to the cost of their care. While living at home with care and support is clearly preferable to living in a hospital, it can also be more expensive for the individual who may have to pay care charges.

3. Thus, while it may be too complex to address the finer details of this issue in the current legislation, an underlying principle of equality of access would ensure that no group is left at a disadvantage when accessing health and social care services.

4. Capability Scotland also support the Coalition of Care and Support Providers in Scotland (CCPS)’s concern that the principles should make reference to involving people in the design of their care and support, and enabling them to exercise appropriate control over how it is delivered. We believe that such a focus will be key to driving change and achieving better outcomes for individuals.

**To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?**

5. Capability Scotland believes that the approach proposed in the Bill could lead to the stated policy objectives being achieved. However, in order for this to happen, the legislation must be accompanied by a cultural shift and wider work force and public education. It will be essential that both staff and members of the public understand the values behind integration and the objectives they are working towards. In particular, we believe staff should receive training on the principles of independent living and disability equality.

6. We also believe that the policy objectives are more likely to be successfully achieved in areas where a great deal of consideration has already been given to the implications of integration. Community health and social care services for older people, for instance, have been at the centre of this Bill’s development and surrounding debate. Less consideration has been given to the implications of this Bill for those age groups (such as children) and services (such as housing) which were not central to its conception. As a result, there has been insufficient consideration of how the requirements set out in the Children and Young People (Scotland) Bill will apply to joint bodies. There is a risk that these various pieces of legislation will lead to an uncoordinated approach to planning.

7. We are also concerned that applying the principles of integration to some services before others will lead to new ‘transition points’ emerging. Currently, young disabled adults, for instance, have difficulties moving between services...
designed for children and those designed for adults. The subsequent changes to entitlement and provision leave many struggling to access the services they need. We would therefore prefer to see a degree of integration across all services to avoid the creation of new transition points between integrated and non-integrated services.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths
8. The rationale of integrated service planning and delivery and shared national outcomes is extremely positive and should help to dismantle some of the barriers that disabled people face to accessing the care and support they require. Problems with existing structures were illustrated by a recent call to Capability Scotland’s Advice Service. The caller explained that his son had struggled to access the care and support he required to live independently. The young man had had a tracheotomy because of breathing difficulties and sometimes stops breathing overnight. His father approached the local authority about the possibility of social work services to allow more flexible care so as to obtain help and support for his son to get out and about. He was told that as his son had “medical needs, not social needs”, this was not an option for him. Hopefully, integration will help to tackle difficulties such as this.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
9. The Bill places duties on integration authorities to consult the third sector. We support CCPS’s view that this duty is not strong enough. The third sector, and specifically its service providers, should be treated as full partners in the planning and delivery of care and support.

10. We are also disappointed that the legislation provides a range of models for integration, rather than requiring joint integration bodies to be established in each area. There is a concern that where Health Boards are responsible for administering the joint budget, spending will be disproportionately focused on medical services. This is a particular worry for disabled people who are likely to benefit disproportionately from spending on more social care services.

11. As the Committee is aware, the Social Work (Self Directed Support) (Scotland) Act will give most older and disabled people the right to receive direct payments to pay for their care and support. Several people have contacted Capability Scotland’s Advice Service to ask whether integration will make it possible for them to use their direct payments to purchase services delivered by the NHS. We would like more clarity to be provided on this issue which will obviously become increasingly pressing as community health and social care services become indistinguishable.

12. We are also concerned 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. It is disappointing that whilst the policy memorandum is specific on the need for independent scrutiny of strategic commissioning, the Bill itself makes no reference to it.
13. Furthermore, Capability Scotland is concerned that there is currently no adequate and independent mechanism available to people who want to challenge joint decisions relating to entitlement for care, assessment of need or care charges. We would urge the Scottish Government to ensure there is an independent, effective and human rights-compliant process available to hear appeals against social care decisions. These could include the assessment of care needs, the provision of care, and the charges applied. It is essential that such a process can review and, if necessary, overturn such decisions.

**What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

14. The Bill places a duty on 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’. As a third sector service provider, we hope this provision will give us a larger role in planning local services which meet the requirements of our customers.

15. The Bill also provides an excellent opportunity to reinforce the social model of disability by enabling people to live independently and maintain wellbeing, rather than becoming overly reliant on medical intervention. It should also begin to break down the needless barriers between budgets which have made it administratively difficult for disabled people to access the services they require.

16. The extent to which the Bill’s proposals benefit those who use Capability Scotland’s services will, however, depend on how actively they are employed by public bodies. There are several areas where we believe integrated budgets would be extremely beneficial to our customers. The Scottish Wheelchair Service, for instance, has traditionally been part of the NHS. However, given the huge impact the service has on people’s ability to live independently – and the fact that wheelchairs often meet a social as well as a medical need – we think there is scope for social work to play a bigger part in the service. Passage of this legislation will give the Scottish Government and NHS Boards an opportunity to consider how the wheelchair service can benefit from this agenda.

**Capability Scotland**  
2 August 2013

**About Us**
Capability Scotland campaigns with, and provides education, employment and care services for, disabled people across Scotland. The organisation aims to be a major ally in supporting disabled people to achieve full equality and to have choice and control of their lives by 2020. More information is available at www.capability-scotland.org.uk.
Public Bodies (Joint Working)(Scotland) Bill

British Dietetic Association

The British Dietetic Association Scottish Board welcomes the opportunity to respond to Stage 1 consideration of the Public Bodies (Joint Working)(Scotland) Bill.

This response reiterates many of the points from our earlier submission at the consultation phase.

Do you agree with the general principles of the Bill and its provisions?

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The general principles of the Bill are supported and the introduction of this legislation, to enable the integration of health and social care, provides a real opportunity to improve the delivery of health and social care services for the benefit of the people of Scotland and provide a seamless system for services users/patients.

As is recognised however, legislation alone will not bring about these changes and the integration of two quite different organisations is going to take time and effort.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

The legislation not only enables Health Boards and local authorities to integrate planning and service provisions for adult health and social care services, the framework permits that this can be broadened further.

The development of a common set of outcomes nationally is welcomed as is the fact that this will introduce a mechanism for ensuring that Health Boards and local authorities are jointly and equally accountable for planning and delivery of effective integrated services.

The stated involvement and consultation with partners is also welcomed. It is important that there is full recognition of the range of health and social care professionals to include AHPs. AHPs are already working across health and social care and have a wealth of expertise and knowledge which it is important to capture and use at all levels, both nationally and locally.

The Allied Health Professions Federation Scotland (AHPFS), which provides collective leadership and representation for its member professional bodies, provides a key route for accessing AHP expertise and access to the AHP professions in Scotland, to include the dietetic profession.

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

AHPs currently have a statutory seat on Community Healthcare Partnership committees. With the removal of these, it is important that AHPs are still in a
position to taken an active role in and provide leadership on decisions around local planning and service provision. As above, AHPs are already working across health and social care and have a wealth of expertise and knowledge which it is important to capture and use at all levels, both nationally and locally.

Whilst there is recognition that in order to address local needs there will be a requirement for some flexibility in terms of structures, functions and delivery etc, it is important that this is balanced with some standardisation of processes and potential regulation as necessary to ensure some consistency of delivery and quality across Scotland.

**What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

For those working in health and social care, including Dietitians, the delivery of integration plans provides opportunities for improved communication and decision making, greater joint working and reduced duplication. It also creates the opportunity for greater flexibility to create different options for packages of care and skill mix.

For these benefits to be fully realised however, there are many challenges that will need to be addressed and systems put in place to facilitate this. IT systems which have the ability to talk to each other and information sharing systems are examples of a number of challenges which will need to be overcome to allow for effective integration between health and social care.

There will be benefits to both the profession and to service users if the profession are fully involved and recognised for their role in the delivery of effective integrated health and social care services.

**What effect do you anticipate integration plans will have on outcomes for those receiving services?**

By facilitating the integration of health and social care services, The Bill provides the framework to provide real opportunities to improve the delivery of health and social care services for the benefit of the people of Scotland.

---

**British Dietetic Association**

2 August 2013

The British Dietetic Association, founded in 1936, is the professional association for registered dietitians in Great Britain and Northern Ireland. It is the nation’s largest organization of food and nutrition professionals with over 7,000 members. About two-thirds of members are employed in the National Health Service. The remaining members work in education, industry, research, sport settings or freelance.

Registered Dietitians (RDs) are the only qualified health professionals that assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Uniquely, dietitians use the most up to date public health and scientific research on food, health and disease, which they
translate into practical guidance to enable people to make appropriate lifestyle and food choices.

Dietitians are the only nutrition professionals to be statutorily regulated, and governed by an ethical code, to ensure that they always work to the highest standard. Dietitians work in the NHS, private practice, industry, education, research, sport, media, public relations, publishing, NGOs and government. Their advice influences food and health policy across the spectrum from government, local communities and individuals.

The title dietitian can only be used by those appropriately trained professionals who have registered with the Health Care Professions Council.
Public Bodies (Joint Working) (Scotland) Bill

Parkinson’s UK

Do you agree with the general principles of the Bill and its provisions?
Parkinson’s UK supports the principle of integrated services, but we have some concerns that this Bill focusses on structures to such an extent that outcomes for people receiving services are largely lost. We would like to be able to see this as truly enabling legislation - not just in the legal sense, but in terms of enabling individuals and families to have a better experience of care and live as well as they can.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
Parkinson’s UK believes that the proposed Bill as proposed will succeed in integrating statutory structures, but we are not convinced that this will necessarily result in improving the quality and consistency of health and social care services.

The Bill’s focusing on statutory agencies, may have the unintended consequence of impeding the development of the broader, cross-sectoral partnerships that are needed to develop more effective person-centred services.

We are also concerned that the Bill itself is silent on matters of quality, as opposed to “improving wellbeing”. We believe that it is essential that integrated services are planned and commissioned on the basis of quality, and not just cost. There is confusion about the extent to which the existing mechanisms in health and social care to promote quality will apply across integrated services.

We believe that contrary to increasing consistency of service provision, the Bill may drive increasing variation. Although the Bill clarifies governance arrangements, it proposes four potential models, and allows for very different approaches to the incorporation of wider issues, such as housing and transport, which have a significant impact on people’s lives. There is also likely to be significant variation in the involvement of non-statutory partners, and the little detail about how locality planning will work in practice. Parkinson’s UK believes that there is high potential for variation between HSCPs.

Please indicate which, if any, aspects of the Bill's policy objectives you would consider as key strengths
The Bill will improve the transparency and consistency of governance arrangements, addressing a major concern raised by Audit Scotland in its recent report on CHPs.¹
Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

Lack of clarity about which existing laws, policies and procedures will apply to service users, providers and professionals

There are a number of areas where the status of people that will use integrated services is very unclear. For example:

- will everyone who uses integrated services be covered by both the Patients’ Rights Act and the Self Directed Support Act?
- which complaints procedures will apply to people using integrated services?
- to what extent will the NHS Quality Strategy apply to integrated services?
- will responsibility for scrutiny of integrated services lie with the NHS Healthcare Improvement Scotland or the Care Inspectorate?

At worst, this could lead to real gaps in independent scrutiny for essential services supporting extremely vulnerable people. Even if HIS and the Care Inspectorate remain clear on their scrutiny duties, there may be confusion amongst service providers, and it is extremely likely that people and their families will find it more difficult to identify their rights and make sure that they receive the quality of care to which they are entitled.

Risk of “Cost creep”
Parkinson’s UK has very particular concerns about issues arising from integrating free, universal NHS Services with means tested social care that is subject to eligibility criteria. We have previously written to the committee outlining our concerns about “cost creep” in the light of the crisis in NHS Continuing Care, where it appears that many people are having to pay for social care to meet health needs that which ought to be funded by the NHS.

We believe that the integration 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. From the experience of NHS Continuing Care, we are particularly concerned that this is particularly likely to affect people in two groups – those with progressive neurological conditions and those with conditions, including Parkinson’s, which most commonly affect older people.

Human rights, Person-centredness and assets
Parkinson’s UK notes that recent legislation covering the NHS and social care were explicit in adopting a human rights framework, and we are disappointed that there is no reference to rights within this legislation.

Parkinson’s UK believes that the Integration planning principles cover very important areas (seamlessness, equity, diversity, local leadership and engagement from a range of sectors, prevention focus, efficiency). However, although the Policy Memorandum refers positively to principles of co-production, the Bill does not reflect them, allowing statutory bodies to avoid
engaging with service users and local communities as equal partners in designing services.

We are extremely concerned that the Bill refers to service users passively, typically as “recipients” with “needs” to be “met”. In contrast, the Self Directed Support Bill typically refers to “a person” and the “support” and “care” that is “provided”.

The Bill’s language and approach is a backward step from the Christie Commission’s focus on harnessing individual and community assets. We believe that the integration planning principles should reflect this approach, including a person-centred commitment to providing services that enable people to live the best lives that they can with their condition.

National health and wellbeing outcomes
Parkinson’s UK warmly welcomes the power for Ministers to prescribe national health and wellbeing outcomes, but we are concerned that the intention is to link these to Single Outcome Agreements rather than HEAT targets. We are concerned that there is considerable variation in the approach that local authorities take to Single Outcome Agreements, that they go largely unscrutinised, and that it is unclear what action will be taken if SOAs are not met. We believe that health and wellbeing outcome targets would have a greater potential impact if they were expressed as HEAT targets.

Marginalisation of voluntary sector and service user voices
Parkinson’s UK shares the concerns of other third sector organisations that the Bill marginalises third sector and service user involvement in integration plans. The title refers only joint working between statutory bodies, yet effective planning and service provision involves joint working between NHS, local authority, voluntary sector, commercial interests and individual service users and families.

There is a duty for statutory bodies to consult on integration plans in Section 6, and to form a consultation group for strategic planning in section 26, but being a consultee is a long way away from being an equal partner. We fear that the locality planning arrangements could very easily become a “rubberstamping” exercise, rather than a genuine process of engagement and partnership working. There is no clear proposal to replace the Public Partnership Forums that exist within CHPs. In many areas of Scotland, these have provided helpful channels for service users, carers and the public to become involved.

The proposal that only NHS Board and Local authority elected members should have voting rights marginalises the voluntary sector, and any public or service user representatives. We recognise that there may be concerns around accountability, but believe that the principle should be that all members of the HSCP have equal voting rights to avoid tokenism. The Reshaping Care for Older People Change Fund enabled voluntary sector representatives to vote, and the evidence shows that they discharged their voting rights responsibly.
There should be safeguards around conflict of interest in the case of service providers influencing outcomes in favour of their services. These should apply to all members, including those from statutory agencies who may have a conflict of interest in respect of service provision.

Parkinson’s UK believes that the Bill needs to do more to recognise the diverse contributions that the voluntary sector can make. While a third of Scotland’s social care is provided by the voluntary sector, many voluntary sector organisations, including Parkinson’s UK, do not provide care services. We have a valuable contribution to make through our work with people affected by Parkinson’s. We support people affected by Parkinson’s as service user representatives and also use our contact with thousands of families in Scotland to give voice to the experiences of people living with the condition.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?
As Parkinson’s UK is not a provider of care services, we will not experience direct efficiencies from the delivery of integration plans. If integration is successful, we would expect it to be easier for our team of local Information Support Workers to provide support and signposting for people with Parkinson’s, unpaid carers and families to access the support that they need.

What effect do you anticipate integration plans will have on outcomes for those receiving services?
We hope that integration plans will improve outcomes for individuals and families, allowing for a more person-centred journey.

However, as the NHS Healthcare Improvement Scotland Clinical Standards for Neurological Health Services\(^5\) state, people with Parkinson’s require ongoing access to specialist multi-disciplinary support throughout the course of their condition.

Without appropriate care, people with Parkinson’s are at high risk of:
- expensive emergency hospital admission
- extended hospital stays
- premature care home admission

About one in four people with Parkinson’s is admitted to hospital at least once each year, and more than half of these admissions are unplanned.\(^6\) One in ten of all people with Parkinson’s are classified by ISD as a very high risk of hospital re-admission within the next year.\(^7\)

It will be essential to ensure that the new framework allows for ongoing specialist “health” input, including from Parkinson’s nurse specialists, alongside social care services, and that reallocation from acute budgets does not have the consequence of reducing specialist input to those who need it most.
Parkinson’s UK also recognises that some hospital and care home admissions are entirely appropriate, and believes it is imperative that integration does not have the impact of preventing hospital admissions when they are needed.

**Parkinson's UK**  
2 August 2013

**About Parkinson's**  
About 10,000 people in Scotland people have Parkinson’s.

Parkinson’s is a progressive, fluctuating neurological disorder, which affects all aspects of daily living including talking, walking, swallowing and writing. People with Parkinson’s often find it hard to move freely. There are also other issues such as tiredness, pain, depression, dementia, compulsive behaviours and continence problems which can have a huge impact. The severity of symptoms can fluctuate, both from day to day and with rapid changes in functionality during the course of the day, including sudden ‘freezing’. There is no cure.

The average age of onset of Parkinson’s is between 50-60 years of age, and incidence increases with age. One in twenty people with Parkinson’s is diagnosed before the age of 40.

For further information, please contact Tanith Muller, Parliamentary and Campaigns Officer for Parkinson’s UK in Scotland, tmuller@parkinsons.org.uk, telephone 0844 225 3726.

---

2 Patients' Rights (Scotland) Act 2011  
3 Self Directed Support (Scotland) Act 2012  
6 Parkinson’s UK analysis of ISD figures (unpublished).  
Public Bodies (Joint Working) (Scotland) Bill

Midlothian Council

1. Do you agree with the general principles of the Bill and its provisions?

Yes, but it is important that there is no uncertainty about the nature of continuing accountability to both NHS Boards and Local Authorities. Recent discussions with Senior Policy Officers from Scottish Government confirmed that such accountability remains the Government’s intention, alongside a determination that the new Boards will have real power to make the service changes required. A more explicit statement to this effect within the Bill is necessary to ensure there is no remaining ambiguity which could unhelpfully deflect attention from improving and transforming health and care services.

2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

It is critical that the structural changes arising from the Bill are not considered an end in themselves but rather a means to strengthening joint working and thereby improving outcomes for users and carers. There remains a danger of preoccupation with structure particularly with the complete dissolution of Community Health Partnerships and the need to develop alternative structure and governance arrangements for all health services, not just those focussing on adults and older people.

The requirement for Integration Plans and Strategic Plans is 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.

3. Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

The emphasis on strategic commissioning is helpful in avoiding the potential preoccupation with governance and internal processes relating to resources, information sharing etc which arguably weakened the previous Joint Future policy implementation.

4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

Whilst the expectations regarding more efficient working are understandable, many of the anticipated improvements from the new arrangements will impact primarily on improved experiences for patients/service user. Clearly, supporting and treating more people at home, based on models of care underpinned by a commitment to prevention and recovery, should reduce public service expenditure. However the increasing demands arising from demographic changes, growing public expectations, and changing models of care including technological change, will inevitably give rise to continued
additional pressure on public service budgets. The expectation, referred to in the Financial Memorandum, that real savings can be achieved through the implementation of the Bill, is not only unrealistic but potentially unhelpful if it were to become the primary indicator of success.

Moving resources from the Acute Sector will be very challenging given the continual pressures on hospitals in terms of growing standards and public expectations. The Reshaping Care for Older People Change Fund has been helpful in enabling a period of bridging to new models of care but this fund is due to end in March 2015. This will potentially increase the pressure on the Acute Sector given the difficulties local partnerships will face in identifying alternative funding for a range of innovative community-based services.

5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

The integration agenda will enable improved service delivery at home supporting the whole health and social care system, thereby helping to absorb increased demand within the current financial envelope. Our local experience in recent years confirms this is achievable but such transformation is not a science and to specify the level of actual real savings within the context of the Bill assumes a greater degree of understanding and control over the rate and scale of the transformation process than is likely to be the case in reality.

The benefits of more joined-up service provision, more user-friendly pathways for patients and a whole system approach to the delivery of health and social care services have driven the local transformation process in Midlothian. We firmly believe the enactment of the Bill will greatly accelerate this approach.

Midlothian Council
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Dr Jenny Ure (Individual)

Context:
I am replying in my capacity as a carer, as a member of the Alliance, and as a researcher involved particularly with the experience of patients, nurses and GPs in the implementation of new telehealth services for long term conditions in the Lothians.

Do you agree with the principles of the Bill & what it is trying to achieve?
Agree with the aims wholeheartedly, as:
- current services are the worst of many different options, economically, clinically, socially because they are not integrated around users

They are fragmented, involve multiple sets of conflicting and often inaccurate records, alienate users and carers, try to make one size fit all, prevent patients and carers informing more targeted care that is more likely to achieve its objectives. In this parents, carers and carer groups are a wasted resource. (This is particularly evident in complex conditions such as mental health, where there are disagreements on diagnosis, and additional legal complexities, over and above fragmentation and duplications of information and services across agencies)

- users of services are an under-utilised resource for adding value, and cutting the cost and risk of failed implementation such as Choose and Book!

In my research capacity, have been most struck by the value of patient/carer input for design and implementation, and the lack of organisational and statutory representation that might harness this free resource in building more cost-effective systems. (eBusiness services on it so why reinvent the wheel!) There's a lot of research on this that is never publicised, showing the economic value of patient/carer input.

Will the proposed approach achieve these aims?
- Unsure is the bill is specific enough about the mechanisms (organisational and legal) to achieve these very laudable and necessary aims, since there will be tensions between stakeholders, and there will be alternative delivery scenarios. The lack of formal mechanisms for including users in practice, and more importantly, the lack of representation of users and carers at the decision-making level means that

The design and implementation of new, often digitally assisted services at scale in eBusiness and in eHealth has also been characterised by lack of differentiation between the structures needed for different kinds of services

(a) those services that can be most cost-effectively organised centrally (e.g. vaccination programmes), using the existing infrastructure
(b) those services that need a lot of tailored local input and agency – as in the care of many older people with complex conditions - where the input of patients, carers and others in the community is essential for this to be effectively targeted, and more cost-effective to boot.

ICT-based services particularly, such as NHS Connect, and other telehealth services have failed precisely as a result of lack of mechanism for engagement with users from the design through to implementation stages. (Can provide research data on this from several studies in eHealth and eBusiness).

Involving users as arbiters of services is already established as more cost effective in eBusiness, as well as obviously the preferred option by users themselves. This is particularly so in areas such as mental health, where there is NO clear pathway in the experience of carers, optimizing the economic, social and clinical damage for service users and their families, and society in general.

The potential weakness of the Bill is if the mechanisms are too vague, at the level of engagement, and more crucially, at the level of feeding back the view of users into policy and practice in a consistent and coherent way. In other words there has to be a new Bill of Rights in essence for the reconfiguration of roles and rights with arises from user centric services, and particularly from digitally-assisted user services at scale.

**Will the proposed approach achieve these aims?**

Given shrinking resources for services, and given competing agendas and models, this will be hard to achieve by any means, although I do believe strongly (as a researcher and a carer) that it is the most cost-effective and the most human approach.

In particular, there is a strong tension between the model adopted in forma/traditional primary care by GPs, which is based on rationing time and specialist resource for those who are clearly already ill, as opposed to the preventative health and well being model which is much discussed, but clearly sidelined in primary care.

There is a need for new legal ‘Bill of Rights’ in this sense, but also because the digital nature of new services has already outstripped the existing legal framework for dealing with new opportunities, and new risks.

**Recommendations**

- New vehicles for service redesign

Look at ‘experience based design’ as a mechanism for getting stakeholding users to identify and enter into negotiation about new roles, risks and resource allocations, the NIHR (Nat. Inst. Of Health Research) have used very effective mechanisms to involve stakeholding users, in what they call experience based research, and which businesses call business process re-engineering, but
which researchers might call collaborative action research, or just straight participation.

- New legal rights for carers and carer communities

  As legal entities in research, development and pathway design for this kind of serviceso that (a) the very abstract aims of user centred services can be translated into the real landscape of needs and use in practice (b) they are not only included in ‘consultations’ but have a statutory and executive role in decision-making. Carers and patients, particularly in groups like PASDA, have the knowledge of the context and the barriers to best inform implementations that often failed when centrally executed. They are a real and under-used resource that is free! (Wikipedia, web 2.0, Facebook are all successfully driven by concerned groups

- Clarity about how service users and their families will manage their information – will it be something like MyDex for personal information management? Until there are pilots and people can have a go, this will be too intangible to challenge the status quo.

Dr Jenny Ure (Individual)
2 August 2013
The GMC is the independent regulator for doctors in the UK. Our statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

We do that by controlling entry to the medical register and setting the standards for medical schools and postgraduate education and training. We also determine the principles and values that underpin good medical practice and we take firm but fair action where those standards have not been met.

Where any doctor fails to meet those standards, we act to protect patients from harm if necessary, by removing the doctor from the register and removing their right to practise medicine. Action may also be taken to uphold public confidence in the medical profession.

The GMC welcomes proposals to improve joint working to support the integration of health and social care in Scotland. In reviewing any structural changes to integrate health and social care you may wish to consider potential impacts on the mechanisms in place to assure patient safety and which ensure referrals to the GMC are made when appropriate.

One key mechanism now in place is medical revalidation, introduced in December 2012. Revalidation is a continuous process through which the GMC ascertains that individual doctors are up-to-date and fit to practise medicine. Any integrated joint boards employing doctors would likely be ‘designated bodies’ under UK regulations pertaining to the GMC’s revalidation process. Joint boards which employ doctors would therefore need to be aware of their responsibilities regarding doctors they employ. These responsibilities are set out in the Responsible Officer Regulations. These regulations were made by the Department of Health (England) and apply to Scotland and Wales also (separate regulations apply in Northern Ireland). The Department has provided guidance to accompany the regulations. The regulations and guidance are below.

[Responsible officer regulations and guidance.](#)

The GMC has well established processes to support new designated bodies. Any new designated body, or any doctor whose employer changes, should contact the GMC.

General Medical Council
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

South Lanarkshire Council

Do you agree with the general principles of the Bill and its provisions?

The general principles of the Bill is to improve health and social care services for patients and service users through more effective joint working. We absolutely agree with these principles, although we feel that integration may not be the only way of ensuring that this is achieved. The Bill, as it stands, provides a framework for integration which should allow for some local flexibility in pursuit of the stated national outcomes.

To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The Bill allows for structural and organisational changes and this will have some impact on service delivery and outcomes for patients and service users. It should help to reduce boundaries between professional groups that are exacerbated by organisational arrangements and result in clearer care pathways. However, the biggest impact on service delivery is linked to practice and the Bill will not necessarily impact on practice, particularly where practice is linked to professional codes of conduct and standards. Integration may start discussions across professional bodies about role, professional competence and boundaries but it will not in itself resolve these issues. Integration of health and social care will also not deal with the greatest area of disconnect which is within the health service: that is, the interface between primary and secondary care. Although the Bill makes some provision for the transfer of Acute budget streams to integrated health and social care partnerships, it is stated that this will relate to unplanned care only, and is likely to focus on professional groups such as AHPs and continuing care nursing and not tackle the more fundamental issues that exist across acute and primary care.

Integration will also have the potential to create new disconnects between services currently provided by Social Work services particularly those which work across justice and adult services or children’s and adult services.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths.

We welcome the national outcomes framework which will both replace and strengthen the former Community Care Outcomes Framework. This provides a clear set of objectives for each health and social care partnership. We would expect, over time, that this set will replace the benchmarking indicators currently proposed by SOLACE to simplify reporting and benchmarking across health and social care.

We also welcome the fact that there is scope for local flexibility in establishing integrated health and social care partnerships. South Lanarkshire has a history of strong partnership working across the key statutory partners, and
this has been strengthened with the implementation of Reshaping Care for Older People. We will be building on these strong foundations when agreeing the best possible model for us at local level.

Please provide details of any areas in which you feel the Bill's provisions could be strengthened.

A great deal of the detail has yet to be determined and this has brought some challenges in considering the potential impact of the Bill. For example, the Bill does not specify the minimum set of services that will be included in the integrated body – in particular the funding streams and services associated with the Acute sector is very undefined - and this makes it difficult to plan in a holistic way.

More specifically there are issues relating to finance and governance that could be strengthened.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

Organisational efficiencies and benefits are unlikely to be achieved in the immediate or short term, but we expect there to be longer term benefits as workforce planning and development is embedded across the new, integrated body.

In a separate response prepared for CIPFA this Council has also raised concerns that the level of funding made available to support integration is inadequate and in places is based on flawed assumptions. Little consideration is given to the financial implications of IT harmonisation, and there has been insufficient provision made for support services, clinical and other stakeholder involvement in locality planning, VAT and ongoing staff costs.

What effect do you anticipate integration plans will have on outcomes for those receiving services?

Our experience of running integrated services is that service users receive a more streamlined service, with greater, more natural contact across different professional groups. This has been the case with the Community Older People’s Team in Cambuslang and Rutherglen, and early indications from the Integrated Community Support Service in East Kilbride and Strathaven support this view. These services have been developed within organisational structures that remain separate but which have worked to create teams that work in an integrated manner. Formal integration should enable this approach to occur as the default position and provide easier access to service users to the services they require.

South Lanarkshire Council
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

British Healthcare Trades Association

The British Healthcare Trades Association (BHTA) is one of the UK’s oldest and largest healthcare associations (founded in 1917). Its membership - of some 460 UK companies employing over 17,000 people - comprises both large and small businesses across the many non-pharmaceutical and assistive technology sectors of the healthcare industry. Our members manufacture goods and supply goods and services.

However, we represent predominantly SMEs supplying the NHS and local authorities. The products our members make and supply are as varied as hearing aids, wheelchairs and scooters, seating and positioning products, electronic communication devices, rehabilitation products, first aid equipment, aids and services for children and for visually impaired people, and even prosthetics and orthotics. We also provide training for health and social care professionals and many of our members are “hands on” in assisting people to live independent lives in their own homes.

BHTA welcome the publication of the Public Bodies (Joint Working) (Scotland) Bill and the contribution greater integration of health and local authority care services can make to improved patient care and a more focussed, strategic approach to key issues. We agree that the main purpose of integrated services should be to improve the wellbeing of recipients and to make the most effective use of public resources.

Our members fulfil an important role as providers of goods and services to both bodies. In this regard we know of occasions where members’ ability to provide the best possible service has been compromised by lack of effective communication between Health Boards and local authority partners and where goods supplied by the acute sector have not been suitable for community use by a patient.

We also welcome recent complementary Scottish Government efforts to harmonise local authority and Health Board boundaries which we believe will be effective in supporting better service provision.

While we agree with the establishment of integration joint boards and joint monitoring committees and the removal of Community Health Partnerships we note that better integration is not guaranteed by a change in structure or the setting up of new bodies.

Effective joint working relies on the individuals working within Scotland’s local authorities and area Health Boards. It requires a change in culture as much as a change of structures. We would not wish to minimise the progress made in terms of joint working. Our members cite good and effective practice in terms of the use of joint stores. It is essential that the issue of joint budgeting is effectively addressed.
We are content that the final decision about how the integration authority will be set up (body corporate or delegation between partners) should be left to the local partners to decide. We note also that some parts of the country already have joint arrangements in place which, our members suggest, are working well and this would allow those arrangements to continue.

We agree with plans to allow Health Boards to contract on behalf of other Health Boards and to allow Scottish Ministers to form a wider range of joint ventures.

We appreciate that there might well be some financial consequential impacts affecting some businesses. However, we believe that these are likely to be transitional costs, such as training, that would not deliver significant, long term detriment to our members.

We note that section 110 of the Financial Memorandum states that “There are no additional regulations or requirements being placed on private sector stakeholders. In respect of collaborative procurement, the powers sought will be used in the context of existing contractual arrangements and documentation. The proposals will not impact on access to public sector markets.” And section 111 says “For Health Boards, there will be increased flexibility in the procurement of facilities and a consequent reduction in both development and on-going costs. Private Sector Development Partners have already been selected via open procurement in accordance with EU procurement law.”

BHTA is engaging with the Scottish Government on the forthcoming procurement legislation as well as on an ongoing basis on behalf of our members. Despite the assurances contained in the Financial Memorandum, we would be concerned if in any way the suggested changes were to restrict choice and innovation in respect of medical devices and other products supplied by our members. Scotland is highly dependent on external supply so it’s important that the Scottish Government encourages suppliers to continue to participate so that choice is not marginalised as a result of integration. We are also aware that patient groups are concerned that any restriction of choice could be to the detriment of patient care. Reducing choice can also be a false economy if it results in further expensive care to rectify resulting problems, often in hospital.

British Healthcare Trades Association
2 August 2013
Public Bodies (Joint Working) (Scotland) Bill

South Ayrshire Council

- Do you agree with the general principles of the Bill and its provisions?

South Ayrshire Council (SAC) supports the principles behind the Government’s proposals to better integrate Health & Social Care Services for Adults and to remove perceived barriers to improving systems of care. In addition, the Council supports 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.

The Council has concerns about the potential created for significant central direction in the provisions of the Bill, which is not in keeping with the Government’s Response to the Consultation Exercise. Ministers are seeking significant powers to direct Integration Joint Boards and Statutory Partners, which as currently drafted, has the potential to significantly undermine local democratic decision making and the stated objective of locally planned services for local people and local communities.

- To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

Beyond a general welcome of the development of national outcomes, the principles of integration and the general management approach detailed in the Bill and accompanying documents, it is difficult, at this time, to fully endorse or otherwise, the Government’s approach as much of the detail will not be known until regulations and guidance are published, potentially, much later in the process.

The Council remains concerned, based on the Bill and the information currently available, that the proposals may not address the key systemic disconnect that exists between the acute and community sectors as stated in the Council’s response to the original Consultation Exercise. 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 there will not be an end to “cost shunting.” There is currently no information available on the extent of the acute budget that will be redirected to Partnerships.

As was stated in the Council’s response to the Consultation Exercise, the current arrangement in relation to GP contracts creates no imperative for them to reduce emergency admissions. The proposals outlined do not remedy this, nor do they create the necessary driver to shift the balance of care away from acute hospital services to community care. SAC urges, therefore, that this is considered as part of the Parliamentary process.
• Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

The Bill creates a framework for change which the Council hopes will provide a catalyst for developing new ways of working and provide access to the most appropriate services delivered in a seamless way for service users, their families and carers.

The creation of national outcomes and principles for service delivery are key strengths, as are the proposals to make Councils and NHS Boards equal partners in the provision of services through Joint Integration Boards. The role envisaged for third sector organisations, service users, carers, G.P’s and other professionals in the planning and delivery of services should improve the quality of decision making.

The emphasis on locality planning and the recognition that service planning, resource allocation and service delivery can be more effectively and efficiently provided at a local level, in a way that seeks to address the individual needs of local communities, is in the Council’s view, an important aspect of the Bill. This more than any other part of the legislation will be fundamental to securing change and driving on-going changes to the provision of care and the balance of care in the future.

Similarly, the recognition of the need for an integrated budget planned and overseen by one Chief Officer is a significant step forward and is likely to facilitate a change in the way services are delivered and in the culture of those involved in delivery.

• Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

It is difficult to be definitive on this point at this time given that so much of the detail of the Government’s approach will remain unknown until regulations and guidance are published, both of which are likely to be informed by the recommendations of the National Working Groups which are still to report. For this reason we think it is very important that the secondary legislation is subject to affirmative procedures.

One of the Council’s primary concerns about the draft legislation, as it is currently presented, relates to the potential to undermine locality planning and local democratic control, which the Government has stated are cornerstones of its approach and fundamental to its success, as a result of the significant powers which Ministers intend be given to them through the legislation to direct operational matters within individual partnerships.

SAC is concerned that the Bill contains no meaningful proposals to address the disconnect between the acute and community care sectors. As this is where the most significant financial resources are spent and where such disconnects impact most significantly on the outcomes for individual services users, this is a weakness in the Government’s proposals as detailed in the
Bill. Given this concern, the need to achieve a shift in the balance of care should be included as one of the new nationally agreed outcomes.

Government and Parliament should also consider ways of requiring the appropriate involvement of all GP’s in Health & Social Care Partnership’s and in actively seeking changes to the balance of care within agreed parameters. Such involvement of GP’s in the planning and delivery of service provision across the full range of all of the alternative services available is likely to be a significant factor in unlocking the redirection of funding from the acute sector to the community sector.

South Ayrshire Council has, through various reforms, taken steps to integrate the delivery of its social work services to provide seamless support for families and service users and has done this in a way that also integrates these with its education and housing services, with all of these services being part of the one Directorate and subject to scrutiny review by the same Panel of Elected Members. Whilst the Council appreciates and supports a move to achieve better integration between adult health and social care services, it regrets the potential that the Government’s proposals have to create new barriers between Partnership delivered services and Council services and the re-creation of barriers so successfully dismantled in South Ayrshire in recent years.

The proposals could be strengthened by more clarity being provided in respect of the employment of staff and in relation to which body or bodies will have responsibility for the delivery of services. The draft legislation appears somewhat contradictory on these points, indicating on the one hand that it is not envisaged that Integration Joint Boards will directly employ staff or deliver services, while on the other stating that the legislation will enable this while indicating that there could be financial reasons for not permitting it. This uncertainty adds to difficulties both in the planning of future service delivery and in the development of management structures to support integration.

Parts of the draft legislation are overly prescriptive and again are at odds with the principles of local democratic control and effective and efficient service planning and delivery through localities. A particularly significant example of this is the minute detail in the Bill about how Statutory Partners will conduct the Strategic Planning process.

It may also be helpful if there was further clarity between performance reporting and outcomes and consideration given to the role of scrutiny within the performance process.

- **What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

The Council expects that there will be efficiencies from the introduction of integrated budgets, joint planning, joint commissioning and through the streamlining of front-line service delivery. However, given the lack of detail within the Bill, it is too early to be able to quantify this in any meaningful way.
and there is a risk, where there is more than one local authority per health board area, that this will present special challenges, one of which could be in terms of efficient working arrangements.

The Council expects, over time, as new cultures and approaches bed in and as strategic plan objectives deliver progress against the new nationally agreed outcomes, that the greatest benefit will be to service users and carers. Although, this will be dependent on the resource base keeping pace with the increasing demand for services.

- What effect do you anticipate integration plans will have on outcomes for those receiving services?

South Ayrshire Council expects, over time, that the integration plans will lead to improved outcomes for those receiving services through more integrated working at local level based on effective joint planning and resourcing of services, improved information sharing and simpler and less risk adverse processes and systems. The delivery of this, however, will be dependant both on effective engagement, particularly with all of the professionals involved and be equally dependant on a significant retraining and organisational development programme designed to change organisational, professional and individual cultures and approaches.

South Ayrshire Council
2 August, 2013
Public Bodies (Joint Working) (Scotland) Bill
Equality and Human Rights Commission

The Equality and Human Rights Commission is the regulatory Body for equality and anti-discrimination law in Scotland, England and Wales, with a statutory remit to protect, enforce and promote equality across the nine "protected" grounds - age, disability, gender, race, religion and belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment. The Commission is also one of Scotland’s two National Human Rights Institutions (NHRIs), with a duty to monitor and report on human rights.

The Commission welcomes the opportunity to give evidence on the Public Bodies (Joint Working) (Scotland) Bill at Stage 1. We previously submitted evidence to the pre-legislative consultation in September 2012. Our comments will be placed in the wider context of the public sector reform agenda in Scotland, particularly the recommendations of the Commission into the Future Delivery of Scotland’s Public Services (the Christie Commission), published in the summer of 2011.

Equality Regulation and Devolved Public Authorities in Scotland
The purpose of the public sector equality duty is to ensure that public authorities and those carrying out a public function consider how they can positively contribute to a more equal society through advancing equality and good relations in their day-to-day business, to:

- take effective action on equality
- make the right decisions, first time around
- develop better policies and practices, based on evidence
- be more transparent, accessible and accountable
- deliver improved outcomes for all.

The public sector equality duty requires equality to be considered in all the functions of public authorities, including decision-making, in the design of internal and external policies and in the delivery of services, and for these issues to be kept under review.

On 27 May 2012 specific regulations, the ‘Scottish Specific Duties’ drafted by Scottish Ministers and passed by the Scottish Parliament, came into force. These set out the steps that key public bodies, including councils and health boards, need to take to meet the requirements of the duty. These steps include requirements to:

- report on mainstreaming the equality duty

---

• publish equality outcomes by April 2013 and report progress
• assess and review policies and practices
• consider award criteria and conditions in relation to public procurement

The EHRC has produced a set of non-statutory guidance on the duties\(^2\). We have published our preliminary analysis of the information published in April 2013\(^3\), and will publish further qualitative analysis in late summer 2013.

With their emphasis on gathering evidence and setting outcomes, the Scottish Specific Duties have clear parallels with the wider outcomes-focused policy environment in Scotland, and the Commission is encouraged that the Scottish Government is planning future work to better align the Public Sector Equality Duty with the National Performance Framework\(^4\). This will have value not just at the national level, but locally, where evidence gathered and outcomes set under the specific duties can and should help public authorities deliver against national outcomes and indicators.

**Equality, Rights and the Public Service Reform Agenda in Scotland**

The Christie Commission report sets out clearly (pp.53-60) the links between inequality and “failure demand”, that is, resource-intensive responses to symptoms rather than causes; and the need to shift to a preventative approach which prioritises early intervention, builds public services which are responsive to users’ needs and is grounded in the principles of dignity and fairness. The report explicitly recommends that public services should be encouraged to tackle inequality and promote equality.

The policy memorandum accompanying the Bill\(^5\) also highlights the Christie Commission recommendations and so situates the Bill’s policy intentions within the wider public service reform agenda in Scotland. With this in mind, it is useful to consider evidence gathered by the EHRC earlier in 2013 on how equality and human rights principles were being applied by policy makers working in public service reform, and particularly health and social care integration. This research was intended primarily to inform the Commission internally, and interviewees were approached on that basis, so the points raised here will be general.

The broad thrust of the evidence gathered by the Commission suggest a strong willingness to embed equality and human rights principles in policy

---


\(^4\) [www.scotland.gov.uk/About/Performance/scotPerforms/Messages](http://www.scotland.gov.uk/About/Performance/scotPerforms/Messages)

\(^5\) [www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20Joint%20Working%20Scott%20Bill/b32s4-introd-pm.pdf](http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20Joint%20Working%20Scott%20Bill/b32s4-introd-pm.pdf)
development and a recognition on the part of officials and others of the value that this brings. However, it also suggests

- widespread confusion between process and outcomes (e.g. setting up a reference group vs. delivering tangible changes to people's lives on the ground),
- at times, a legalistic and compliance-led understanding of equality and human rights (e.g. what needs to be done to avoid censure or to remove the threat of legal action), and
- challenges around identifying the impact equality and human rights principles have actually had on policy development.

This evidence suggests that there is a lot of value in the distinctive, outcomes-based approach to policy-development and implementation in Scotland, but it also suggests that there remains a gap between the Christie principles of promoting equality in public service reform in Scotland and the reality.

**Comments on the Bill**

The Commission supports the general principles of the Bill, and recognises the significant shifts since the 2012 consultation, and the impact that our and others' arguments have had on policy makers. For example, we welcome the shift away from age-specified older people as the initial focus for health and social care outcomes, and the move to a more general focus on all users' wellbeing. We also welcome the shift to a less prescriptive approach, with more emphasis on providing a minimal framework and on allowing agencies to determine locally what specific arrangements will work best for them and those they serve. In line with the context provided above however, we would make several further points:

1. **Policy Aims:** The consideration of equality and human rights in the accompanying policy memorandum is still very process-oriented, with the emphasis on the steps taken in drafting an EQIA and setting up a reference group. In line with the comments above, we feel that this is a missed opportunity to demonstrate how the policy intentions of the Bill are aligned with the Christie Commission's emphasis on the links between equality, talking "failure demand" (see above) and building more responsive services. Building a solid analytical framework based on the very different experiences and expectations of all health and social care service users requires robust equalities evidence at the very start of the policy process. This opportunity is removed if equalities groups are only invited to give views to already partially developed proposals.

   The policy aim of delivering more person-centred and responsive services is likewise strengthened where outcomes are formulated with reference to clear human rights principles such as dignity, liberty, and agency. Human rights and equality principles should help policy makers articulate where it is they want to get to.

2. **Structures and User Involvement:** A common criticism of the pre-legislative proposals was that they were very professional and clinician-
led, and that the voice and priorities of the end user was in danger of being lost. To that end, more still needs to be done to ensure that users are equal partners not just on the process of integration, but to the wider purpose of integration (e.g. resource allocation, seamless delivery of health and social care services, eligibility criteria and assessment). This is, again, in line with the Christie recommendations, and would go some way towards the kind of embodiment of equality and rights principles which we have touched on elsewhere.

3. Explicit Reference to Equality and Human Rights Principles: health and social care leaders, working together with service users should articulate explicitly how integration joint boards will, through their integration plan deliver services which are based on human rights principles and equality outcomes. The key public authorities sitting on these boards are all subject to the Scottish Specific Equality Duties, so should be able to refer back to their individual corporate equality outcomes and ensure that these are properly aligned with integration boards’ shared plans. We would support recommendations made by disabled people’s organisations and the independent living movement that the related principles of independent living and co-production are also embedded in the development and revision of integration strategies.

Conclusion
The Commission welcomes and supports the policy intentions of the Bill, and recognises its role in the wider policy challenges of public service reform in Scotland. Similarly, we support ministers’ and policy makers’ recognition, in line with the Christie recommendations, of the value of embedding equality and human rights principles in this process. However, there remain challenges, many of which are wider and more complex that any one piece of legislation, in developing a clearer sense of how and why equality and human rights are integral to the development of more responsive, person-centred and, ultimately, sustainable public services in Scotland.

Equality & Human Rights Commission
16 August 2013
The Chartered Institute of Public Finance and Accountancy

CIPFA, the Chartered Institute of Public Finance and Accountancy, is the professional body for people in public finance. CIPFA shows the way in public finance globally, standing up for sound public financial management and good governance around the world as the leading commentator on managing and accounting for public money.

EXECUTIVE SUMMARY
There are a series of tests which should be applied and passed before any new legislation is brought forward:

1. the impact of existing legislation is clear and has been tested;
2. the case for new legislation has been made;
3. the cost and consequences of the new legislation are transparent, and that
4. there is a clear timescale for post-legislative impact assessment to determine whether the legislation is having the impact claimed in the original case for legislation

In submitting comments to the current proposals for integration of adult health and social care in Scotland, we have assessed and considered the extent to which new and revised primary legislation is in fact required. It is our view that the case for new legislation has not been made within the current consultation document.

The absence of any significant post-legislation scrutiny has meant that Parliament and government have not reviewed the impact of existing legislation in the area of health and social care integration.

All evidence points to leadership as the key ingredient to improving outcomes and the consultation document fails to address leadership capability and capacity and instead focuses on matters which would be cornerstones for structural reform.

1 THE CASE FOR NEW LEGISLATION

1.1 The current proposals for the integration of health and social care are being presented against the background of an existing and established legislative framework. That framework which has been in existence since 1999 was formalised by primary legislation with the introduction of the Community Care and Health (Scotland) Act 2002. This was later followed by further primary legislation, the NHS Reform (Scotland) Act 2004.

1.2 This existing legislation was designed as the statutory basis as part of the then emerging joint future agenda which built on earlier local health care cooperatives (LHCC’s) to encourage a more formal framework for joint planning and joint resourcing. The 2004 legislation established Community Health Partnerships (CHP’s). The existing legislation which enables
integration of health and social care is less than ten years old. We have therefore sought evidence that the Scottish Parliament could demonstrate that it had received clear evidence of the impact of the existing legislation and that the legislation had in fact been tested.

1.3 We found that no such tests had in fact been carried out other than the recent Health and Sport Committee inquiry into integration of health and social care. This enquiry was held in 2012 following the Scottish Government announcement of (then) forthcoming proposals for integration. The scope of that inquiry was limited to two questions only. These questions focused upon the challenges of integration and the barriers to be addressed. The intention of the inquiry was to use the findings to scrutinise “...any future legislation”. The inquiry did not review the effectiveness (or otherwise) of existing legislation.

1.4 In examination of the final inquiry report and of the quoted witness statements we observed that no adverse comments were made or conclusions reached on the existing legislation.

1.5 Consequently, we undertook further investigation to identify what evidence there was available to support the introduction of further legislation. The Scottish Government undertook a study and published a paper which assessed progress, evidence and options on integration. The study reflected on integration based on the Clyde Valley study undertaken by Sir John Arbutnott. The Scottish Government document in considering the potential for further integration in Scotland noted that:

“The benefits of integration can be realised in Scotland using the flexibilities already permitted by existing legislation...”

1.6 Although this is only one extract from a lengthy document, the meaning is not in doubt. Unsurprisingly, given this phrase, the Scottish Government paper, in referring to the existing enabling legislative framework did not indicate any deficiency in legislation.

1.7 We then reviewed Audit Scotland’s report on their review of community health partnerships. Audit Scotland’s key messages did not conclude on any deficiency of existing legislation but, included references to the need to streamline partnerships, a more systematic joined up approach to planning and resourcing and the need for strong leadership. We will return to leadership later in this paper

1.8 We have seen no evidence which would indicate that the existing legislative framework is in any way deficient. Any perceived failure to integrate is not as a result of a failure of legislation.

1.9 We conclude therefore that, the case for new legislation has not been made and we recommend that before there is any further legislative development, that robust post-legislative scrutiny is undertaken of the existing legislation.
2. THE CASE FOR INTEGRATED HEALTH AND SOCIAL CARE DELIVERY

**Leadership**

2.1 In our review of the evidence base for integrated service delivery, there was one recognisable and recurring theme. That theme was consistently identifiable as a key ingredient for success and which was summed up in one single word. Leadership. There is a body of evidence which indicates that the need for strong leadership is greater than the need for a further legislative solution and is greater than any focus on any particular model of delivery\(^\text{11}\).

2.2 The Scottish Government 2010 paper sets out key lessons from all available evidence on integration. It specifically refers to Leutz’s sixth law that all integration is local and success will hinge on strong local leadership which identifies solutions to specific local problems\(^\text{12}\).

2.3 Audit Scotland’s review of CHP’s in 2011 identified that partnership working for health and social care is a challenge and that it required “..strong, shared leadership by both NHS boards and councils”\(^\text{13}\).

2.4 The 2012 Health and Sport Committee inquiry identified leadership and culture as a key theme concluding that there must be a development of “strong and collaborative leadership…at a local level”\(^\text{14}\).

2.5 Finally, the Institute for Research and Innovation in Social Services identified the need for leadership as one of the factors which enhanced integrated working.

2.6 We have found the evidence for the case for leadership to be convincing and we consider that efforts to empower local leadership will be a stronger instrument of change than the development of further legislation will be.

**Structural Integration**

2.7 The consultation paper does not propose either structural reform or integration of a structural nature. The Scottish Government funded research in 2010 entitled ‘Financial Integration Across Health and Social Care: Evidence Review’ stated that\(^\text{15}\)

*There is little evidence that structural integration is either necessary or sufficient for achieving integration of care and partnership working*.

2.8 Surprisingly, given this statement, the consultation paper does address a range of issues which relate to external and internal governance frameworks. For example, the paper considers the issue of joint accountability, a feature of a bodies external governance framework and the detail of committee structure, generally regarded to be a feature of a bodies internal governance framework\(^\text{16}\). External and internal governance framework issues would generally be regarded as key issues when considering structural reform of an organisation.

2.9 The consultation document therefore feels contradictory. It does not set out to achieve structural reform of NHS and Local authority social services and yet many of the issues under consideration (and therefore being
considered for legislation) are the cornerstones of structural reform.

**Financial Integration**

2.10 A full chapter of the consultation paper is dedicated to integrated budgets and resourcing. The paper describes that a key priority is to “put an end to cost shunting between the NHS and local authorities”\(^{17}\). The proposed solution, as well as stated cornerstone of the consultation paper, is that there should be an integrated budget.

2.11 The proposal is for the integrated budget to include health, social care and some acute hospital services. The paper goes on to make the case that a fully integrated budget will result in a shift in the balance of care and ultimately ensure “..the best ..outcome for the individual”\(^{18}\).

2.12 A Scottish Government Social Research paper in 2010 explicitly stated however that\(^{19}\): 

“there was no evidence that the use of joint financing was associated with improved health outcomes”.

2.13 The institute for Research and Innovation in Social Services reflected on “tentative evidence that financial integration can be beneficial” while concluding that evidence for improved outcomes or cost savings was lacking\(^{20}\).

2.14 The Audit Commission noted difficulty in being able to quantify the extent to which joint financing arrangements have directly achieved better value for money or has demonstrated improved outcomes for users\(^{21}\).

2.15 Despite this evidence the Scottish Parliament’s, Health and Sport Committee in its inquiry concluded that being unable to establish genuinely integrated budgets has acted as a barrier to efforts to integrate health and social care.

2.16 Audit Scotland’s 2011 review found that there was limited progress in joint funding in Scotland and considered it unlikely that local authorities and NHS boards would move quickly towards more integrated budgets.

2.17 Overall, the evidence base does not support the significant focus which is applied to budget integration within the consultation document. Evidence would suggest that financial integration does not result in better outcomes. Limited progress to date in Scotland with financial integration is not because of an absence of legislative power to integrate financially. Effective post-legislative scrutiny of the impact of the existing powers for financial integration would identify some of the issues underlying a perceived failure to integrate. Consequently, we remain unconvinced that financial integration is the key driver to achieving improved outcomes.

**Achieving Outcomes with Integration**

2.18 The base premise for the consultation and for the existing legislative framework is that essentially that integration will result in an improved service
and in better outcomes. This is the essence of the proposed new legislation – that the revised arrangements will in fact make a difference to the service user.

2.19 The Institute for Research and Innovation in Social Services reviewed the evidence base for partnership and integrated working. It concluded that there was\textsuperscript{22}:

“a dearth of research evidence to support the notion that joint working between health and social services is effective”

2.20 It further concluded that most of the research had focused upon the process of partnership working rather than the consequences of that joint working. The Scottish Government in its summary of available evidence on effective integration stated that any integration should be for the right reasons and that\textsuperscript{23}:

“attempts to impose integrated care in a top down manner have been less successful”

2.21 Of most significance however is the finding again from the IRISS which stated that\textsuperscript{24}:

2.22 Although the consultation paper states that the focus is on “what matters most to people who use services”\textsuperscript{25} no evidence is provided that service users wish to see changes to governance, accountability and to integrated budgets or indeed that these are cornerstone issues for securing better outcomes. We do support the vision of the Scottish government and its commitment to improved outcomes. We do however doubt, based on available evidence, that further legislation is the solution to achieving better outcomes.

The Chartered Institute of Public Finance and Accountancy
8 August 2013

Notes:
1 Introduction of GP led Local Health Care Cooperatives. April 1999.
4 Health and Sport Committee 5th Report, 2012 (Session 4) Inquiry into Integration of Health and Social Care. 4 May 2012
5 Page 3, paragraph 14, Health and Sport Committee 5th Report, 2012 (Session 4) Inquiry into Integration of Health and Social Care. 4 May 2012
10 Pages 4-5, Review of Community Health Partnerships. Audit Scotland,
June 2011.
12 Page 3 paragraph 3.3 i), Integration Across Health and Social Care Services in Scotland – Progress Evidence and Options. The Scottish Government, March 2010
13 Page 10, Key messages, Review of Community Health Partnerships. Audit Scotland, June 2011
14 Page 13, paragraph 68, Health and Sport Committee 5th Report, 2012 (Session 4) Inquiry Into Integration of Health and Social Care. 4 May 2012
16 Chapters 4 and 5, Integration of Adult Health and Social Care in Scotland, Consultation on Proposals. May 2012.
17 Paragraph 5.1, Chapter 5, Integration of Adult Health and Social Care in Scotland, Consultation on Proposals. May 2012.
18 Paragraph 5.9, Chapter 5, Integration of Adult Health and Social Care in Scotland, Consultation on Proposals. May 2012
23 Page 3, paragraph 3.3 a) Integration Across Health and Social Care Services in Scotland – Progress Evidence and Options. The Scottish Government, March 2010

"The journey towards integration needs to start from a focus on service users and from different agencies agreeing a shared vision for the future rather than from a structures and organisational standpoint"
Public Bodies (Joint Working) (Scotland) Bill

East Renfrewshire Community Health and Care Partnership

Background to Comments
East Renfrewshire Council and NHS Greater Glasgow and Clyde took the decision to create a fully integrated Community Health and Care Partnership in 2005. The CHCP has a single Director accountable to both the Chief Executive of the Council and to the Chief Executive of NHS Greater Glasgow and Clyde. The Director is on the Council’s Corporate Management Team and the Senior Management Team of the NHS Board.

Evidence on principles and approach
We agree with the principle of a focus on wellbeing. East Renfrewshire CHCP was established with an ambitious agenda. The purpose of the CHCP included both the management of ALL local NHS and social care services, i.e. fully integrated provision; and to improve the health of its population and close the inequalities gap.

As we move towards more of a focus on early intervention and prevention, the importance of the new integrated health and care partnership being fully embedded within both partner organisations cannot be under estimated. As a fully integrated CHCP, our Health Improvement Team has provided support and encouragement to the wider in their public health role and is seen as an integral Council as well as health service. Similarly the Early Years Collaborative is being led by the CHCP with the full support of the Council CMT and elected members.

When East Renfrewshire CHCP was established, the CHCP Committee became a formal part of the community planning structures. The CHCP Director represents the NHS at community planning meetings and leads the NHS contribution to the Single Outcome Agreement making this a very simple and efficient process. We consider it vital that this ‘golden thread’ is retained and strengthened through the new.

Evidence on outcomes and benefits
East Renfrewshire CHCP was formed to create a single integrated mechanism for service delivery when previously services had been split across health board areas resulting in very different models and access to health care within the same local authority area. The scale of the CHCP and the principle of being co-terminus was important to the partners’ vision of modern and integrated community health and social care services focused on natural localities. We have found this successful in terms of outcomes for local people and local accountability and ownership.

The whole of the local authority social work service is managed within the CHCP as well as the majority of community health services. The CHCP is also responsible for the prescribing budgets for local GPs and for the contracts with local GPs, dentists and pharmacists.

There are advantages in this arrangement which significantly outweigh the challenges:
• Care pathways are developed from a customer/patient perspective not along organisational boundaries. For example, there is one senior manager responsible for older people services – from home care to district nursing to older people’s mental health services.
• Close relationships with local voluntary organisations and community groups – essential for developing community capacity and networks of support.
• Close relationships with other Council Departments – essential for truly collaborative working to promote health and wellbeing in its widest sense.
• No dislocation between children and families services and adult community care – particularly important when working with vulnerable families.
• Developing strong relationships with primary care enabling us to cluster services around this ‘universal’ provision – the family doctor.
• Significant savings in management / accommodation and back - office costs.

Evidence on barriers and issues where the Bill could be strengthened

Integration plans

We assume that section 3 and 4 and others apply equally to Integration plans: same local authority and Health Board area and Integration plans: two or more local authorities in Health Board area but this is not clear due to the current layout of the proposed legislation.

Assessment

Locally we have developed plans for a Single Point of Access to screen all referrals for both health and social care “help”. Instead of having parallel routes the plan is to have all referrals coming to one place and decisions being made on the most appropriate response by a multi disciplinary team involving health and social work professionals.

However our understanding based on discussions with the Council’s Chief solicitor is that due to the local authority’s responsibilities under the SW Scotland Act 1968 to promote social welfare and by extension offer an assessment where people with potential needs come to their attention and issues around indemnity where functions normally undertaken by local authority employees are “delegated” to health employees is that the referrals will all need to be assessed (not a full written assessment, but a professional judgment made) by a local authority member of staff (usually social work but could be an Occupational Therapist). The decisions then need to be “signed-off” by a social work team manager since unlike most health professionals (nurses etc) social workers are not “independent practitioners”. All decisions they make are subject to oversight and scrutiny by a more senior professional. Potentially, the net result is a potentially clumsy and time-consuming system which requires a social work manager to oversee many more referrals than...
they would previously have done and fails to make best use of valuable people and other resources

Another potential issue is that where an assessment is undertaken by an NHS staff member for and this leads to a ‘local authority’ services being accessed the council has essentially delegated an assessment function to the NHS. The advice is that this brings potential difficulties for the council’s liability. This may even be problematic where assessment is reviewed by a local authority employed professional (usually social work, but could be occupational therapist).

We would like to understand how the Bill will overcome these barriers and enable a more streamlined service for adults and older people without putting either the Local Authority or NHS at risk of additional liabilities. It should also be noted that any emerging arrangements for operational leadership and management need to take into account the differences between professional groups and their registration arrangements.

Information sharing
We are currently experiencing barriers in enabling NHS staff to access Council IT systems and Council staff to access NHS IT systems. This is vital in developing shared records and facilitating shared management. In particular we are very concerned about the implications of recent advice from the Cabinet Office that PSN cannot be ring fenced and that unmanaged end user devices (i.e. non council or non corporate devices) cannot be allowed to connect to the council network. Our current agile working programme rests on the assumption that NHS staff using NHS devices can access council systems when out visiting patients in order to read and record appropriate information about their care and support needs, thus ensuring a service that is integrated from the point of view of recipients. We would like the Bill and its guidance to overcome some of the information security barriers that currently prevent the integration of information systems and networks.

Conclusion
We would like to reiterate our support for and commitment to integrated health and social care. We have worked hard to achieve integration under current legislation and our observations have been made in the light of this practical experience of promoting wellbeing from within both the NHS and Council and trying to deliver an integrated service that is focused on supporting people to achieve their personal outcomes.

East Renfrewshire Community Health and Care Partnership
8 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Marie Curie Cancer Care

1. Marie Curie Cancer Care is pleased for the opportunity to respond to the Health and Sports Committee’s call for written views on Public Bodies (Joint Working) (Scotland) Bill which was introduced in Parliament on 28 May 2013.

2. Marie Curie gives people with all terminal illnesses the choice to die at home. Our nurses provide them and their families with free hands-on care and emotional support, in their own homes, right until the end. In Scotland we run hospices in Edinburgh and Glasgow, which provide free specialist medical care for those with serious illnesses, and emotional support for their families, giving them the best possible quality of life.

3. Wherever possible, we work with statutory partners to support service redesign and innovation that will benefit people at the end of life and their families. In Scotland we work in partnership with NHS Scotland – funding 50% of every Marie Curie Nurse commissioned. We spend approximately £12million directly on the care of patients at the end of life. Highly skilled and experienced staff within our two hospices in Edinburgh and Glasgow along with our 400-strong nursing service provide palliative and end of life care to patients and support to their carer’s and families. We care for more than 1,500 patients a year in our hospices in Scotland and over 3,500 at home through our nursing service.

4. End of life care often relies on both health and social care working together to deliver a person-centred package of support that meets their needs. For example, those wishing to receive their care at home may need to have adaptations and adjustments made to their home, before they can be discharged from hospital. Without an integrated and seamless approach patients can face unnecessary delays to discharge.

5. Our response is based on our experience as a charity which specialises in end of life care and is a major care provider. We believe that a strong emphasis on end of life care must be at the heart of the integration agenda. Our ageing population, together with the increasing number of people who have multiple morbidities, means that over the coming decades there will be increasing pressure on services and a clear need to focus on the way that we provide services for people at the end of life.

6. We welcome the Scottish Government’s integration agenda and its commitment to delivering improved outcomes through integration as set out in the Bill. We believe that everyone should have the right to receive integrated, person-centred and seamless support based on their needs and wishes at the end of life. This Bill has the potential to play a significant part in achieving this.

7. Marie Curie has a number of successful services and projects which are currently using an integrated approach to delivering health and social care, which we believe can act as examples of good practice for NHS Boards and
local authorities across Scotland.

8. In 2013 we launched the ‘Confident Caring’ programme, which works to empower the carers of patients with terminal illness to care with confidence. The programme was designed in partnership with a multi-disciplinary group of representatives from NHS Boards, the third sector, NHS specialists in the acute setting and those based in a community care setting.

9. In June 2011, we started our Palliative Care ‘Fast-Track’ Discharge Service in Glasgow and Lothian. Our specialist, Fast-track Palliative Care Discharge Liaison Nurses arrange the support patients need immediately after their discharge home. This is done in discussion with other healthcare and social care professionals involved in the patients’ care in the hospital and community.

10. We would be happy to provide further information on each of these projects, as well as facilitate any visit the committee might like to make to see these projects as part of its deliberations on the Bill.

11. Marie Curie has a number of concerns, questions and suggestions that we would like the Committee to consider as the Bill proceeds through Stage One, which we have set out below.

Integration Planning and Delivery Principles

12. We welcome the integration planning and delivery principles of the Bill, however we feel that they are too vague and the language is somewhat divorced from the principles of co-production and person-centred care. The Bill defines individuals as ‘recipients’ according to ‘need’ as opposed to partners who have the right to receive quality care. Until legislation defines people as equal partners in the delivery of their care there will remain a disconnect between providers and those requiring care. We would like to see the principles of the Bill amended to put individuals at the heart of the Bill to encourage a more person centre approach to care, that would see them as partners and not ‘recipients’.

13. The Bill very clearly sees integration as primarily between health and social care, which we believe undervalues the crucial role that the third and voluntary sector plays in delivering health and social care. We would also like to see the principles set out in the Bill strengthened so that they adequately address/outline the need for integration between statutory providers and the third sector.

Strategic Commissioning and Culture Change

14. We welcome the commitment in the legislation to strategic commissioning. Effective strategic commissioning and co-production must follow the integration process in order for the new regime to be successful. It is vital that those responsible for joint commissioning at a strategic level are proactively engaging with service users, their carers and the third sector as a significant
provider of services. We welcome that the third sector has been recognised in the Bill, but believe that too often the sector is limited to a consultative role. Voluntary and community organisations have expert knowledge of local populations, strong delivery records and their unique nature and situation should be recognised by commissioners and their advice and support seen as integral to informing decisions at a strategic level.

15. Currently, far too often we see local authorities and others resort to competitive tendering for the recruitment of services, which often leads to a ‘race to the bottom’ rather than a quality service that will truly meet the needs of the service users.

16. What is not clear is if/how the Bill will define strategic commissioning as different from public sector procurement. Commissioning in post-integration Scotland must not cherry pick the public procurement reform programme’s focus of ‘maximising efficiency’ and ‘delivering cash savings’ without remembering the need for collaboration and a focus on outcomes. Third sector service providers such as Marie Curie have the experience, the expertise and the ethos that enables us to advise commissioners on what is required dependent upon the best interests of the patient and the value that a provider can bring.

17. We believe that the Bill does not suitably address what will be sea changes in culture for the majority of statutory health and social care providers. The effects of the Bill will see not only a systems change across the board but a change for the people that work within these deeply embedded systems. All those involved in the integration agenda will need to work hard in order to overcome those cultural challenges. The third sector can provide a real insight into the provision of flexible, constantly changing services whilst working alongside a variety of partners and as such can play an important role in bringing health and social care bodies together.

Voting Rights and Representation

18. Within the Bill, we welcome the Scottish Government’s overarching premise that the third sector should be more involved in the delivery of health and social care. However, such a premise is undermined by the fact that the proposed integration authorities will be accountable only to NHS Boards and local authorities. Marie Curie believes that the third sector should be included as voting partners on the proposed integration authority boards.

19. It should be noted that if the third sector was granted voting rights it would not outnumber the statutory partners. The benefits of engaging fully with the third sector are numerous – the sector would add an invaluable and informed voice to proceedings. This was demonstrated during the ‘Reshaping Care for Older People’ initiative. The opportunity for true collaboration across sectors should not be lost.
National Outcomes

20. Marie Curie supports an outcome-based approach to the delivery of health and social care. National health and wellbeing outcomes show a clear commitment to the rights of the individual as opposed to top-down, budgetary based priorities of delivery. At present we believe that the proposed outcomes, along with the integration planning principles, are too vague and we are looking forward to further details in the subsequent guidelines. In addition it is not clear how the proposed national health and wellbeing outcomes will fit with the national outcomes set out as part of The National Performance Framework, or how they will sit with Single Outcomes Agreements. We believe that the relationship of these outcomes needs to be explained so that it is crystal clear what outcomes organisations and services are working towards. It will be crucial for the third sector to be involved in the shaping of these outcomes from the very beginning of the process.

21. The commitment to health and wellbeing outcomes must not be lost within the process of integration. Improving outcomes for people has long been a staple of the third sector and in the midst of changing cultures, budget-sharing, IT streamlining, workforce planning and other issues, this must remain the goal of integration.

Integrated Budgets and Self Directed Support

22. We believe there is a need for further clarity on how integrated NHS Board and local authority budgets are to be calculated, agreed and managed. The recently passed Social Care (Self Directed Support) Act will result in a significant amount of the local authority’s social care budget being earmarked for those seeking to directly manage their own budget and those that want a third party to manage their budget. This raises a number of questions and concerns that need to be addressed. Will calculations for establishing an integrated health and social care budget be taken before or after budget planning for self directed support has taken place. How will this process affect the final integrated budget for the integration authority? Under the integration model will those individuals that have opted for option one under the Social Care Act, and who also require healthcare, be able to manage their own health budget or will healthcare budgets remain the preserve of the NHS Board? Will local authorities become more involved in assessing who requires end of life care? Will the jointly accountable officer have oversight of the patients care pathway in order to inform their decisions?

23. We would ask for clarity on how the Bill will link in to legislation such as the Social Care (Scotland) Act as well as other upcoming legislation such as the Community Empowerment Bill and would strongly suggest that this is laid out within the Government response to the consultation.

24. Though it is stated that the minuitiae of each integrated budget will be outlined within the strategic plan, we would suggest that there is a need to explain how this will work before the Bill proceeds to allow the third sector to fully appreciate the implications.
25. We welcome the Government’s recognition that the Bill should not be seen as a cost cutting exercise however we would urge caution that it may be used as such at a local level.

Approval and Accountability

26. The fact that strategic plans are to be approved by Scottish ministers throws up issues that are not addressed within the Bill. Upon what grounds will ministers approve or reject plans? Will they be required to consult the third sector and service users about the final approval of plans? Local authorities and health boards have the power to revise rejected integration plans without further consultation, which we believe should not be the case. We believe that if a plan is rejected that there should be additional consultation.

27. During the Reshaping Care for Older People process, sign off by the third sector provided a tangible bridge to cultural change within Change Fund initiatives and the power of such engagement should be harnessed to inform future integration initiatives such as those contained within the Bill.

28. The integration of health and social care cannot provide a solution to every problem. This comes sharply into focus when looking at the resourcing of healthcare services. With or without the integration process we have a number of resource issues such as an ageing workforce and the shortage of nurses who are vital to ensuring transition from the acute to the community setting without the loss of service provision.

29. As a significant member of the third sector we are concerned that the Bill’s focus is upon merging two very different cultures and the structures involved with that. We would urge caution that the integration process does not become the complete focus of the Bill and its aftermath. This will lead to agencies losing sight of improving outcomes for service users, which will ultimately affect service delivery.

30. We would be happy to provide further written or oral evidence during the committee’s deliberations during Stage One of the Bill.

Marie Curie Cancer Care
9 August 2013
Council of Deans of Health

About the Council of Deans of Health
The Council of Deans of Health (CoDH) is the representative voice of all 85 UK higher education institutions (HEIs) with faculties providing education and research for nursing, midwifery and the allied health professions. The Council seeks to play an influential leadership role in improving health outcomes through developing an expert health workforce and through utilising its collective expertise to inform innovative educational practice and translational research. In Scotland, our membership comprises the universities of Edinburgh Napier, Glasgow Caledonian, Aberdeen, Strathclyde, Dundee, Abertay, Stirling, Edinburgh, Glasgow, Robert Gordon, West of Scotland, Highlands & Islands and the Open University. All Scottish HEI members of CoDH are also members of SHANAHP (Scottish Heads of Academic Nursing and Allied Health Professions) and the two organisations work closely together.

Overview
The Council of Dean welcomes the opportunity to submit written evidence on this Bill. We have answered those questions which are relevant to our membership and areas of expertise. There are 4 main areas that we have concerns with and have been expanded on in answer to the questions below:
- Quality assurances for service provision
- Safeguards for existing healthcare budgets
- Adapting the workforce for the new structures - in particular, as to organisational culture differences

Written Evidence Questions & Answers

Do you agree with the general principles of the Bill and its provisions?
To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

CoDH cautiously welcomes the principles of what the Bill is trying to achieve. That is, seamless care for service users.

However we also recognise that in bringing the health and social care services together, there are a number of challenges which will arise. For example, the bringing together of two different professional sectors with their own cultures and practices will need to be addressed. This will range from the approach of patient care to differences in terminology. Furthermore research and practice has shown that relationships, communication and culture are core to successful joint-up working. This does not appear to be articulated in the Bill, but rather focuses more on the structures, governance and performance elements. We do recognize that fostering a culture change is not easy and cannot simply be defined in statute, but something could be included in the Bill which acknowledges this issues that requires providers to take measures (such as conduct appropriate training) where appropriate to ensure a smooth transition and ensure that the workforce is suitably prepared for the changes.
A further area of concern for Scottish HEIs, is the possible impact that is had on the availability of placements, particularly in light of the possibilities that budgets may move between NHS boards and local authorities and vice versa. A great deal of effort amongst the HEIs and placement providers is involved in arranging and coordinating students and we would like to see reassurances that the importance of this is giving consideration when deciding how services are to be delivered.

Some CoDH members also raised areas of concerns about the non-ring-fencing of funding. Where healthcare funding has been safeguarded in past, if financial resources are moved over to local authorities, then there is a possibility that funding could be reduced, as has been seen in areas of local authority services. The Bill does not appear offer any reassurances as to this.

Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths
No comments

Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
There is reference to “national health and wellbeing outcomes” in the Bill. Given the diversity of Scotland’s population we believe there should be more focus on outcomes which reflect the demographic in one particular area of Scotland, rather than a one-size-fits-all approach. Whilst we acknowledge the need for the Scottish Government to set targets, this should be done in the context of the localised needs of the patients.

CoDH is also concerned at the lack of reference to quality assurance. Whilst there is a need to deliver more for less, there should be elements included in the statute which safeguards high standards of care. Whilst it should be expected that standards don’t fall, it should not be taken for granted that it won’t become an issue, and inclusion of such a provision would compel service providers to take this in to account.

What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?
No comment

What effect do you anticipate integration plans will have on outcomes for those receiving services?
As noted above, the aspiration of joint seamless services across health and social delivery is to be welcomed. However we would reiterate the points made above as it is ultimately the service receiver i.e. the patient – who stands to benefit or suffer as a result of the changes and this will be the most important measure of the Bill’s success.

Council of Deans of Health
12 August 2013
Public Bodies (Joint Working) (Scotland) Bill:

Scottish Social Services Council

The Scottish Social Services Council (SSSC) is the statutory Non-Departmental Public Body responsible for registering people who work in social services in Scotland, regulating their education, learning and development and generating workforce information for the sector, including the publication of Official Statistics. The SSSC is also one of the partners of Skills for Care and Development, the Sector Skills Council for the social service workforce in the UK.

There are approximately 195,000 workers in the social service workforce in Scotland. The SSSC’s role is to raise standards of practice in social services, to strengthen and support the workforce and to increase the protection of people who use the services. Our vision is a competent, confident workforce, capable of delivering high quality services that has the confidence of the public, those who use services, and their carers.

The SSSC welcomes the opportunity to provide evidence on the Public Bodies (Joint Working) (Scotland) Bill. The SSSC’s general position on the integration of adult social care and health services remains unchanged since the Scottish Government consultation in 2012. The response to that consultation is attached as an Appendix from page 4 onwards. Our comments below focus on the Bill. A number of the points may be more relevant to the regulations and guidance to follow the publication of the Act.

General Principles of the Bill

5 The SSSC agrees with the general principles of the Bill and its provisions. We reiterate a number of points made in our previous consultation response, particularly:

- The need to integrate services a way which recognises the unique contribution made by partners across all settings

- The need to recognise a number of examples of partners working together effectively to share knowledge and expertise across social care and health services.

Achievement of stated policy objectives

The Public Bodies (Joint Working) Scotland Bill primarily focuses on the structural changes that will be necessary to deliver effective and efficient services which are integrated at the point of delivery. The Bill’s aspirations will be achieved through changes to culture, learning and practice.

A key part of any culture change is the effective engagement of the workforce from backroom services and frontline practitioners through to senior strategic managers and leaders. This will be a substantial change, particularly bearing in mind the size of the workforce potentially involved in the delivery of integrated services. Significant attention has to be given to the experience, knowledge and skills needs of the current and future workforce. Allied to this
agenda is the key role played by Self-Directed Support (SDS). The SDS approach is primarily about negotiating a different type of relationship between those providing and those accessing health and social care services. These changes in relationship, role and responsibility are significant and the investment required to achieve this shift should not be underestimated. We would recommend that the subsequent Regulations and Guidance specifically address issues of culture change, workforce development and learning and workforce planning. These agendas should be a prominent feature within strategic integration plans.

**Key Strengths of the Bill**

There are a number of key strengths within the Bill. These include:

- the proposed National Outcomes for health and social care
- the integration planning principles and their focus on the recipients of services.

Further information on these topics can be found within our response to the original consultation.

**Areas where the Bill could be strengthened**

There is mention in the Bill of the need to engage with local communities in developing the integration locality and strategic plans. The Social Care (Self-Directed Support) (Scotland) Act 2013 places a strong emphasis on the direct involvement of people engaged in using health and social care services in directing their care, and being active participants in the development of services. The Public Bodies (Joint Working) Scotland Bill does not have the same strength of emphasis. We would recommend the inclusion of a stronger voice of those who are using public services in the design, delivery and monitoring of the effectiveness of the integration strategic and locality plans.

**Efficiencies and Benefits from the delivery of integration plans**

One additional issue that will have to be addressed is the workforce development needs of commissioned and private sector services. For example, the private sector (40 per cent) and voluntary sector (25 per cent) employ a substantial proportion of the social services workforce. Workforce development activity must encompass the whole workforce to ensure that there are shared values, learning and skills. The guidance and regulations can play a key role in delivering this agenda.

The SSSC is working closely with NHS Education for Scotland (NES) on a number of resources to support the development of the social services and health workforce. Key drivers for this work include the Dementia and Carers Strategies.

**What effect will integration plans have on outcomes for those receiving social services?**

We believe that it is essential that, whatever arrangements partnerships put in place to delegate authority, sufficient attention must be paid to the provision of professional leadership, practice governance and supervision for social workers and social care workers, and it would be helpful to reference the relationship between the jointly accountable officer and the Chief Social Work
Officer in the Bill, with detail in associated guidance. Professional supervision is a core component of good practice, and one on which practitioners place great significance. The statutory Codes of Practice for Social Services Workers and Employers places a responsibility upon employers to “support effective practice and good conduct”.

In addition, it should be noted that a Health & Social Care Partnership that employs workers engaged in the delivery of a care service (as defined by the Regulation of Care (Scotland) Act 2001), will be subject to the Scottish Social Services Council Code of Practice for Employers, and the workers within those care services would remain subject to the Code of Practice for Social Service Workers and regulation with the Scottish Social Services Council, where there is a requirement to be registered.

Scottish Social Services Council
12 August 2013

Appendix

Health and Social Care Integration Consultation, SSSC Response (September 2012)

The Scottish Social Services Council (SSSC) was established in 2001 by the Regulation of Care (Scotland) Act. We are responsible for registering people who work in social services, regulating their education and training and the collation and publication of data on the size and nature of the sector’s workforce.

Our work will increase the protection of people who use services by ensuring that the workforce is properly trained, appropriately qualified and effectively regulated. Our aims are to protect people who use services, to raise standards of practice, to strengthen and support the professionalism of the workforce and to improve the outcomes and experience of people who use social services.

Our vision is that our work means the people of Scotland can count on social services being provided by a trusted, skilled and confident workforce. Our purpose is to raise standards and protect the public through regulation, innovation and continuous improvement in workforce planning and development for the social services workforce.

The SSSC welcomes the opportunity to respond to the Integration of Adult Social Care and Health consultation. The SSSC supports this policy and welcomes the policy’s drive towards improving the quality of outcomes both now and in future.

We use terminology such as “social care” throughout this response although we also typically refer to the wider language of “social services” in our work.
The social services sector employs approximately 200,000 individuals in Scotland, including workers in:

- care at home services
- housing support services
- care homes for adults
- residential child care
- day care services for children
- criminal justice social work services
- adoption and fostering services
- school care accommodation
- offender accommodation.

Approximately 40% of the overall social services workforce is now employed by the private sector, 34% by the public sector and 26% by the voluntary sector. The SSSC is incrementally registering social services workers in accordance with Scottish Ministers’ timetable. Approximately 50,000 workers were registered with the SSSC as of July 2012. We will be registering a substantial number of additional workers over the next few years. For example, all practitioners in care home services for adults had to be registered with the SSSC by 29 March 2013, while support workers must do so by 30 September 2015.

In recent years the sector has also experienced an increase in the number of personal assistants employed by individuals in receipt of Self Directed Support (SDS).

We note that differing terms are used in the consultation paper to describe the same or similar services, for example, care at home and home care. Our experience of supporting multi-agency workforce development, and much of the research into multi-agency working, emphasises the importance of having a shared and agreed definition of technical and non-technical terms. We highlight the importance of using a single definition that is agreed by the agencies represented in the partnerships and recommend that the use of specific language is given priority in the development of the Bill and associated guidance. We suggest that this may be achieved through the use of a glossary compiled in consultation with the health and social services sectors and that the same definitions are employed across all government departments.

Our response now focuses on the specific questions contained within the consultation document.

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

Yes ☒ No ☐

The outcomes contained within Annex A of the consultation document reinforce the rationale for integrated adult social care and health services. We believe a key challenge is to do this in a way which recognises the unique contributions made by partners across all settings. There are already
many examples of partners working together to share knowledge and expertise across social care and health services. It will be important to ensure that the Health and Social Care Partnerships are encouraged to build on the skills, knowledge and effective partnership working practices that already exist so that there is a recognition of what they have already achieved, as well as a challenge to make further improvements.

Outline of proposed reforms

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

**Yes □  No □**

**YES (comprehensive framework) and NO (nothing to add or remove)**

We believe that the variation in identified need, current service provision, partnership development and demographic differences mean that there needs to be a balance between there being a national framework and flexibility to adopt a framework which meets local need. We suggest that in order to do this, the Health and Social Care Partnerships should be asked to demonstrate their ability to adapt and develop services to meet local need through new ways of working to achieve the outcomes that the partnerships are asked to evidence.

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

**Yes □  No □**

There is evidence of good practice in children’s services in relation to the integrated Children’s Services Planning process; in adult services within the Community Justice Authorities (CJAs) and Alcohol and Drug Partnerships. In these instances the identification of shared outcomes has supported the development of effective partnership working to achieve objectives. Anecdotal evidence from the sector would show that when the HEAT targets and the local authority outcome measures differ, each agency tends to allocate resource and prioritise their own outcome. A joint and equal accountability to achieved shared outcomes will actively encourage shared priorities for the partnerships.
Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Yes ☒ No ☐

Single Outcome Agreements would seem to us to be an appropriate way of monitoring performance towards these objectives while maintaining the required levels of local flexibility. We believe Health and Social Care Partnership outcomes should be monitored and evaluated through the community planning processes (the Single Outcome Agreements) so that there is one reporting mechanism for the impact of the delivery of public services in each local authority area.

We welcome the proposed Health and Care Integration Outcomes. The only one we comment on is number six, engaged workforce:

“People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.”

The term “supported” implies the importance of workforce development. We recommend that the link between workforce development and an engaged workforce is reinforced here. We suggest the inclusion of “development” or similar language within the outcome to reinforce the value of education and training. As an example:

“People who work in health and social care services are positive about their role. Workers receive support and development to improve the care and treatment they provide”.

Question 5: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

Yes ☐ No ☒

We have no comment to make on this question.

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

Yes ☒ No ☐

The importance of being able to flexibly deliver and manage services according to local need has been highlighted earlier in the response. Where Health and Social Care Partnerships are able to demonstrate that they are better able to meet need, deploy staff more effectively and provide improved consistency of service delivery, there should be scope for Partnerships to cover more than one LA area. This could be evidenced by the Partnership in their agreement. However there are issues in relation to the membership of the partnership that would need to be considered. There may also be particular issues relating to the governance of the Partnership.

There are examples of strategic and operational partnerships which are delivered across more than one local authority area, such as Child
Protection Committees, Alcohol and Drug Partnerships and Community Justice Authorities.

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

Yes [ ] No [ ]

We welcome the involvement of a non-voting representative on “the service user and carer experience of care” in the Health and Social Care Partnership Committee. We would suggest that representation from the private and voluntary sectors is also considered here.

**Question 8:** Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

Yes [ ] No [ ]

We have no comment to make on this question.

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

Yes [ ] No [ ]

We have no comment to make on this question.

**Question 10:** Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?

Yes [ ] No [ ]

**PERHAPS**

The provision of a structure or model provides a framework for delivery. However, the integral and essential element of effective partnership working is the development of a positive culture of collaborative practice which is solution focused and prioritises a values-based approach to service development, service delivery and relationships between service users, professionals and carers. The proposed models and structures will provide that framework for the partnerships but their impact and effectiveness will be fundamentally influenced by their leadership and culture. We recommend that significant priority be given to supporting Partnerships to develop positive cultures and a values—based approach in the work undertaken in relation to workforce development.
**Question 11**: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

Yes ☒ No ☐

The SSSC is working with NHS Education for Scotland (NES) on a range of initiatives to support the education and development of health and social services staff. Examples include the development and promotion of the Promoting Excellence Framework for social services and health staff working with people who have dementia and the on-going work around the development of an education and training strategy for carers. Both projects have required some flexibility in terms of financial resources and staffing from SSSC and NES. The SSSC will also be a member of the new Working Group which will examine the strategic workforce developments relating to the integration agenda.

**Question 12**: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Yes ☐ No ☐

**PERHAPS**

We note the intentions for Ministers to provide guidance on the categories of spend for Health and Social Care Partnerships. Employees and employers have clearly defined responsibilities in relation to personal and workforce development. These expectations are defined in the Codes of Practice for social services workers and employers. We note the recognition of the importance of organisational and workforce development in achieving many of the policy’s aims and we welcome the inclusion of an outcome which focuses on the vital role of the workforce in delivering this agenda.

**Question 13**: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

Yes ☐ No ☒

We have no comment to make on this question.

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

Yes ☒ No ☐

We would suggest that there is a need to clarify the role of the Chief Social Work Officer (CSWO) in relation to the Partnerships and Jointly Accountable Officer. The CSWO have various roles which are particularly relevant to the partnerships including their Quality Assurance role in relation to service delivery, which may have implications for workforce development.
Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

Yes □ No □

We have already indicated our view about the need to ensure that Partnerships have the flexibility to make decisions which reflect local need. We would suggest that locality planning is – as far as possible – also left to local determination.

Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

Yes □ No □

We set out our views on the need to involve practitioners in the planning process in our response to question 17.

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

We could point to examples such as the Changing Lives Practitioners’ Forums as one potential model for this work but our sense is that the Partnerships must seek to develop a collaborative culture of contribution, innovation and change that is driven from the ground up. Partnerships should seek innovative ways of fostering empowerment and enabling practitioners to get involved with service planning. It is important to ensure that practitioners, service users and carers are all given opportunities to shape the delivery of future services.

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

Yes □ No □

We believe that these issues are matters for local decision makers within the Health and Social Partnerships to consider.

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

See our response to question 18.
Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

Yes ☐ No ☐

See our response to question 18.

Do you have any further comments regarding the consultation proposals?

One final point we would make is that there are a range of workers in adult social care and health settings who bring different experiences, backgrounds and expertise to service delivery. Many workers are required to hold qualifications and/or register with a relevant regulatory body. As an organisation supported by Scottish Government, the SSSC aims to protect people who use services and their carers by promoting high standards of conduct and by taking action where the public are at risk. Research clearly demonstrates that skilled, confident and qualified workers offer the safest, best quality care, with the best outcomes for people who use services. These aims bring us back to our earlier points about the need to continue to recognise the unique contribution made by workers, to maintain a focus on workforce development and to provide opportunities for sharing knowledge and expertise.

We welcome the observation in the consultation paper about the importance of “robust, trustworthy information and evidence” as a means of planning service design, joint management of risk, benchmarking and accountability for delivery. One of the consequences of moving towards an integrated resource is that it could become increasingly difficult to differentiate between the social care and health workforce. We already see evidence of this as data from the National Health Service’s Information Services Division (ISD) highlights the recent movement of staff across social care and health services in the Highlands. Social services data plays a valuable role in supporting employers and stakeholders to undertake workforce planning. The data has various roles to play. The local and sub-sector workforce data that we have developed has informed the Change Fund partnerships, supports employers in their benchmarking/workforce planning processes and informs our work around promoting careers in the sector. There is a need to develop a better understanding of the relationship between data on the workforce, services and demand. We are working with colleagues across health, Scottish Government and other regulatory bodies to address this challenge.

Do you have any comments regarding the partial EQIA? (see Annex D)

No.

Do you have any comments regarding the partial BRIA? (see Annex E)

We agree with the recommendation that Partnerships make their own decisions about appropriate governance arrangements.
EAST LOTHIAN COUNCIL
East Lothian Council is pleased to support the response from our partners, NHS Lothian. Additionally, it would want to highlight the following.

1. Do you agree with the general principles of the Bill and its provisions
Yes, East Lothian Council agrees with the general principles of the Bill. In response to the Bill East Lothian has, like other authorities and NHS Boards, established a Shadow Health and Social Care Partnership Board.

East Lothian Council has concerns regarding the Governance implications of the ‘body corporate’ model as it is detailed in the Bill. This requires clarification and more detail as it will strongly influence which model of integration partners choose to follow. For example, the nature and level of accountability to both NHS Boards and Local Authorities should be made explicit. There should be clear legal and financial structures to enable alignment of budgets and rules if integration is to achieve the desired outcomes.

Further clarity on the division of statutory responsibilities between the Jointly Accountable Officer, the Chief Social Work Officer and other Statutory Officer posts (including Chief Finance Officer and Monitoring Officer) would be required.

2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
The Bill will only achieve its objectives if local authorities and health services are each enabled and required to delegate statutory responsibilities, and resources either to each other, or to a new body. As an example, are Local Authorities and their partners should be enabled to choose the financial model most appropriate for the partnership. The outcomes for patients and service users will be as limited as has happened with previous integration initiatives if the model does not fit with the partnership requirements.

In addition, the approach taken will not in itself reduce demand for both health and social care services, or the expectations of the public. It will, if successful, improve access, quality and deliver efficiencies and deliver some savings in the medium term. There will be one off costs, as well as those arising from the process of change. If these are not recognised and supported by Government then the Bill cannot achieve its objectives.

3. Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths
It is good to see that the Bill offers different options and models for integration and that local areas can make decisions about which model best suits their local needs, circumstance and history. It will be very important, however, that
this approach is supported by very clear required outcomes and quality standards.

The policy objectives indicate the potential that the integration of services can achieve. However, the achievement of these objectives will be dependent on the local plans.

4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
Shifting the balance of care from institutional to community care is a key driver for NHS and Local Authorities. Although Delayed Discharges are part of this agenda, the Bill seems to fall short of acknowledging the resources required to implement effective support in a community setting. As demand grows, integration should, if fully achieved, enable improvement to the experiences and outcomes for patients and service users through faster access and more streamlined less bureaucratic delivery. It will not significantly reduce the overall resource pressures currently experienced by both health services and local authorities, nor significantly add capacity to meet future demands.

The provision of the draft Bill relating to Housing Services should be significantly strengthened. The representation of Housing Services on the Board needs to be re-considered. The importance of adequate provision of aids and adaptations to people’s homes, in making sure they have the most appropriate community based care or do not become delayed at discharge or an unplanned admission to hospital, should be acknowledged.

5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?
East Lothian Council anticipates that an integrated service should eliminate duplication in assessment, speed up decision making, clarify accountability for individual care, and should improve the delivery of person centred services to those who most need them.

The change from current models to the future models of service will incur some transitional costs, as referred to in ‘2’ above, and this should be fully recognised within the Financial Memorandum. Given the severe pressure on local authority community care resources, it should be emphasised that there can be no immediate capacity to meet the inevitable costs of a change of this significance as well as the Council continuing to achieve its Local Outcome Agreements.

6. What effect do you anticipate integration plans will have on outcomes for those receiving services?
East Lothian Council expects that it will become easier for people who need services to understand an integrated system, how to access it, and how to hold it to account.

Working together to improve outcomes for those receiving services has been a key policy driver for health and social care in East Lothian for many years.
There have been notable successes and achievements in services for people with mental illnesses, and learning disabilities.

Integration should improve the service users’ and carers’ ability to meet their individual outcomes. It has to be recognised that improvements in services, including those for older people, were not achieved to the extent that was hoped from earlier integration initiatives such as ‘Joint Futures’. If lessons are learned from those experiences (for example, as particularly referred to in ‘2’ above), and included in the provisions of the Bill, the beneficial effect on outcomes will fall short.

East Lothian Council
12 August 2013
Public Bodies (Joint Working) (Scotland) Bill

NHS Lothian

1. Do you agree with the general principles of the Bill and its provisions?
Yes. Lothian NHS Board and its four local authority partners supported the general principles in their joint response to the consultation. At the same time we appointed Joint Directors for each of our four local authority areas. Shadow Health & Social Care Partnership Boards are in place in West Lothian and in Edinburgh, and being established in Midlothian and East Lothian.

At the same time we are organising two workshops in September 2013 for NHS Board members (including local authority stakeholder members) and the joint directors to consider the subject of integration and the provisions of the Bill as it stands.

Whilst the initial focus has been adult services, we are also keen within Lothian to explore the opportunities for children’s services.

The Bill obviously compels change. Through Section 21, the Bill uses similar language to describe the effect of delegation as is used in the National Health Service (Scotland) Act 1978 to describe the legal responsibilities of NHS Boards for functions delegated to them by Scottish Ministers.

Taking Section 21 together with the (body corporate) “integration joint board” model (Section 1(4) (a)) and its associated provisions, we believe the Bill is potentially materially different from the pre-bill consultation document and elements of the accompanying Policy Memorandum. We have been working on the understanding that the body corporate model is a vehicle that is accountable to the parent bodies, whose chief officer is directly accountable to the chief executives of the parent bodies, and whose strategic plans must be consistent with and led by the strategic plans of the parent bodies. The Bill appears to suggest something quite different. When the body corporate model is taken, the body corporate becomes the Integration Authority (section 42), and leads the strategic planning process with the parent bodies becoming mere consultees. This issue requires urgent clarification as it will strongly influence which model of integration partners choose to follow.

We would welcome clarification on the following questions within the final version of the Bill:

- Section 21 appears to give the body that receives the functions all duties, rights, powers and liabilities associated with carrying out the delegated functions. Section 21 (4) appears to state that all legal processes should be brought by or against the delegate. It appears to be a transfer of functions from one public body to another. Given the corporate governance implications, is this the correct interpretation of the meaning and intention of the Bill?
If an NHS Board delegates functions to a local authority or a new integration joint board, is the NHS Board Chief Executive still the Accountable Officer for those delegated functions under the Public Finance and Accountability Act 2000?

If the Board and Council delegate functions to Integration Joint Boards, does Section 21 mean that the Board and Council will be relieved of all legal responsibilities/ liabilities etc for those functions?

Who shall be members of the Integration Joint Boards? If the members are to be existing NHS Board members and councillors, does this create an inherent conflict of duties and interests for them?

If the Integration Joint Boards appoint their own Chief Officers (rather than the NHS Board and local authority Chief Executives), how can the Chief Officers be directly accountable to the Chief Executives of NHS Boards and local authorities?

Are the Integration Joint Boards empowered to operate autonomously from the parent NHS Board and local authority, by virtue of sections 9-11, 21, 42(a), 43(a), 28, 30, and 33?

Are the proposed default powers of Scottish Ministers to introduce Integration Joint Boards appropriate, given the emphasis on localities within the planning provisions in the Bill (Sections 23, 25 & 32)? If the Board and local authority fail to produce an Integration Plan on time, would it not be more appropriate for the Scottish Ministers to take a more facilitative role?

2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

The Bill has the potential to achieve its stated policy objectives, subject to the points below.

The first two policy objectives relate to the design and the delivery of care. Their achievement and the timing of delivery depend on many factors, including:

- The range of functions being delegated
- The extent of innovation
- The availability and capability of ICT
- How successfully change is managed, e.g. transferring staff to a new employer, introducing new ways of working, addressing any identified gaps in skills, experience and training & development.

The third policy objective relates to resources.

The Scottish Government has published “Explanatory Notes”, within which is a Financial Memorandum. The Scottish Parliament’s Finance Committee has issued a separate call for evidence on the Bill, and therefore this response shall not cover that ground.

We believe that integrated functions and resources should produce greater efficiencies. However it is important to note that efficiencies do not always lead to cash-releasing savings. If we were able to reduce the number of people delayed in our system this would release beds, which in itself is an
efficiency and is also an important aspect of quality of care for the patient. If we can free up beds we then have more capacity and this in turn would allow us to reduce the number of people boarding or even the need to cancel elective, scheduled operations due to a lack of available beds.

The process of implementing re-design often requires upfront investment, particularly alternatives to hospital admission. Resources across the public sector have been severely constrained in recent years and one initiative that would be important to see continue is that of the investment made through the Change Fund for Older People. This is particularly important given the projected demographic changes in Scotland and Lothian, and the growth in the prevalence in dementia, offer two primary challenges to resources:

1) The ability to continue to provide routine services, and
2) The inevitability that the overall costs of providing health & social care services to the over 75s will rise in real terms.

Integration gives an opportunity to mitigate the impact of some of the growth in demand for specialist forms of care at home, care in residential settings or care in hospital.

The rate of admission to hospital will have to be massively reduced just for hospital services to stand still, let alone release resources for alternative methods of service provision. If a material amount of resources is to be released from hospital care, this would require the closure of some acute hospital facilities. There is extremely limited evidence of this being done quickly or successfully in Scotland in recent years and this would require full partnership support, engagement and consultation.

3. Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths
All three policy objectives are sensible, but they are a significant understatement of the scope of this Bill.

There is the potential to interpret the Bill as it stands to give significant powers to Scottish Ministers to re-structure the Scottish public sector, with the potential for the Scottish Ministers to have more direct control of public functions without further legislative debate or consultation.

The provisions of Part 1 of the Bill do not limit the scope of the delegation of functions to adult services, or those relating specifically to older people. Any function can be captured. Part 2 of the Bill (Shared Services) applies to services and organisations beyond the realm of health and social care.

4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened
Our response to Question 1 sets out a number of key questions for clarification.

A body corporate is a distinct legal entity, separate from those who created it. The term body corporate is used in many other laws which confer
responsibilities and liabilities to the body corporate, e.g. Health & Safety Act, Data Protection Act, Corporate Homicide Act, various tax laws etc.

The delegation of functions does have significant governance implications, and the review of the Bill should give due regard to how this will actually affect NHS Boards, local authorities, and any new integration joint boards.

There must be clarity on which organisation and which officers are responsible and accountable (and liable in Court) for observing the law in the discharge of “functions”.

Section 33 is about the performance report. This section could be improved by stipulating to whom the performance report is to be provided.

Section 33 refers to an assessment of the performance in “carrying out the integration functions for the area of the local authority.” Section 14 states that the role of the “Integration Joint Monitoring Committees” is “monitoring the carrying out of the integration functions for the area of the local authority.”

Section 21 of the Bill explains the effect of delegation. If a body receiving a delegated function assumes all responsibilities and liabilities of that function, then logically the oversight of the carrying out of that function is primarily a matter for the receiving body’s existing governance arrangements.

**Example - A local authority delegates a function to the NHS Board**

| The associated local authority employees are consequently transferred to the NHS Board (Sections 15(1) & 19) |
| The NHS Board (as a result of Section 21) is the body accountable in law (criminal and civil) for matters arising from carrying out the function. |

In the above example, the NHS Board has the corporate governance responsibility to be assured that the function is conducted in line with the principles of internal control, the law, quality standards, safety standards etc. The NHS Board would discharge this responsibility through its primary governance committees, e.g. Staff Governance Committee, Healthcare Governance Committee, and Audit & Risk Committee. With regard to the transferred employees, the Board’s Staff Governance Committee would be responsible for getting assurance (on behalf of the NHS Board) that those employees are being managed in line with employment law and the NHS Scotland Staff Governance Standard.

When the body corporate integration model is not being used, Section 14 of the Bill applies. It defines the role of Integration Joint Monitoring Committees as follows:

“(a) the local authority and the Health Board must jointly establish a committee (an “integration joint monitoring committee”) for the purpose of monitoring the carrying out of the integration functions for the area of the local authority,”

Section 5 of the Bill does not state who will be responsible for the achievement of the national outcomes.
Taking these points together, the following questions should be considered:

- Are councillors (on the joint committees) being given governance duties (assurance) for functions that have been purposely delegated to the NHS Board?
- Is there a risk of duplication of governance oversight between the Integration Joint Monitoring Committees and existing governance arrangements in NHS Boards and local authorities?
- With regard to the National Outcomes, should there be a distinction between “monitoring the carrying out of the integration functions” and monitoring the delivery of national outcomes?

Part 1 of the Bill refers to the delegation of “functions”. Part 2 of the Bill refers to “services”. It would be helpful if the Bill could define these terms, as it is relevant to how integration is progressed.

We do not think that a global delegation of existing portfolios of services and budgets from one organisation to another will be effective. A more refined approach would be to focus only on the functions where their delegation is:

a) Pertinent to the achievement of the policy aims, and
b) The receiving body is actually able to make changes required to the functions in order to achieve the policy objectives.

This approach will require NHS Boards and local authorities to look through what is currently established, and focus on the fundamental nature of the functions being performed. From the perspective of an individual service user, several “functions” will operate so that he or she receives the service required. Some functions may be pertinent to all services.

Examples of possible “functions” are:

- The booking of all appointments
- The handling of all complaints and compliments
- The provision of a clean and equipped hospital and other facilities (to accommodate which could host any clinical services a body may want to deliver there)
- Patient and client transport
- Care and support to individuals with learning disabilities
- Provision of all aspects of care and support to older people (excluding secondary/tertiary clinical care), including the process of managing admission into a hospital when this is required.
- Provision of secondary/tertiary clinical care to older people
- The process to get patients out of hospital once their clinical intervention is complete, to the place they are meant to be.

This approach appears to be consistent with the Integration Planning Principles set out in Section 4 in the Bill.
NHS Boards currently have Community Health Partnerships in place. In Lothian these continue to be run alongside the new shadow Health & Social Care Partnership Boards that have been jointly established to advance the integration agenda. It is likely that the Community Health Partnerships will have an increasingly irrelevant role through the passage of time. It would be helpful if the Bill allowed for local flexibility, to allow for earlier dissolution of the current Community Health Partnerships where this can be agreed locally. This can be assisted if the date of implementation in law or regulation is given as a final date, rather than a given date in which all Community Health Partnerships end at the same time.

5. **What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

Although Integration Plans are to be developed and the financial issues require further work there is a clear theme arising. The change from our current models to the future models may incur some transitional costs and this is already recognised within the Financial Memorandum. Thereafter, we consider that there will be a range of synergies generated as currently separate services are managed collectively, and these synergies will support the creation of capacity to meet the further demands on our system from demographic and other changes.

6. **What effect do you anticipate integration plans will have on outcomes for those receiving services?**

The Integration Plans could lead to re-design that should improve the experience of the patient or client, and consequently improve their outcomes. An example would be reducing the number of different people involved in delivery of the person’s care. Integration could lead to the removal of the demarcation of tasks that can develop between professions, people of different grades within the same profession, and people in different organisations.

From the perspective of the patient / client, it is arguably better if they see fewer members of staff, but those members of staff spend more time with them and do more for them. This should improve quality of care, experience and outcomes. We will need to build on where we are now, and to engage with communities of interest and place to achieve better outcome for people, to streamline access to services as they are required (which is often in a crisis situation) and for people and their carers to have a bigger role in working in partnership in the decision making about the care they will receive.

**NHS Lothian**
**13 August 2013**
Public Bodies (Joint Working) (Scotland) Bill

Glasgow City Council

- Do you agree with the general principles of the Bill and its provisions?
The council is supportive of the general principles underpinning the Bill. However, the provisions are in the main very prescriptive. For example, the integration plan, to be approved by Ministers, must outline the model to be adopted, functions that are to be delegated, and the method by which payments are to be made. The question does therefore arise as to whether or not a Partnership has any real control over its plan/approach to integration.

A key feature of the Bill is the demonstrable shift in power in the delivery of local services in local communities away from local government. This necessarily impacts on local accountability within a democratic environment. It is a cornerstone of local government that citizens are able to scrutinise and hold to account decision makers in relation to local public services. The provisions within the Bill that prescribe the role and authority of the Chief Officer and the Partnership Board, the reduced oversight of the parent bodies and the lack of accountable relationship to the community planning partnership undermines this cornerstone.

- To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?
The policy objectives around integration are principally about improving outcomes for service users/patients. Glasgow City Council’s response to the Scottish Government’s consultation pointed out some fundamental weaknesses in the proposal for integration in being able to deliver these objectives.

For instance, a key issue in the patient/service user overall experience is the disconnect between acute and primary care within the NHS in relation to the patient experience and their outcomes. This is in addition to the disconnect between Health and Local Authorities which the Bill provides for. The draft legislation fails to address the first disconnect. From this perspective it is 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 and indeed failure to address one of the disconnects may only serve to undermine the changes made under this legislation.

Most patients, when they hear the word ‘health’, as in ‘health and social care integration’, are probably likely to think ‘health’ first of all has something to do with their GP, then something to do with hospitals, and then assuming they have heard of it, the services provided for within a CHP. Because GPs and acute hospital services are not included in the Bill and it is only CHPs that are required to ‘integrate’ with social care, it is difficult to see how a patient lying in a hospital bed can see the service they receive as being ‘integrated from the point of view of recipients’ (s4 (1)(b)(i)).
Current national policy objectives focus on shifting the balance of care from institutional to community based care in order to meet the demographic challenges that Scotland faces in the future. In order for this to be achieved, at the very least, resource needs to shift from acute as well as residential and nursing care; the draft legislation fails to address this.

The Bill does require Partnerships to engage with health professionals, however, this in itself is not sufficient to ensure that GPs for instance will engage effectively given the independent status of that group of professionals.

We know from some of our previous experience of CHCPs in Glasgow that integration works best when GPs and other stakeholders are engaged effectively. Therefore, merely requiring in law 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 to participate and work collegiately for the greater good.

When one third of total spend on older people's services is on 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.

- Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths.

This council is supportive of the policy objectives as stated around improved outcomes, care at home and the effective and efficient use of resources to meet the needs of an increasing number of people with complex needs.

- Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.

The general thrust of ministerial powers within the Bill represents a significant shift of power from local to central government. Scottish Ministers have powers at every level of the operation of the Integration Joint Boards. The powers detailed grant Scottish Ministers authority over the structure, membership, functions, financial arrangements, monitoring and staffing arrangements.

Glasgow City Council raised the issue of a centralised, prescriptive approach during the consultation stage. Research has demonstrated that central prescription does not equate to effective partnership working. It is disappointing that this fundamental issue raised by consultees has not been addressed in the drafting of the Bill. The view remains that legislation has a place in relation to joint outcomes, however how these are achieved should be left to local determination.

The Bill would be strengthened by abandoning central prescription and minimising the potential for significant levels of secondary legislation. This
would enable local authorities and Health Boards to develop effective local partnership arrangements which are appropriate to local circumstances.

It is concerning that Scottish Ministers may refuse to approve (s 7(3)) an integration plan presented by a Health Board and a Local Authority following a likely considerable period of time jointly working to develop and reach agreement.

It is also concerning that Scottish Ministers may if they ‘think fit’ make provision as to the appointment of staff, numbers of staff, terms and conditions (s11 (2)) as this has the potential to contradict the strategic direction of travel developed either within the broader Partnership or the locality planning groups.

It is not reassuring that the Bill also proposes that Scottish Ministers would have the power to instigate the transfer of staff, property, rights, liabilities or obligations away from a local authority or Health Board (s12 (3)). This only serves to reinforce the perspective that the Bill is a concerted move away from local democratic accountability.

Practical and technical issues around e.g. VAT and confusing staffing arrangements have not been addressed in the drafting of the Bill. As it is laid out, the Bill creates concern around the impact on workforce planning especially given the potential for direction to be subsequently provided by way of secondary legislation in relation to staffing.

Finally, 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.

- **What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

  It is difficult to quantify efficiencies and benefits arising from the integration plans. This is not to say that closer joint work will not be beneficial, rather that we are integrating a system that we know is already stretched and which demographic projections, as well as the current economic climate, indicate will lead to continued pressure.

  The Financial memorandum suggests efficiencies of between £138-£157M within hospitals as a consequence of a positive impact of improved anticipatory care and reduction in delayed discharges. However, as indicated above, there is no expectation that this will be a cashable saving that would then be redirected within the Partnership Board into alternative community provision thereby enabling the achievement of the policy objectives.
The cashable efficiencies that will be realised from integration therefore are likely to be around the margins only, albeit effective joint work does have the potential to ensure we are utilising joint resources to best effect.

The cost implications of delivering an integrated service outlined in the Bill also do not appear to be realistic. We know from experience that integration costs money.

Glasgow City Council in its response to the consultation intimated that there is a risk that the legislation will lead to the fracture of social work services with some (adults) being ‘in’ and others (children and families; criminal justice) remaining ‘out’ certainly at the outset and in some areas potentially long term.

This necessarily increases risk to vulnerable children in complex family situations where the adults in the family may be in receipt of social work services in relation to addictions or mental health provided through the body corporate or delegated model, to all intents and purposes by a separate organisation. Clearly, there would be an expectation of effective multi agency working but such a fracture must only mean that the efforts required to achieve this is increased because of the creation of a separate delivery model. This cannot be the most efficient use of precious resource.

Furthermore, the Council across all of its Departments has been able to establish significant efficiencies in the delivery of aspects of shared ‘back office’ provision in recent years in relation to ICT; human resources; payroll and customer services; office accommodation; health and safety and so on. Scale has enabled this to be achieved.

Integration of the adult social work services with health in a separate entity is likely to see the fracture of such back office provision as the Partnership Board makes alternative arrangements and this necessarily reduces the scale of what remains within the council and therefore may impact negatively on the associated efficiency that has been achieved.

In other words the unit cost for continuing the provision of the remaining back office services in the parent organisation is only likely to increase.

Alongside this, in the event of integration of adult services only, alternative systems and infrastructures will require to be developed in order to ensure the council’s statutory duties in relation to what remains (children and families; criminal justice etc) are adequately resourced and managed.

The corollary of this of course is that all services are ‘in’ from the outset. Glasgow City Council has consistently raised concerns about the scale of operation that this would entail equating to an organisation with limited democratic accountabilities with a publicly funded budget of c£1.2b. This is not to say that such an eventuality cannot be considered, but there would be an expectation that significant safeguards and accountabilities beyond what is outlined in the draft legislation are put in place beforehand.

- What effect do you anticipate integration plans will have on outcomes for those receiving services?
The development of joint outcomes for health and social care does have scope to improve outcomes for those receiving services. This council is in agreement with the principle around ensuring that health and social care services should be seamless from the perspective of those receiving them.

Currently, we know that there is scope for improvement in this regard and it is the practical development of joint arrangements to improve the experience of the service user that we want to focus on.

We remain concerned that the imposition of structural reform from above will only create more upheaval in this realm, risking scattering this vital focus.

We know that genuine, practical, and practicable integration must be built from the ground up, and that imposed structures, lacking in local accountability, impede rather than hasten improved outcomes for our citizens.

Glasgow City Council
15 August 2013
Public Bodies (Joint Working) (Scotland) Bill

The Housing Coordinating Group

1 Introduction

1.1 The Housing Coordinating Group (HCG) welcomes this opportunity to contribute to the Committee’s stage 1 scrutiny of the Public Bodies (Joint Working) Scotland Bill.

1.2 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. Thus, this evidence comes from representative bodies of strategic housing authorities, social housing providers (councils, housing associations and co-operatives), the housing profession, and many third sector providers particularly Care and Repair services. To reflect our common views, in this response we use the collective term “the housing sector”.

1.3 Together we make a very significant contribution to national outcomes on health and well-being by:

- Co-ordinated strategic planning of the supply and quality of housing and related services across tenures and stages of life;
- Providing individuals with information and advice on housing options;
- Directly providing or facilitating, ‘fit for purpose’ housing for rent and for sale / part sale, that gives people choice and a suitable home environment;
- Providing local, personal, preventative services such as aids and adaptations, and care and repair or “handyperson” schemes;
- Building capacity in local communities.

This paper sets out a response to each of the committee’s questions.

1.4 In summary, 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. The success of the new ‘integrated authorities’ will largely depend on effective joint strategic commissioning to which the housing sector can make a crucial contribution. The current arrangements for involving the housing sector have not produced a consistent nor 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

---

1 The Joint Improvement Team has provided support and assistance to the Housing Coordinating Group
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.

2 Do you agree with the general principles of the Bill and its provisions?

2.1 The HCG agrees with the planning and delivery principles as set out in the Bill (sections 4 and 25). These are in line with those originally set out in the consultation document and have gained the support of housing professionals across the sector. In promoting integrated services, the principles include taking account of the personal experience of individuals in terms of their improved wellbeing. We believe this focus on personal outcomes to be important. However we have concerns that quality of services is not mentioned and we feel that the principles would be strengthened with heightened focus on involving people in decisions about their care and support.

2.2 The principles also emphasise the anticipation and prevention of need. Housing providers offer varying levels of care and or / support to vulnerable adults and older people, and have long been committed to working with colleagues in health and social care to enable people to continue living in the community rather than institutional settings. There are examples where this has happened already and the Bill could promote this approach more widely across the country. The housing sector has much to contribute to this agenda.

2.3 The policy memorandum (para 9) states, and we agree, that an aim of the legislation is to deal with the variations in quality across the country. The forthcoming review of National Care Standards provides a significant opportunity to explore the scope to align regulatory standards with the principles of the Bill and the associated national outcomes being currently being developed.

2.4 The Bill sets out a requirement on local authorities and health boards to set up new integrated authorities’ but leaves it to local areas to decide whether and how to involve the housing sector. The possibility that any ‘integrated authority’ could lack the involvement of the housing sector at a strategic level is of some concern. Whilst the need to maintain a focus on housing issues in order to achieve the outcomes of integration has been acknowledged this cannot be achieved without proper engagement with the housing sector in both planning and delivery.
3 To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

3.1 The success of the new partnerships will largely depend on effective joint strategic commissioning plans (JSCP). It has already been acknowledged that housing plays a part in effective planning and Housing Contribution Statements (HCS) were introduced in 2012/13 as a way of highlighting the potential housing contribution to existing JSCPs. This first round of HCSs has been reviewed by the Joint Improvement Team and various issues have been highlighted. Whilst we acknowledge the challenge that local partnerships faced in developing and agreeing HCSs within a short timescale we nevertheless think it important to take the opportunity to learn lessons from the exercise.

3.2 The review found that although HCSs were submitted with partnerships’ JSCPs, only a minority actually integrated issues around improving housing and housing related services into the body of the JSCP. There was a tendency for the HCS to appear as a “bolt on”. HCS could be the key mechanism for linking Local Housing Strategies with JSCPs, and will be vital for the housing sector to play a strategic role in meeting the national outcomes associated with integration of health and social care. The housing dimension of integrated planning needs to be dealt with within the JSCP rather than sitting on the margins. In other words, we believe the best place for housing to demonstrate its actual and potential contribution to improving outcomes for people within the health and social care system is through proper integration of housing issues within JSCPs.

3.3 To further the integration of housing issues in JSCPs there needs to be a shared understanding of data relating to housing, health and social care, and a shared commitment to producing meaningful information from such datasets for planning purposes. We note that a review of the guidance relating to Housing Need and Demand Assessment (HNDAS) is currently underway. This will consider explicitly improvements needed to aid our collective understanding of the housing needs of vulnerable groups such as older people and those with particular needs, and we propose that revised HNDAS be regarded as part of the toolkit required for JSCPs.

3.4 Together with ALACHO and SFHA, the JIT is currently surveying the sector to extend understanding of the housing sector’s experience of the first round of HCS. The review of HCSs submitted in March 2013 identified that these tended to consider housing with care and adaptations, but there was concern about a lack of focus on housing advice, lower level housing support services and other housing related services. The sector, working with the Scottish Government will use the

---

2 Housing Need and Demand Assessments are undertaken to assess local housing need and demand to inform the development of local housing strategies and development plans.
information obtained to provide feedback and advice to practitioners across the housing health and social care sectors on how the housing contribution to JSCPs might be improved.

3.5 Housing planning and housing services already play a fundamental role in providing ‘homes or a homely setting’ for those using health and social care services particularly as people face long term conditions.

3.6 The Bill sets out integration across all adult age groups rather than simply older adults and this seems appropriate given the experience of housing providers in deprived areas where the onset of long term conditions tends to happen at a lower age. We note, however, that much of the Bill continues to focus solely on the needs of older people and suggest this should be addressed if the principles set out in the Bill are to be pursued effectively.

4 Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

4.1 A central policy objective of the Bill is to provide ‘joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so’. The requirement that integration authorities share a budget and that they develop JSCPs mark a real step change from previous aspirations about joint working and are key strengths of the Bill. The housing sector, as stated already, has much to contribute to the overall policy objective but its role and contribution needs to be strengthened, as set out below.

4.2 The development of a set of national outcomes will be fundamental in pursuing this objective and we look forward to further opportunities to reflect on the way housing related issues are reflected in the national outcomes and indicators.

5 Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

5.1 Effective leadership at a local level will be crucial if the required change is to be implemented. The role of social landlords as a community anchor at a local level could be fundamental to helping to link leaders within public bodies with local people and leaders in the voluntary sector and in community based organisations. The Bill could be strengthened by requiring integration authorities to work with housing and the third sector as partners rather than simply adhering to principles to engage with ‘community and local professionals’. As a comparison, there is currently in place a requirement that Reshaping Care for Older People Change Fund plans are signed off by four signatories: the NHS Board, the local authority, the third sector and the private sector. We would urge that the housing sector more generally be acknowledged as a signatory for future integration plans in addition to the third sector.

5.2 There is a lack of clarity about the elements of funding which will go into integrated budgets and the extent to which local authority budgets
currently directed at housing related services, such as housing support for homeless people, will be expected to be part of this. If each integration authority is left to decide this there is a risk that the financial context within which housing related services operate will become increasingly complex, to the detriment of the individuals who currently benefit from such services, with an increased risk that the policy objectives set out in the Bill will not be achieved.

5.3 Social landlords and many of the individuals they serve are already dealing with financial uncertainty resulting from welfare reform. It will be important that the financial arrangements introduced under the Bill do not destabilise housing related services further.

6. **What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

6.1 The main efficiencies and benefits potentially arising from integration plans are likely to be improved living conditions for our tenants and residents rather than benefits accruing directly to housing organisations themselves. There is increasing recognition of the preventative benefits of housing investment such as keeping people safe at home longer through the timely provision of appropriate housing adaptations, or the reduction of respiratory illness through efficient modern central heating systems. The housing sector argues for an “investment dividend” arising from an established link between housing investment and a consequential reduction in other more expensive forms of provision such as hospital treatment or long term stays in care homes. As stated above, housing has much to contribute to achieving the objectives of integration but its contribution would be put on a more secure footing through a continued commitment to the HCS and through Community Planning Partnership arrangements to ensure that housing issues and housing sector are properly tied in with JSCPs and the delivery of the national outcomes being developed – the first 3 of which are particularly pertinent to housing: Healthier Living; Independent Living and Positive Experiences and Outcomes.

6.2 There are efficiencies and benefits to be had for the housing sector to work with integrated authorities rather than separately with social care and health. Conversely, it is important that integrated authorities work with the housing sector otherwise the opportunity joint working presents will be lost in some areas. One way to ensure that this joint working occurs is to require the new partnerships engage formally with the strategic function of housing in local authorities and delivery of housing more generally. This is too important to leave to chance.

7 **What effects do you anticipate integration plans will have on outcomes for those receiving services?**

7.1 See our response at Para 6.1 above. Members of the HCG are enthusiastic about the principles set out in the Bill. If the principles are to be pursued effectively and reflected in national outcomes, the integration of public bodies serves merely as a means to an end and
must not be regarded as the end in itself. The development of a set of indicators will be important in helping to chart progress but there needs to be accountability at a local level for improvement otherwise there is a danger that the outcomes and indicators will become little more than a reporting exercise.

7.2 The policy memorandum, which suggests (paras 98 onwards) that the scope of Bill should extend to adults of all ages, creates an opportunity to offer more consistent approaches to people with similar conditions or situations irrespective of their age. This may particularly assist those living in areas of deprivation, especially those with long term conditions, who are likely to face poorer health outcomes.

7.3 The Bill requires an integration authority to consult with service users where it decides to change the arrangements for carrying out of integration functions. Consultation is required where an authority wants to make changes ‘significantly affecting provision of service in an area’. This could be interpreted to include large tendering exercises, in which case this new duty might provide a means of ensuring that there is a process of consultation with service users in relation to such exercises. This is to be welcomed in order to achieve better outcomes for those using services.

The Housing Coordinating Group
16 August 2013
Public Bodies (Joint Working) (Scotland) Bill

Association of Directors of Social Work

Background

ADSW is pleased to submit written evidence on the above Bill to the committee and is happy to provide evidence orally when that is appropriate.

ADSW is supportive of the integration of social care and health in order to improve outcomes for the people who use our services. People who depend on our services should have seamless care, no matter who delivers, manages or pays for that care. Many local authorities and their health partners are already working in integrated ways or have some or all or their services integrated.

ADSW has been working with government to ensure the legislation is focused on achieving those outcomes. In 2011, we commissioned the Institute of Research in Social Services to carry out research on our behalf, to help establish the evidence base on the factors essential for health and social care integration to deliver the outcomes for people that matter most.

In 2013 ADSW has led collaboration with our partner organisations in England, Wales, Northern Ireland to produce a paper on best practice when seeking to integrate health and social services, based on extensive evidence. This work, though not yet finalised informs our position.

Summary of response

The Bill is more prescriptive than we anticipated and is very mechanistic about the steps expected to be taken by local authorities and NHS Boards to achieve integrated services. The Bill ascribes extensive powers to Ministers that had not previously featured in the consultation document. ADSW is firmly of the view that these cover areas that are a matter for local determination and reasons for this are covered later in this response.

ADSW welcomes the specific inclusion of the Chief Social Work Officer in paragraph 115 of the Policy Memorandum and in particular the “firm reassurance of the Scottish Government’s commitment to the role of the Chief Social Work Officer role.”

We welcome the Bill’s focus on outcomes and support the concept of a national outcomes framework – the development of which must be based on a parity of respect and a shared responsibility for its development. However, we are of the view that the requirement for partnerships to adopt one of two models reduces the ability of those with the best local knowledge to plan according to local need. Our reasons for this are covered within this response.
It is also notable that the principles of quality and safety in health and care services are not included in the key principles of the Bill. We have had sight of the Royal College of Nursing response and would agree with the position stated that the Bill itself is focused too heavily towards resolving difficulties in delivering seamless care, and too lightly towards ensuring robust assurances of care quality and safety.

The Bill has the potential to fragment high profile professional activities- for example those associated with public protection. The creation of different organisational arrangements across services may actually disintegrate services that are already successfully integrated. Adult services that focus on mental health, addiction and criminal justice, for example, are a crucial part of the whole system that works to create the best environment for children to grow up in. Scotland’s children need responsible adults to thrive. We need to ‘Get it Right’ across the whole system-achieving a sophistication in policy development that reflects this shared responsibility. The Bill provides Scotland with the opportunity to build upon the Francis Report by embedding effective, safe, dignified care at the heart of this legislative reform. This is covered further within the response.

The importance of ensuring the acute dimension of health is appropriately represented in new partnership arrangements cannot be underestimated. This is covered in more detail within the response.

These are crucial components to ensuring that people get the care and services they need and want. They should guide all aspects of the Bill and ADSW believe that the committee should consider amending the Bill to incorporate these principles.

ADSW would support an amendment at Stage 2 to address this matter. The Bill should also ensure that the duties of the Self-Directed Support (Scotland) Act are extended to relevant parts of the NHS through an amendment to this Bill, as the two positions are incompatible.

**Specific questions**

Your committee has asked us to focus our response around 6 questions. Our answers are detailed below.

1. **Do you agree with the general principles of the Bill and its provisions?**

   ADSW agrees with the general principles of the Bill and its provisions. However, we have concerns about the powers Ministers are granting to themselves to intervene in the management of services when they perceive that services are not delivering effectively. The Bill ascribes extensive powers to Ministers that had not previously featured in the consultation document- for example
   - powers to transfer local authority functions without recourse to primary legislation
Ministers may, by order, make other provisions (e.g. membership of integration joint boards).

ADSW is firmly of the view that these are a matter for local determination. Managerial arrangements for partnerships are a local, not government concern; integration plans are for local agreement not government approval. Best outcomes will be achieved through the application of local knowledge and skill and through engagement with communities.

ADSW’s 2013 study into the critical factors for successful integration based on best research and practice knowledge from the four UK nations shows that there is no one solution for successful integration and that good practice cannot be centrally mandated-

“the main factors that promoted integrated working were locally determined- local leadership, vision, strategy and commitment” (NHS Confed.; 2010)

Central level input is shown in the study to be most successful when focused on developing a coherent legislative and policy context – on rationalising multiple regulatory frameworks, financial reporting and performance regimes – and without which no momentum for change could be sustained. It is essential that governance arrangements at all levels, as well as operational practices, reflect best knowledge in order to achieve best outcomes.

There is evidence of significant progress across partnerships in delivery of quality integrated services. Partnerships have worked closely together, supported by the older people’s Change Fund, to develop enhanced, flexible and joined up services in the community to support proven reductions in delayed discharges and unplanned admissions. We appreciate that there need to be accountability on partnerships for achieving the intended outcomes within the Bill, but the inclusion of what is essentially a power for Ministers to remove functions from local government seems to anticipate failure from the outset.

2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

Much of the detail of the Bill is being left to regulation and guidance. We await these documents to in order to be able to comment meaningfully on the details proposed.

The most important issue that is still to be clarified is the proportion of the acute NHS hospital inpatient budgets that should be included in the partnership arrangements as a minimum. The scope and extent of the budget made available across adult community care, primary care and acute care will determine how creative the total system can be in responding to local priorities, and whether the objectives of the Bill can be met.
The Scottish Government clearly stated the case for change in its 2012 consultation paper. Health and social care integration was necessary to address the “two key disconnects” within the system:

The first disconnect is found within the NHS, between primary care (GPs, community nurses, allied health professionals etc.) and secondary care (hospitals). The second disconnect is between health and social care. (para 1.2)

Addressing these disconnects would allow the balance of care to shift from institutional care to services provided in the community, and resources to follow people’s needs (para 1.8). This would support more preventative strategies based on “assessment, treatment, rehabilitation and support in the community” (para 1.10) – a strategic change now made urgent by the ageing of the population and by increasing numbers of people with long term conditions or disabilities.

The most recent ISD “Integrated Resources Framework” information on the balance of care for older people (we do not yet have this for all adults) is shown below – hospitals and care homes account for nearly 60% of spend, and nearly 31% of all health and social care spend is on acute emergency admissions (£1.4 billion):

For the integration vision to be achieved, health and social care partnerships need to unlock the budgets currently funding inpatient admissions. They would do this by having control over a significant proportion of inpatient budgets – focussing on specialities with high rates of emergency admissions.
– which in the short term would be returned to hospitals to manage current bed capacity, but in the medium to longer term would be used to take beds out of the system to fund the expansion of preventative and community based health and social care services. This would be achieved by joint strategic commissioning which would specify the hospital and community based services needed over the forward planning period to deliver better outcomes for public expenditure on health and social care.

There are three potential problems with this delivery model, all with potential solutions:

- First, funding. If successful, the model will reduce future demand for inpatient care but is unlikely to eliminate the need for more funding to address increased demand due to demographic change. Change funding is also needed to cover double running costs enable the expansion of community health and social care that is necessary to provide less expensive alternatives to inpatient admission. Unless demographic and change funding continues, these shifts in the balance of care will be difficult to make on the scale required.

- Secondly, many hospital catchments cover several local authority areas. Transferring relevant parts of hospital budgets between different health and social partnerships carries risks of destabilising hospital management. ADSW believes that these risks can be managed but that further work is required on mitigation measures as a matter of some urgency.

- Thirdly, there are issues of power. Health Boards are reluctant to lose control over in-patient budgets, and local authorities have analogous concerns about loss of control over social care. Within the medical profession “acute specialties often have the loudest voice”. These are serious challenges that the national and local work underway on governance and cultural change needs to address.

While these three problems are all challenging, ADSW believes that they can be resolved, given political will and leadership. The acid test will be the quantum of acute budgets transferred to partnerships. ADSW believes that there is general agreement that all or most mental health and learning disability inpatient budgets, and those for non-obstetric GP beds, and any other continuing care or community hospital beds, should transfer to health and social care partnerships. In 2009-10, all of general psychiatry, psychiatry of old age, learning disability, and non-obstetric GP beds, accounted for adult

---

spend of around £621 million, or about 18% of total inpatient spend on adults (aged 15+ for this illustrative modelling).

At the time of writing there is less agreement about the budgets for other inpatient specialisms. However, if we are serious about the resource following the person, and establishing commissioning budgets genuinely capable of reducing emergency admissions and shifting the balance of care, then our focus needs to be on redesigning the emergency care pathway. This would mean transferring inpatient budgets for range of acute and other inpatient resources including: front door (accident and emergency), general medicine and receiving services, and those specialisms which are mainly emergency-driven: such as medicine of the elderly, rehabilitation medicine, and palliative medicine – all of which currently spend more than 70% of their annual budgets on unplanned admissions. Their combined spend on adults in 2009-10 was just under £1 billion. With the £621 million mentioned earlier, the combined budgets of £1.6 billion amount to 46% of the total inpatient spend but 64% of expenditure on emergency inpatient admissions. (In time, there is also a case for further extending the commissioning budgets to include other specialism such as respiratory medicine, renal medicine and cardiology, which also currently spend more than 70% of their annual budgets on unplanned admissions).

The Scottish Government is currently preparing guidance on this issue. We are extremely concerned that this may set the minimum inpatient budgets to be transferred to Partnerships at too low a level to deliver the step change required. Without control over a significant proportion of inpatient budgets, the new Health and Social Care Partnerships will not be able to commission the changes to the whole system of care that are necessary to achieve the vision for integration; by itself “joint strategic planning”, without responsible power over budgets, will prove to be insufficient.

This is now the most important policy issue concerning health and social care integration.

3. **Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths**

The Bill builds on the impact of the older people’s change fund and together they provide the impetus for productive change. Research evidence and practical experience across the UK suggests there are four critical factors for successful integration-

- A clearly articulated and widely shared vision of ‘why, how and for what benefits?’
- A medium to long term financial strategy that is realistic about costs
- Flexible organisational arrangements that support a common purpose
- Attention to matters of culture through leadership

The Bill and its underpinning principles have presented Scotland with an opportunity to consider our ambitions for the public now and in the future and reflect upon current practices and their fit for purpose. ADSW is determined
to make a real and positive contribution to delivering this change and focus attention on these four key factors.

4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

The proposals for the integration of adult social care and health, and those in the Children’s Bill for the integration of children’s health and social care, should not result in a disconnect between adult services on which children depend for their safety and wellbeing. Where children are at risk, it is primarily from the actions or inactions of their adult carers. Children, therefore, depend as much on adult services for their safety, as on services targeted directly at them as children. The integration agenda is an ideal opportunity for services to bridge the gap between adult and children’s services, both within and across agencies. Legislation should support this effective integration, and not create additional boundaries, either strategic or operational, which then have to be managed.

Although the Bill seeks to create seamless services, there is still the issue of self-directed support to be resolved. The Parliament rejected amendments to the Self-Directed Support Bill, which would have extended it to appropriate health services. We need to find a way of avoiding confusion amongst professionals and the public and ensure that these two very positive pieces of legislation benefit people as much as possible.

The Bill leaves many important details to regulation, on which we are unable to comment at this stage.

5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

There is the potential for efficiencies to be gleaned from joint budgets, joint planning and joint commissioning, but the Bill itself focuses very much on the mechanistic arrangements to join services. Progress against nationally agreed outcomes and joint performance management frameworks will show progress in due course. The real benefits however will be in streamlining processes, having a more joined up approach, joint ownership of issues and a shared change agenda.

The Financial Memorandum, published alongside the Bill, provides estimates of the savings that integration may deliver:

The Bill will enable Health Boards and local authorities to plan and deliver holistic integrated health and social care services and to improve efficiency in allocation and utilisation of their joint resources. In summary, it is estimated that the potential efficiencies for partnerships from the combined effect of Anticipatory Care Plans, reducing Delayed Discharge and reducing variation, to be between £138m and £157m. These potential efficiencies should be considered in the context of the scale of the projected increase in expenditure attributable to demographic change, noted in paragraph 17, and will need to be
reinvested within the partnerships in order to help meet demand. (FM para 34).

ADSW welcomes this acknowledgement that any savings require to be reinvested. The FM refers in paragraph 17 to demographic projections of the increasing numbers of older people in Scotland but does not give data on costs. That can be found on page 5 of the Final Business and Regulatory Impact Assessment (BRIA) published\(^2\) by the Scottish Government alongside the Bill:

The challenge for health and social care services is seen in projections for demographic change in terms both of the expected growth in the older population and in terms of rising costs for health and social care for all ages. Over the next 20 years health and social care costs in Scotland are expected to rise by a total of £2.5 billion, so that by 2031 total annual costs will exceed today’s by £2.5 billion, at today’s prices.

The figure of £2.5 billion is 16 to 18 times larger than the savings estimates of between £138m and £157m contained in the FM.

Even so, ADSW believes that the Financial Memorandum savings estimates are problematic. The anticipatory care savings of £12m per year are modest and are based on grossing up a small pilot project\(^3\) in Nairn (para 29). Anticipatory care planning\(^4\) is used to support people living with a long term condition to plan for an expected change in health or social status. It also incorporates health improvement and staying well. Completion of a common document called an anticipatory care plan is suggested for both long term conditions and in palliative care. The results of the Nairn pilot were encouraging, but grossing up potential savings to Scotland from a study of 96 patients receiving ACP in Nairn is bound to involve a wide margin of error.

**Delayed discharge**: Chart 1 at paragraph 25 of the FM shows a dramatic fall in the number of people in hospital whose discharge is delayed from over 3,000 in early 2002 to under 500 in April 2008, since when numbers have fluctuated. The FM acknowledges that “progress has been more difficult in recent years” but does not explain why. The Final BRIA identifies “Savings from reduced cost shunting e.g. reduced delayed discharges” as one of the benefits of integration (also mentioned at para 159 of the Policy Memorandum). Certainly for some individuals with high cost care needs there are difficulties in securing the joint NHS and council funding to support timely discharge from hospital; however, such “cost shunting” cases are not sufficiently numerous to explain the difficulty in making further progress to

\(^2\) Final Business and Regulatory Impact Assessment (May 2013), available at: [http://www.scotland.gov.uk/Publications/2013/05/3959](http://www.scotland.gov.uk/Publications/2013/05/3959)


reduce delayed discharges. Data from Edinburgh, for example, suggests other causes: an 5.4% increase in home care hours in 2012-13, compared to the previous year, still left delayed discharge numbers at much the same levels. As more people are discharged, their beds are filled with new admissions who in turn become delayed.

The FM states that delayed discharge can be reduced by “by reallocating expenditure from hospital to community based health and social care to facilitate timely departure from hospital and provide alternatives to admission to hospital”. If no-one waited for more than 14 days £22m per year could be saved, increasing to £41m if no-one waited for more than 72 hours (paragraph 27). These calculations are based on the cost differences between inpatient beds and a weighted average of residential and home-based care. However, unless longer term investment capable of reducing future admission to hospital is increased, these savings are unlikely to be realised. The goal must be to ensure that GPs can get direct access to services or resources to care for someone at home as easily as it is currently to admit someone to a hospital or care home. In turn this requires that all GPs know about the services and resources available in Partnerships, and know that using them will deliver better outcomes for their patients.

The £104m savings modelled in the FM from “reducing variation” in health spend per weighted population down to the average are even less convincing. The statement that “For healthcare, the variation cannot be explained by differences in need across partnership populations or in input costs and may be due to inefficiencies” (para 30) assumes that populations weighted by the “NRAC” resource allocation variables adequately reflect all spending needs – a bold claim for any resource allocation formula, however good. Moreover annual health board budget allocations still reflect the phased changes from the previous “Arbuthnot” allocation formula to the current National Resources Allocation Committee (NRAC) formulae. So variation in NRAC standardised spend per head could reflect imperfections in the measures of need, transitional allocations, or externalities such as council spend (acknowledged in para 30), levels of unpaid care, inputs by of the third sector, etc.

Finally, depending on how the Scottish Government deals with the issue of acute inpatient budgets, discussed earlier, health and social care integration, together with the wide range of prevention work-streams and more concerted action on health inequalities, could do much to reduce the financial impact of increasing numbers of older people and people of all ages with disabilities and long term conditions. However, these policies are most unlikely to reduce the fiscal impacts of demography to zero. If GDP growth rates returned to their 30-year pre-austerity average, then the full cost of additional services required by 2030 would be affordable, provided there was appropriate political leadership and sufficient societal support for increased spending on care. If the long boom is past, then tougher choices are inevitable. Either way, ADSW believes that a wider review of future options for the resourcing of health and care is required in Scotland, similar in scope (but not necessarily in outcome) to reviews undertaken in England by Derek Wanless, Andrew Dilnot and others.
It is acknowledged that the financial memorandum to the Public Bodies Bill is focussed on ‘adult’ care and health budgets and costs. The comments from ADSW therefore centre on resources associated with adults and older people. The association would however wish to underline that these budgets and costs do not exist in isolation and in particular there are very similar cost pressures with local authority Children’s Services. In social work services (and in education services) these demand led cost pressures are considerable and are driven by issues such as the 16,200 children who are looked after, the largest number for 30 years. ADSW would submit that any consideration of ‘adult’ budgets experiences in children’s services and the impact that this can have on the whole social care and health system and this is not referred to in the memorandum.

6. What effect do you anticipate integration plans will have on outcomes for those receiving services?

As previously stated, ADSW welcomes the focus on outcomes and we will be keen to monitor effectiveness in terms of achievement of the national outcomes. However, we are of the view that a requirement for partnerships to adopt one of two models reduces their ability to make best, locally sensitive decisions. Partnerships should be responsible and accountable for the outcomes associated with integration. Either model has the potential to destabilise existing, effective arrangements across high profile services. They may increase risk to vulnerable groups/ be counter-productive to joint working. Best outcomes will not be possible unless services are provided in a coherent, rational manner.

A fundamental issue in improving outcomes is the long term sustainability of funding social care in the context of major reductions in local authority budgets and the need to protect best NHS practice. The role of the acute sector is central to the achievement of outcomes and we must ensure that it is appropriately represented in new partnership arrangements.

To develop sustainable change that delivers best outcomes for individuals, we need to commit to an appropriate scale and pace of change. Evidence shows that success depends upon effective change planning for a 5 year period (see Ham, C 2010) and requires the financial and wider resource cost of change and of changed practices to be recognised.

Without due recognition of the activities that are required to create an environment where integration can flourish, best individual outcomes will not be sustained. For example, investments are needed in new innovation before funds are released from traditional models of practice; there requires to be a concurrent focus on self directed approaches within an integrated environment; we need to establish clear responsibilities for market development to ensure the correct supply of appropriate adult care services within a plural market; develop joint financial governance frameworks and joint strategic commissioning plans as well as integrated budgets.

Culture is an essential factor – we must develop a persuasive vision for staff and the public through good leadership.
“Rhetoric must be mirrored by collaborative leadership practice in action, as without this the sustainability of change aimed at improved outcomes will be severely limited” (Bardsley et al; June 2013)

Essentially, we must base integrated work on outcomes defined by service users not targets. National outcomes need to be defined by the views of service users -

“defining outcomes that matter to service users and carers is important...(they)...may differ from policy and [practice imperatives but are a crucial aspect of understanding the effectiveness of joint or integrated services” (Cameron et al:2012)

Good, cost effective outcomes are those built around individuals using approaches that maintain local determination.

Association of Directors of Social Work
16 August 2013
Q1. Do you agree with the general principles of the Bill and its provisions?

In general, Alliance Boots supports the Scottish Government’s vision for integrating health and social care services. The structural changes within health and social care organisations contained within the Bill will help but they will not, by themselves, achieve a shared culture or integrated delivery of services from a patient perspective.

This Bill is mainly enabling legislation and there is a lack of detail about how the principles of integration will be applied in practice.

The Government also needs to place greater emphasis on promoting healthy lifestyles and preventative public health and screening services. Without this, it will merely store up problems that will be more expensive for health and social care services to deal with in the long term.

Community pharmacies sit at a nexus between health and social care. Many of our customers will be receiving support from both services. Pharmacies also have extensive contact with formal and informal carers, and many pharmacies make deliveries to patients, providing a regular point of contact with NHS services.

We expect community pharmacy representatives to be consulted at all stages in the design, development and implementation of local plans, allowing our awareness of patients’ needs across the spectrum of health and social care to be incorporated into the integration process.

Q2. To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

In our submission to the Scottish Government’s consultation on “The integration of adult health and social care” last year, we said that the proposed structural approach was complex, difficult for patients and outsiders to grasp and did not set out clear lines of accountability. The approach in the Bill does little to address this.

Health Boards and Local Authorities could end up working in a complex matrix of partnerships and delegated authority, potentially diluting the “joined up thinking” approach that the Government is seeking to achieve. Ministers need to explain how this will solve rather than create problems locally.

As mentioned above, there is a significant lack of detail on the face of the Government’s Bill, with much to be decided by Ministers or included in secondary legislation (as yet to be written). Therefore, it is difficult to predict with any certainty the extent to which the Bill will produce a more unified service, as experienced by patients and providers.
Q3. Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths.

We believe that the creation of “national health and wellbeing outcomes” could be a key strength, as long as these are clear, pragmatic and achievable in the medium to long term.

In England, the creation of overlapping NHS, Public Health and Social Care Outcomes Frameworks is giving greater recognition and clarity to the shared responsibilities that each sector has for improving patients’ wellbeing. We hope that the Scottish Government will also be able to create a similar set of shared outcomes for organisations to achieve.

Q4. Please provide details of any areas in which you feel that the Bill’s provisions could be strengthened.

We believe that there should be more explicit recognition of the need for clinical professionals (including pharmacists) to be represented on new bodies and fully involved in the planning of services, as was the case with Health and Social Care Partnerships. This should include representation from those working in a variety of sectors and locations across the pharmacy profession.

The Scottish Government has commissioned a review of NHS pharmaceutical care of patients in the community from Dr Hamish Wilson and Professor Nick Barber (known as the Wilson review). This is due to report to Ministers shortly. We would like the Committee to consider any implications for the planning of integrated health and social care services that might arise from the review, once it is made public.

On a wider note, the Bill specifies [Part 1, Section 1] that where there is one Health Board and one Local Authority in a co-terminous locality, then they have four approaches for developing an integration plan, ranging from a joint board to various permutations of delegated authority. The Bill should be clear about what approaches are available where a Health Board shares its boundaries with multiple local authorities.

Q5. What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?

As stated under Q2 (above), without seeing the detail of how such plans will be put together, what they will contain and how they will be delivered, it is difficult to quantify any potential benefits at this stage.

We re-iterate our concerns that having a multitude of approaches to arranging local service provision will increase costs for organisations operating nationally.

Pharmacies are located at the heart of the communities they serve and are able to reach those who are currently well, not just those who are ill. Pharmacies are already making a huge contribution to health and public health. They can do more with the right resource and support. We want to see
integration plans that recognise this and which combine national standards and outcome measures with local flexibility and innovation.

Pharmacies can support patients at all stages of health and care. Public health services make interventions that reduce current and future burdens on the NHS. Support for patients who are taking medicines for long-term conditions enables them to get the best outcomes, reducing demand on other parts of the health system. Variations in adherence to medicines can be a pointer to wider health or social care issues and early interventions can prevent unnecessary hospital admissions.

Pharmacists’ knowledge of medicines helps identify issues related to medicines taking, including adherence and side effects, which could have consequences for social care, such as falls. Pharmacies support patients and their carers to ensure medicines are taken safely and appropriately, avoiding waste and adverse incidents.

Q6. What effect do you anticipate integration plans will have on outcomes for those receiving services?

Integration plans will not by themselves improve outcomes. Instead, they set the direction that each locality will pursue in establishing a shared health and social care service. These new organisations then need to demonstrate how they are supporting health and social care professionals to work together to deliver better care and outcomes for patients.

We support the development of shared anticipatory care plans for high-risk patients who are frequent users of health and care services. Given the place of medicines in the treatment of long-term conditions, we would expect all such plans to have a pharmacy element and for there to be formal involvement of community pharmacies in the development and use of such plans.

Alliance Boots
Boots UK
Public Bodies (Joint Working) (Scotland) Bill

Late Submission - NHS Highland

Following integration in the Highlands when NHS Highland became the lead agency for Adult Services a period of redesign over a five year period was initiated. This was in line with the Partnership Agreement signed between the Health Board and the Council and reflected the outcomes framework outlined therein.

The following are examples of improvements that have occurred over the first 18 months of the Lead Agency model. It must be remembered that a number of changes and initiatives are coming together in adults care commissioning, co-production, community development, anticipatory care but these examples illustrate the real benefits as a result of adopting this integrated model.

Care Homes – As part of the transfer of functions to the Lead Agency, care homes previously run by the Council are now the responsibility of NHS Highland. This has enabled a consistent approach to training of staff in moving and handling, infection control, tissue viability and falls prevention across community health and social care staff and those working in care homes. There are obvious benefits in relation to economies of scale but more importantly, all are working to the same policies and procedures providing a consistent approach. The joint training has also enabled better sharing of information and learning of roles and responsibilities across the sectors.

In addition to this care homes are seen as a central resource in communities where a flexible service can be delivered providing a range of respite, step-up-step-down and intermediate services in conjunction with other health and social care services delivered across all of the sectors. An impact of this was when an Independent care Home crisis was averted by local mobilisation of support, thus avoiding the emergency transfer of 8 vulnerable people on a Friday afternoon. Another example is of a lady admitted for a 2 week stay but was able to go home after 8 days due to the coordinated support.

Integrated teams – work is ongoing to develop a more holistic approach to health and social care in our communities accessed by one single point of access. Many teams are already co-located with sharing of information across community, Primary and Social care teams to speed up access and deployment of services. Teams are able to consider more flexible use of all of their resources and services on a daily basis. For example, in the past in order to access a respite place a client needed to be on a Social Worker’s case load. Now that all professional groups are more integrated and linked in, they have a greater awareness of who would benefit from a period of respite and can allocate accordingly. The development of this holistic approach involves a wider range of staff and affords greater working together opportunities. Another example is the delivery of a memory clinic delivered by a Community
Psychiatric Nurse in a Day Centre. Not only do the people attending get the benefit on the day but also at all other times as staff gain insight and understanding that allows them to better support people with failing memory.

NHS Highland
Public Bodies (Joint Working) (Scotland) Bill

Supplementary Submission – Scottish Health Council

The Scottish Health Council is part of Healthcare Improvement Scotland. We are providing this further evidence to clarify and expand on points raised during the oral evidence sessions on 24th September 2013 and 2nd October 2013.

Role of Scottish Health Council in supporting Public Partnership Forums
The Scottish Health Council was established in 2005 to ‘support, ensure and monitor’ patient focus and public involvement activities of NHS Boards. As such the Scottish Health Council has a role to support the development of Public Partnership Forums, with the prime responsibility for establishing them and maintaining their effectiveness resting with Community Health Partnerships. The Scottish Health Council support is provided primarily through our network of Local Offices, but we have also at times in the past engaged at national level with Public Partnership Forum representatives to get feedback and share good practice.

The Scottish Health Council has a functional approach, with dedicated teams providing:

- Community engagement and improvement support (local advice and support)
- Service change (quality assurance and advice)
- Participation Network (evidence and promoting good practice, national support)
- Performance and Planning (quality assurance/evidence/standards)
- Public Involvement Unit (providing support to Healthcare Improvement Scotland in relation to its Duty of User Focus and Equalities duties).

The Participation Standard
The Participation Standard was developed by the Scottish Health Council to enable NHS Boards to assess how well they were doing and how to improve in relation to patient focus and public involvement. We recently produced a National Overview Report that demonstrates that the majority of Boards have improved over recent years, as verified by local patients/community groups.

Standards for Public Involvement in Health and Social Care
The Scottish Health Council commissioned research to explore the future possibilities for public involvement in Scotland, in the context of integration between adult health and social care services gathering views from members of the public, and health and social care practitioners through discussion groups, telephone interviews, an online survey and a workshop. Subsequently a think piece was developed which outlines ideas about how people – as individuals and communities – could be involved in discussions and decisions about health and social care in Scotland in the future.

To explore the debate on both the expectations and options for the development of Public Partnership Forums the Scottish Health Council held
four regional events under the title of “Developing a shared vision for public involvement in integrated adult health and social care services”. This work reported that:

‘Most felt that a common standard could help with building a joint ethos, culture and language around public involvement across health and social care’.

The Scottish Health Council considers that there is an opportunity for the Bill to be clearer on the involvement of the public and that there should be a single standard for the integrated structures that build on existing good practice standards and principles. The Participation Standard is now demonstrating that it is driving improvement and should be used as the basis for a revised single standard, that brings together the National Standards for Community Engagement and other good practice guidance, and that includes indicators linked to the delivery of a national outcome.

A single standard for participation in health and social care should be developed. There should be a quality assurance system to ensure improvement can be demonstrated.

An Outcome for Public Involvement in Health and Social Care
On the question of a national outcome for public involvement, participant views were mixed although there was a sense that a national outcome would give public involvement a higher profile and status and give a clear signal to all about its importance. People also suggested that an outcome should be realistic, something that everyone could understand and couched in generic language rather than in jargon that is specific to either health or social care. The outcome should be about both the process and outcome of involvement.

The Scottish Health Council suggests that a national outcome should be developed to read along these lines:

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.

Structures for Public Involvement in Health and Social Care
The Scottish Health Council considers that through the Bill process guidance should be provided to health and social care partnerships with recommended mechanisms for public involvement in each health and social care partnership area, with local areas asked to comply with the guidance or explain their local variation.

Practice should build on existing networks and relationships with condition specific and equalities groups taking account of geography and culture.

Scottish Health Council
Health and Sport Committee

Public Bodies (Joint Working) (Scotland) Bill

Note of a meeting of members of the Health and Sport Committee NHS Highland staff and board members, held at the Mackenzie Centre, Inverness on Monday 23 September 2013

Members Present: Duncan McNeil MSP (Convener), Rhoda Grant MSP, Nanette Milne MSP

NHS Highland staff, board members and service users:

David Donaldson – Service User
Garry Coutts – Chair
Elaine Mead – Chief Executive
Jan Baird – Director of Adult Care
Fran Macleod – Manager – MacKenzie Centre
Frances Gair – District Manager – Inverness East
Allyson Harrison – Charge Nurse – RNI
Jane Williams – Senior Physiotherapist RNI
Thomas Ross – Lead Pharmacist – South & Mid Operational Unit
Gillian Swanson – Deputy Lead Pharmacist – South and Mid Operational Unit
Vivian MacKenzie – OT – York Day Hospital
Carol Jackman – Physiotherapist – York Day Hospital
Lisa Fox – Speech and Language Therapy – York Day Hospital
Fiona MacDonald MacKenzie Centre
Mary McCormick MacKenzie Centre

Summary of discussion

The meeting had been arranged in order to assist the Health and Sport Committee in its stage 1 scrutiny of the Public Bodies (Joint Working) (Scotland) Bill. As it appeared that Highland would be likely to be the only partnership that would be adopting the “lead agency model”, the Committee agreed to send a delegation to learn about the scheme of integration being developed in Highland and to meet staff involved in delivering integrated services.

- Gary Coutts, HNS Highland Chair explained that the board and the local authority (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.

- “Hundreds” of issues had emerged but council and NHS staff had worked through them all and agreed solutions. Final partnership agreement document runs to hundreds of pages.
• Approximately 1400-1500 Highland Council staff had transferred to NHS Highland and about 200-300 from NHS Highland to Highland Council. Budgets had been moved at the same time.

• The first year had been very much about understanding the business, but work was progressing apace on the development of the Highland Quality Approach, which was based on “getting it right first time”.

• It was noted that there had been an increase in delayed discharge from hospital; this was due to a dramatic reduction in care home capacity, which staff were making urgent efforts to address.

• Asked about why it appeared that no other partnerships appeared likely to adopt the lead agency model, it was stated that this model “is best for people, but involves giving up power and requires trust between the partners”.

• It was noted that the Public Bodies (Joint Working) (Scotland) Bill, if passed, would not have a significant impact on the integration agenda in Highland, as the development of integrated care and health services had been undertaken using existing powers. However, it was noted that there was nothing in the Bill that would be to the detriment of the existing work that had been carried out, and no steps would require to be undone as a result of the provisions contained in the bill.

• Workforce issues. It was noted that the intention was to develop a single workforce, but it would take time to ensure that the correct management structures were in place in order to be able to devolve services fully to staff teams. It was reported that there had been while there had been issues to resolve with regard to harmonisation, salaries and conditions of service, these had not so far proved insurmountable. Equal pay issues were not being seen as a major risk.

• Co-location of staff had been very successful and had helped staff from different backgrounds gain a better understanding of each other’s roles. Some joint visits were already going on and one health centre was now surplus to requirements

• Policies for fall prevention, infection control etc were now the same across all hospitals and care homes. Care homes were now being seen less as a place to spend the last few years of a person’s life and more a place where they could go for a short spell.

• It was noted that NHS Highland had been granted a “licence to occupy” care homes but, for technical accounting reasons, the assets remained with the council.

• Enhanced pharmacies were being developed across the area.

• An advocacy service was now being established in care homes.
• Multi-disciplinary teams had been established in north and west of the partnership area.

• It was suggested that redesign opportunities are “huge”, though it was acknowledged that this takes time and requires goodwill and trust.

• Strategic commissioning is a vital part of the process, for which everyone needs to be at the table. The partnership was pursuing commissioning techniques that had been developed elsewhere in the world and which insisted on patients and careers being involved.

• It was also suggested that there was an integration job to be done within NHS as well as across other agencies. Housing had not yet been integrated but all adult services have been. Integration was said to be a process, not an event. The emphasis was on shifting the balance of care and health and not about isolating people in their own home.

• Finally, there was a need to continue evidencing success.
Public Bodies (Joint Working) (Scotland) Bill

Members took part in a study visit hosted by the West Lothian Community Health and Care Partnership (CHCP) on Monday 30 September 2013. The aim of this visit was to assist the Committee in its consideration of the Public Bodies (Joint Working) (Scotland) Bill at stage one.

The delegation visited REACT (the Rapid Elderly Assessment Care and Treatment Team) at St John’s Hospital, Livingston; First Steps to Health and Wellbeing, Broxburn; and finally, met with the Mental Health and Mental Wellbeing Steering Group for Children and Young People at the Civic Centre in Livingston.

Members Present: Richard Lyle MSP, Aileen McLeod MSP and Nanette Milne

West Lothian CHCP staff and officers:

REACT
Scott Ramsay, Consultant Physician & Geriatrician, St John’s
Linda Yule, Team Leader, REACT
Suresh Sanders, Community Geriatrician, St Michaels Hospital and REACT
First Steps to Health and Wellbeing
Chris Dickson, Health & Fitness Development Manager, West Lothian Leisure
Shena Brown, Respiratory Facilitator
Mental Health and Mental Wellbeing Steering Group
Susan Johnstone, Team Manager, Children and Young People Team
Mike Moss, Counsellor, Children and Young People Team

West Lothian CHCP
Anne McMillan, Executive Councillor, West Lothian Council
Jim Forrest, Director, West Lothian CHCP
Marion Christie, Head of Health, CHCP
Jennifer Scott, Head of Social Policy, CHCP
Carol Bebbington, Primary Care Manager, CHCP
Pamela Main, Senior Manager Community Care, CHCP

Summary of discussion

West Lothian Community Health and Care Partnership

West Lothian CHCP was set up in 2005 with the aim of enhancing and developing the delivery of integrated health and social care services to the population of West Lothian. The CHCP is headquartered at the West Lothian Civic Centre in Livingston, which also houses the West Lothian Command Centre of Police Scotland, the Sherriff and Justice of the Peace Courts, Crown Office and Procurator Fiscal service, Scottish Children’s Reporter Administration and the Scottish Fire and Rescue Service. CHCP staff were very positive in their views of how this co-location of agencies had helped to encourage integrated working.

REACT
REACT is a new service in West Lothian for over 75s to offer an alternative to hospital admission as well as supporting early discharges from hospital and provides rapid assessment of adults in their own homes. The service operates on a 9-5 Monday-Friday basis, however there is also a 24/7 crisis care service.

Members visited the REACT base at St John’s Hospital and met with members of the REACT team.

The REACT service has enjoyed notable success in terms of reducing hospital admissions.

Members heard that the initiative had led to greater levels of interaction between primary and secondary care than anywhere else in Scotland. There were also good links with care agencies and the voluntary sector. The nature of the service had increased the degree of personalisation of care provision. For example, it was noted that REACT had the ability to make referrals to care homes. There were also good links with local pharmacists.

Most referrals originate from GPs. After some initial hesitance, the team had observed a growing confidence amongst GPs to work with the team in taking decisions on referrals.

A database is maintained recording qualitative data, including response times, the time spent by patients in the service, details of follow-up contacts, mortality figures and the length of hospital stays resulting from referrals and the related number of bed days saved.

The team consists of:

1 (whole time equivalent) consultant
1 doctor
4 nurses
4 physiotherapists
4 occupational therapists, and
1 speech and language therapist

First Steps to Health and Wellbeing

First Steps to Health and Wellbeing is an exercise referral scheme run in partnership between West Lothian Leisure and the CHCP, based at the Strathbrock Partnership Centre in Broxburn. The aim of the scheme is to increase physical activity levels in referred patients and encourage longer-term commitment to exercise and activity. 28% of participants continue to use West Lothian Leisure sites beyond 12 weeks (the national average is 10%). 90% of those who continue in the project for 12 weeks remain in it at 26 weeks.

The scheme has seen around 7,500 people through its service since establishment in 2007. Sessions are delivered in appropriate venues within communities, for example community halls. In addition, facilities are available on the acute admissions ward at St John’s, including a fully-equipped gym.

The service is jointly funded 50-50 by West Lothian Council and West Lothian Leisure, and jointly accountable, reporting to the CHCP. Unlimited access is
available for the first 12 weeks, thereafter monthly membership is £22.50 (half price for benefits recipients) and community activities are charged at £2.50 per session.

**Mental Health and Mental Wellbeing Steering Group for Children and Young People**

Members met with representatives of the Mental Health / Mental Wellbeing Screening Group, an initiative between health, education and social policy, which aims to streamline mental health and mental wellbeing services for children and young people. The Group works with local groups and organisations across the three policy areas.

Referrals are managed by a screening group, which comprises Children’s Counsellors, Resilience Worker and Mental Health link worker services. Referrals are discussed by these specialist workers and they decide what service is most appropriate, and advice is provided and any follow-up action is initiated. Early intervention is central to the Group’s work, allowing quick identification of what services are required – a discussion that involves all service providers. The voluntary sector is also involved.

There is continuity of counselling services from early years through school age children to post-school/younger people. 191 children have been seen in the first 6 months of its existence. The service has achieved a 100% attendance rate as a result of its initial screening processes.

As well as GP referrals, counsellors also have a presence in GP surgeries and attend schools, which have facilities available to them.

Overall, the initiative has been well received by partners in education and health, primarily because it has sped up the process of screening and referral.
Health and Sport Committee

Public Bodies (Joint Working) (Scotland) Bill

Lothian Centre for Inclusive Living

Members of the Health and Sport Committee, Richard Lyle MSP, Aileen McLeod MSP and Nanette Milne MSP attended an event organised by the Lothian Centre for Independent Living (LCiL) on Monday 30 September 2013. This was arranged in conjunction with Inclusion Scotland, the Independent Living in Scotland Project (ILiS), Self-Directed Support Scotland (SDSS), and members of the Independent Living Movement.

LCiL organised this event to provide the Committee with the opportunity to hear directly from a cross-section of disabled people and disabled people’s organisations (DPOs) their views of the Public Bodies (Joint Working) (Scotland) Bill, which the Committee was considering at stage one.

Participants were divided into small discussion groups, with one Member allocated to each group.

Central to the overall theme of the event was the document ‘It’s our world too: 5 Asks for a better Public Bodies (Joint Working) (Scotland) Bill’. This document consisted of evidence pulled together from disabled people at a series of workshops organised by ILiS. In summary, the ‘5 asks’ (www.ilis.co.uk) are:

1. Independent living, equality and human rights should be explicit in the principles and outcomes of health and social care integration.
2. Disabled people must be considered as full and equal stakeholders and co-producers in health and social care integration.
3. Disabled people, other users of the integrated systems and the wider third sector should be involved in leading on the principles of an integrated system and on how money within it is spent.
4. Social Care (Self Directed Support) (Scotland) Act 2013 and Public Bodies (Joint Working (Scotland) Bill 2013 must work together to promote seamless care provision.
5. The integration agenda should not further entrench health inequalities.

The overriding theme that emerged from each of the discussion groups was that the principles of independent living and human rights should lie at the heart of the Bill.

On the Bill itself, points raised by participants included:

- there is a need to formally link the Bill to the Self-Directed Support Act: “SDS and health and social care integration should work together”.
- It “should be about supporting people to participate in society and lead an ordinary life”.
The issue of ‘portability of care’ was raised for people who had moved from one part of the country to another.

Comments against the intentions of the Bill included:

- “health and social care integration as perceived will make things worse”; and
- one participant was concerned that “there’ll be less money, less care, less resources”.
- Other concerns in relation to integration included a silo-working mentality; and
- the fact that Health Boards covered several local authority areas.

Regarding the involvement of disabled people and DPOs, participants were clear that disabled people should “have a seat at the table” right from the start and that DPOs should also be involved to represent disabled people at all levels in the integration process. Participants wanted to see proactive support offered by the new integrated boards; that is to say disabled people shouldn’t need to request services when they are already known to health and social care providers.

Participants stressed the important role of GPs, who in some cases, may be the sole source of support for disabled people.

Some issues of oversight were raised:

- some participants felt that the Ombudsman lacked independence - the ‘community health council’ model was suggested as an alternative as this is a panel of people who use the system and so understand it by direct experience.
- It was felt that an independent monitoring system would oversee a fairer distribution of services to disabled people; and the Bill should contain provision for an independent review body to consider complaints (as current systems for handling complaints weren’t felt adequate).

Participants raised other points in relation to current systems that they hoped the legislation would address, including:

- the time taken by social work services to put provisions in place, which can lead to ‘bed-blocking’;
- a concern that the current system lacks a continuity of care, so for example, disabled people are repeatedly asked to explain their circumstances to different people.
- There was also concern raised of a lack of awareness-raising about disability and long term chronic conditions in BME communities.

Finally, there was some concern about the integration of budgets between health and social care systems, particularly where the first is predominantly free at the point of use and the other has charges associated with it.
Introduction

1. The Public Bodies (Joint Working) (Scotland) Bill (referred to in this statement as ‘the Bill’) gives Scottish Ministers a power in Section 12 to make an order that makes provision for the membership, proceedings, powers and other matters with regard to the integration joint board. Section 12 as introduced sets out;

12(1) The Scottish Ministers may by order make provision –

   a) about the membership of integration joint boards,
   b) about the proceedings of integration joint boards,
   c) giving integration joint boards general powers (such as powers to contract, acquire or dispose of property or rights or borrow money or incur other liabilities) in connection with the carrying out of their functions,
   d) about the supply of services or facilities to integration joint boards by their constituent authorities,
   e) about any other matter relating to the establishment or operation of integration joint boards that the Scottish Ministers think fit.

(2) Without prejudice to section 49(1)(a), an order under this section may make different provision in relation to different integration joint boards.

(3) The Scottish Ministers may by scheme make provision about the transfer to an integration joint board of staff, property, rights, liabilities or obligations of a constituent authority.

By virtue of section 49(4) of the Bill, orders under this section will be subject to the negative procedure.

The Scottish Government intend to propose amendments at Stage 2 to this section which will have the effect of broadening the scope of Ministers’ powers under section 12.

The effect of these amendments would be to confer an additional power on Ministers to make provision by order:

   a) enabling integration joint boards to establish committees for any purpose,
   b) about such other matters relating to any such committee as the Scottish Ministers think fit, and
   c) enabling an integration joint board to delegate to its chief officer, any other member of its staff or any such committee functions delegated to the integration joint board in pursuance of an integration scheme.
**Integration Joint Board**

2. The Bill requires Health Boards and local authorities to agree a model of integration. Where partners agree to put in place a Body Corporate, an integration joint board will be established to oversee the integrated arrangements and onward service delivery. The integration joint board will exercise control over a significant number of functions and a significant amount of resource. It is essential that the process of how the Board will operate, and by whom, is set out within an order to put in place the robust arrangements required for this level of responsibility over public services and finances.

3. In the first instance, Scottish Ministers intend to use the powers set out in Section 12 to create the appropriate order to achieve this level of assurance and give the integration joint board the necessary powers to discharge its functions. This will largely draw on powers in Section 12(a), (b) and (e) to set out the standard arrangements for integration joint boards as concerning their membership and proceedings. Ministers also intend to limit the use of the powers in Section 12(1)(c), (d) and (3) to allow integration joint boards to enter into agreements or contracts which are necessary for them to carry out their duties under the Bill. For example, as part of the preparation and implementation of a strategic plan, it is likely that an integration joint board will require to receive professional advice, such as legal or accounting advice, or when making arrangements in relation to premises, equipment and staff, among other things.

4. The powers in Section 12 would also be used if local partners and Scottish Ministers agree to empower an integration joint board to deliver services in the exercise of integrated functions at some point in the future. Scottish Ministers have confirmed their intention that integration joint boards will not be empowered in this way in the first instance. This policy statement therefore, focuses on the orders that Scottish Ministers intend to make under Section 12 in the first instance and does not consider the possible future use of orders under section 12 in relation to empowerment of these bodies to deliver services.

**Proposed provisions to the membership and proceedings of the integration joint board**

*Membership of the integration joint board*

5. Scottish Ministers intend to set out in the order two categories of membership for the integration joint board. The first category is voting members, made up of representatives nominated by the Health Board and the local authority. The second category is non-voting advisory members of the integration joint board.

*Voting members of the integration joint board*

6. The Body Corporate model of integration creates a new legal entity that binds the Health Board and the local authority together into a joint
arrangement in which they are equal partners. The voting membership of the integration joint board is to reflect this equality in its membership arrangements to ensure that there is joint decision making on the Board.

7. Following consultation with stakeholders, policy work has been taken forward to strike the right balance with regards to how the voting membership should be established. It is intended that the order will reflect the following arrangements:

- The local authority and the Health Board must nominate the same number of representatives to sit on the integration joint board;
- The Health Board and the local authority must agree on the number of representatives that they will each nominate, subject to the provision described below;
- They must put forward a minimum of three nominees each, and local authorities can insist on a maximum of 10% of their full council number.
- The local authority will nominate councillors to sit on the integration joint board;
- The Health Board will nominate non-executive directors to sit on the integration joint board;
- Where the Health Board is unable to fill all their places with non-executive directors they can then nominate other appropriate people to fill their spaces (such as GPs or other clinical staff) but these people will require the approval of Scottish Ministers;
- Where Health Boards intend to nominate ‘other appropriate people’ to an integration joint board they would need to submit the list of proposed nominees to the Scottish Ministers with the integration plan when it is sent for approval.
- After this time, Health Boards would need to submit proposed nominations to Scottish Ministers for approval as and when they arise;
- Where Ministers have approved a nominee, the Health Board would need to obtain Ministerial approval to remove the members from the integration joint board.
- A Health Board must have at least two non-executive directors on each of the integration joint boards created within their geographical area.

8. The Scottish Ministers intend to use the power under section 1(4)(e) to require the Health Board and local authority to set out in the integration plan the detail of these arrangements agreed locally.

Non-voting members of the integration joint board

9. The integration joint board will make decisions about how health and social care services are planned and delivered for the communities within their areas. To do this effectively, they will require professional advice, for example, to ensure that the decisions reflect sound clinical and financial practice. It is also essential that integration joint boards have a duty to include key stakeholders within the decision making processes to take advantage of their advice and experience. The intention is to set out a minimum requirement for advisory membership in the order, and to allow local flexibility
to add additional nominations as the Health Board and local authority see fit. It is intended that the minimum advisory membership required will be:

- The identified Clinical Director of the Health Board;
- The Chief Social Work Officer of the constituent local authority;
- The Health Board Director of Finance or the local authority Section 95 Officer;
- A staff-side representative;
- A third sector representative;
- A carer representative;
- A service user representative;
- The Chief Officer of the integration joint board appointed under section 10(1) of the Bill.

10. The ways in which the members of the integration joint board are to be identified and appointed to the Board will differ. The first three are professional officers of the Health Board or the local authority and will be appointed because of the role they fulfil. It is intended that the integration joint board co-opt the staff-side, third sector, carer and service user representative once the integration joint board is established. The Scottish Government will provide guidance about the most appropriate way of doing this and if there are key groups that should be involved.

11. Locally, the integration joint board might wish to add additional non-voting members in an advisory capacity, perhaps because they are a key stakeholder locally or because they would seek more representation from a particular group. Alternatively, this might occur because the integration joint board have included functions outwith the minimum scope and they require additional professional advice; for example, from children’s services or housing.

12. The integration joint board will have the ability to co-opt further non-voting members as they see fit.

Chair and Vice Chair

13. It is intended that the chair and vice chair will be drawn from the voting membership. If a local authority nominated member is to serve as chair, then it is intended that the vice chair will be a member nominated by the Health Board and vice versa. It is intended that the member of the Integration joint board drawn from the Health Board who will serve as chair/vice chair is a non-executive Director. It is intended that the chair will have a casting vote, and the Scottish Government will provide guidance regarding the use of the casting vote.

14. It is intended that the appointment to chair and vice chair will be time-limited and that they rotate at least every three years. It is intended that if, at the end of this period, a local authority nominated member has served as chair, a Health Board nominated member (who is also a non-executive director) will then be elected to the chair and vice versa.
15. Health Boards and local authorities will need to agree who will serve as chair and vice chair and the period for which they will serve (if less than three years) and then rotate. Scottish Ministers intend to use the power set out in Section 1(4)(e), to require that this is included within the integration plan.

**Removal of voting members**

16. It is intended that the order will provide a mechanism for Health Boards and local authorities to remove and replace the voting members that are drawn from their respective organisations. The only exception to this will be if the Health Board has sought approval from Scottish Ministers to put forward a member who is not a non-executive director. In these circumstances, it is intended that the Health Board will be required to seek approval from Scottish Ministers to remove the member from the integration joint board.

17. The Health Board and the local authority will not be able to remove members that are drawn from each other’s organisations, so the Health Board could not remove a councillor who has been chosen to serve as a member by the local authority and vice versa.

18. It is intended that where the Health Board or the local authority remove a board member then they must nominate a new member at the same time. The ability of the Health Board and local authority to remove members includes all members including the chair and the vice chair. It is intended that the Health Board and the local authority will not be required to provide reasons for removing a member and can do so at any time but must provide the member with one month’s notice of the decision.

19. The provisions in relation to the removal and replacement of voting members are additional to the general provisions set out below. Therefore, it is intended that a voting member can also be removed if they are guilty of a serious breach of the code of conduct, imprisoned for an offence, etc. Removal under these circumstances would be automatic and the Health Board or the local authority would be required to nominate a new member.

**Multi-council integration joint boards**

20. The Bill provides for a Health Board to enter into integrated arrangements with more than one local authority where there is more than one local authority within the Health Board’s area. The current permutations of multi-council arrangements range from two local authorities to one Health Board, to six local authorities to one Health Board.

21. It is currently intended that the order setting out general requirements for integration joint boards will apply only where an integration plan has been prepared by one Health Board and one local authority. Given the complexity of describing the permutations of multi-local authority integration joint boards, the provisions of the order that relate to membership, voting and chairing will not apply to integration plans involving more than one local authority.
22. It is intended that in this circumstance the Health Board and the local authority will be required to present to the Scottish Ministers a proposal of how the governance arrangements will work (including the membership, the voting and chairing of the integration joint board). A proposed provision will be made in an order under section 1(4)(e) requiring details of these arrangements to be set out in the integration plan so that the Scottish Ministers may take it into account when deciding whether to approve the integration plan.

**Engaging in contracts**

23. It will be necessary for the integration joint board to have powers to enter into contracts so that they can seek professional advice and assistance, and make arrangements for staff and premises to carry out its functions. It is intended that the order will give such powers to the integration joint board so that it is able to discharge its functions under the Bill.

**Financial Advice**

24. Scottish Ministers intend to require that the Health Board and the local authority agree a financial management and reporting process for the integrated budget and set this out within the integration plan. To further strengthen the requirements for financial management, the Scottish Ministers intend to include within this order the requirement that the Chief Officer seeks advice from the Health Board Director of Finance and the Local Authority Section 95 Officer on financial matters.

**Intended provisions as to general operation of the integration joint board**

25. Scottish Ministers intend to include in an order a number of general provisions that will apply to all categories of the integration joint board. The areas noted below mirror those in the Health Board (Membership and Procedure) (Scotland) Regulations 2001 and The Community Health Partnership (Scotland) Regulations 2004.

**Term of Office**

26. It is intended to restrict the length of time that members can sit on the integration joint board to three years, and make a provision to provide that would enable a member to be eligible for re-nomination. Members who have membership due to the position that they hold, such as the Chief Social Work Advisor, will automatically be re-nominated while they remain in post.

**Expenses of members**

27. It is intended that the integration joint board will have the ability to pay any reasonable expenses (travel and subsistence) that members incur as they carry out the business associated with their membership of the board.

**Committee structure**
28. It is intended to allow the integration joint board to put in place a sub-committee structure should that be desirable.

Resignation and removal of members

29. It is intended that members will be able to resign their membership of the integration joint board at any time during their term in office by giving notice to the chair of the integration joint board. The integration joint board would need to inform the relevant Health Board or local authority should that member be a voting member. If a member misses three consecutive meetings then the integration joint board will be able to remove the member, if it is satisfied the absences were not due to illness. If this occurs in the case of a voting member, the integration joint board will need to seek agreement from the Health Board or the local authority. It is intended that, if a member brings the integration joint board into disrepute through their actions, they can be removed from the integration joint board.

Disqualification

30. It is intended that the order will set out those that are disqualified from being nominated or co-opted as a member of the integration joint board and will include those who have been imprisoned for longer than three months, dismissed (other than being made redundant) from a Health Board or a local authority, have been declared bankrupt or have been struck off as a practising health or social care professional.

Proceedings

31. It is intended that the order will require each integration joint board to make standing orders for the carrying out of the business of the integration joint board that will include, but are not restricted to:

- Calling of meetings;
- Notice of meetings;
- Quorum;
- Conduct of meetings;
- Conflict of Interest;
- Records.

The Scottish Government
January 2014
Policy Statement - integration joint monitoring committee  
Section 16(1)(a-d)

Introduction

1. The Public Bodies (Joint Working) (Scotland) Bill (referred to in this statement as the Bill) gives Scottish Ministers powers to prescribe the membership, proceedings, powers and other matters with regard to the integration joint monitoring committee. These matters are to be prescribed by order under section 16(1) of the Bill which provides:

16(1) The Scottish Ministers may by order make provision about –

   a) the establishment of integration joint monitoring committees,
   b) the membership of integration joint monitoring committees,
   c) the proceedings of integration joint monitoring committees,
   d) any other matter relating to the operation of integration joint monitoring committees that the Scottish Ministers think fit.

By virtue of section 49(4) of the Bill, orders under this section will be subject to the negative procedure.

Integration Joint Monitoring Committee

2. The Bill requires Health Boards and local authorities to agree one of four models of integration. Three of these models are described as ‘delegation between partners’ and allows the delegation of functions and budgets between statutory partners. Section 4(b)(c)(d) of the Bill sets out these three models of delegation that partners can undertake.

- Delegation of functions by the local authority to the Health Board;
- Delegation of functions by the Health Board to the local authority;
- Delegation of functions by the local authority to the Health Board and delegation of functions by the Health Board to the local authority.

3. Section 14(2)(a) of the Bill provides that where the Health Board and the local authority agree a ‘delegation between partners’ model of integration, they are required to jointly establish an integration joint monitoring committee for the purpose of monitoring the carrying out of the integration functions for the integration authority area.

4. It is intended that the integration joint monitoring committee will hold the body or bodies to whom the functions are delegated to account for the delivery of integrated services and provide assurances to the Health Board and the local authority of the progress that is being made to achieve the national health and wellbeing outcomes. It will have the ability to write reports and make recommendations to the lead agency, where it sees fit, and is key to providing on-going scrutiny and joint accountability of the integrated arrangements.
5. Scottish Ministers intend to use the powers set out in Section 16(1)(a-d) to ensure that operation of the integration joint monitoring committee is robust.

Intended provisions as to membership and proceedings of the integration joint monitoring committee

Membership of the integration joint monitoring committee

6. Scottish Ministers intend to set out in an order a single category of membership, all of whom shall have the same rights and responsibilities. It is intended to set out a minimum requirement for the membership of the integration joint monitoring committee but also allow flexibility for additional members to be added. It is intended that the minimum required membership will be:

- 2 nominations drawn from the local authority (Councillor);
- 2 nominations drawn from the Health Board (Non-executive director);
- Chief Social Work Officer;
- Associate Medical Director / Clinical Director;
- Health Board Director of Finance / local authority Section 95 Officer;
- Staff-side representative (on behalf of both Local Government and the NHS);
- Third Sector representative;
- Carer representative;
- Service User;
- Any other members as required by the Health Board or the local authority.

7. The ways in which the members of the integration joint monitoring committee are to be identified and elected to the Committee will differ.

8. It is intended that the nominees from the local authority and the Health Board will be nominated directly to the integration joint monitoring committee by the local authority and the Health Board.

9. It is intended that the professional officers of the Health Board and the local authority will be nominated because of the statutory role that they fulfil, in the case of the Chief Social Work Officer and the local authority Section 95 Officer, or because they have been identified by the Health Board as the appropriate person for the Clinical Director or Health Board Director of Finance.

10. Scottish Ministers intend to provide by order that the chair of the integration joint monitoring committee is to seek and recruit the staff-side, third sector, carer and service user representative once the integration joint monitoring committee is established. The Scottish Government will provide guidance about the most appropriate way of doing this and if there are key groups that should be involved.
11. Locally, the integration joint monitoring committee might wish to add additional non-voting members in an advisory capacity, perhaps because they are a key stakeholder locally, because they would seek more representation from a particular group, or alternatively because the integration plan includes delegation of functions beyond adult health and adult social care, which will require additional professional advice; for example, from children's services or housing.

12. It is intended that the order will give the chair of the integration joint monitoring committee the ability to elect further non-voting members as they see fit.

Chair and Vice Chair

13. It is intended to require the Health Board and the local authority to agree who will chair the integration joint monitoring committee and, in agreement with each other, change the chair of the integration joint monitoring committee by giving the chair one month’s notice in writing.

Removal of members

14. It is intended to allow the local authority and the Health Board to change the members that they nominate at any time. They do not need to provide a reason for changing their nominated members but must provide the member with one month’s notice of the decision. At the time of removal they should provide a substitute for the member for appointment to the integration joint monitoring committee.

Multi-council lead agency arrangements

15. The Bill provides for Health Boards to enter into integrated arrangements with more than one local authority where there is more than one local authority within the Health Board’s area. The current permutations of multi-council arrangements range from two local authorities to one Health Board to six local authorities to one Health Board.

16. It is currently intended that an order will apply where there is one Health Board and one local authority, and that, given the complexity of describing the permutations of multi-local authority integration joint monitoring committee, the provisions of the order that relate to membership and chairing will not apply to integration plans involving more than one local authority.

17. It is intended that in this circumstance the Health Board and the local authorities will be required to present to Scottish Ministers a proposal of how the governance arrangements will work (including the membership and chairing of the integration joint monitoring committee). It is intended that provision will be made in an order under section 1(4)(e) requiring details of the arrangements to be set out in the integration plan so that the Scottish Ministers may take it into account when deciding whether to approve the integration plan.
Intended provisions as to general operation of the integration joint monitoring committee

18. Scottish Ministers intend to include in the order a number of general provisions that will apply to all integration joint monitoring committees. The areas noted below are similar to those in the Health Board (Membership and Procedure) (Scotland) Regulations 2001 and The Community Health Partnership (Scotland) Regulations 2004.

Term of Office

19. It is intended to restrict the length of time that members can sit on the integration joint monitoring committee to three years, and to provide that a member is eligible for re-nomination. Members who have membership due to the position that they hold, such as the Chief Social Work Advisor, will automatically be re-nominated while they remain in post.

Expenses of members

20. It is intended to allow the integration joint monitoring committee the ability to pay any reasonable expenses (travel and subsistence) that members incur as they carry out the business associated with their membership of the committee.

Committee structures

21. It is intended to allow the integration joint monitoring committee to put in place a sub-committee structure should that be desirable.

Resignation and removal of members

22. It is intended that members will be able to resign their membership of the integration joint monitoring committee at any time during their term in office by giving notice to the chair of the integration joint monitoring committee. The integration joint monitoring committee would need to inform the relevant Health Board or local authority should that member nominated by them. If a member misses three consecutive meetings then the integration joint monitoring committee will be able to remove the member, if it is satisfied the absences were not due to illness, and with agreement of the Health Board and the local authority. It is intended that if a member brings the integration joint monitoring committee into disrepute through their actions then they can be removed from the integration joint monitoring committee with agreement of the Health Board and the local authority.

Disqualification

23. It is intended that the order will set out those that are disqualified from being nominated or co-opted as a member of the integration joint monitoring committee and will include those who have been imprisoned for longer than three months, dismissed (other than being made redundant) from a Health
Board or a local authority, have been declared bankrupt or have been struck off as a practicing health or social care professional.

Proceedings

24. It is intended that the order will require each integration joint monitoring committee to make standing orders for the carrying out of the business of the integration joint monitoring committee that will include, but are not restricted to:

- Calling of meetings
- Notice of meetings
- Voting
- Quorum
- Conduct of meetings
- Conflict of Interest
- Records

The Scottish Government
January 2014
Introduction

1. This note summarises Ministers' intentions in relation to the regulations that will be made under section 1(3)(e) of the Public Bodies (Joint Working) (Scotland) Bill. These regulations will prescribe information about prescribed matters that must be included within an integration plan.

The power conferred on Ministers is:

1 (3) An integration plan is a plan setting out –

   (e) prescribed information about such other matters as may be prescribed.

Section 48(1) of the Bill provides:

(1) In this Act – “prescribed” means prescribed by regulations.

Regulations under this power will, by virtue of section 49(4) of the Bill, be subject to negative parliamentary procedure.

Background

2. The Bill and the associated regulation will require that the Health Board and the Local Authority agree and include within the integration plan three broad categories of detail:

3. Firstly, the context and scope within which the integration authority will operate. This includes agreements such as the scope of the functions delegated, the resources delegated, and the model of integration. The requirement to include these arrangements are as provided for in Section 1(3)(a-d) and associated provisions within the Bill.

4. Secondly, key areas that will ensure effective joint working and decision making. This would include areas such as dispute resolution, data sharing and complaints handling. Scottish Ministers will use the power in Section 1(3)(e) to set out the areas that must be agreed and included within the integration plan. The regulation will provide for flexibility to allow the Health Boards and local authorities to add further areas of local agreement that they feel would aid integrated working into the integration plan.

5. Thirdly, arrangements that the integration authority should implement to provide the necessary assurance to the accountable officers of the Health Board and the local authority that the integration authority has fit for purpose arrangements for the discharge of functions and the associated resources. This includes the arrangements for finance governance and clinical and care governance. Scottish Ministers will use the power in Section 1(3)(e) to set out these areas of agreement within the integration plan. It is notable that the integration plan does not legally bind
the integration authority. However Scottish Ministers intend to use their powers in section 40 of the Bill to direct integration authorities to comply with the integration plan in respect of these matters as they are fundamental to the safe and effective operation of health and social care services.

**Summary of matters to be prescribed in regulations**

Ministers intent to provide that all integration plans must include:

- An agreement on clinical and care governance;
- An agreement and arrangements for the settling of liability;
- The inclusion of financial detail as noted above;
- An agreed process for dispute resolution;
- An agreed process for data sharing;

Ministers intend to provide that, where the integration model described in 1(4)(d) is chosen the integration plan must include:

- Details of the integration joint board arrangements and
- Details of agreed local measures and performance reporting arrangements.

Ministers intend to provide that, where the integration model described in 1(4)(a), (b) or (c) is chosen the integration plan must include:

- Details of the integration joint monitoring committee.

**Detail of matters to be prescribed in regulations**

**Clinical and Care Governance**

6. Clinical and care governance is a system that assures that care, quality and outcomes are of a high standard for users of services and that there is evidence to back this up. It includes formal committee structures to review clinical and care services on a multidisciplinary basis and defines, drives and provides oversight of the culture, conditions, processes, accountabilities and authority to act of organisations and individuals delivering care.

7. Health Boards are under a statutory duty to put in place and maintain clinical governance arrangements and local authorities have similar duties for social care provisions, many of which are discharged through the statutory role of the Chief Social Work Officer. These systems currently provide a holistic framework within their respective organisations.

8. In general, the responsibility for professional oversight in both health and social care services flow back to a lead professional. Be it the Chief Social Work Officer, the Medical Director, the Nurse Director etc. Whilst there will be clinical representation on integration joint boards, this will not be a substitute for detailed clinical and care governance arrangements that practically assure the quality of services, professional regulation and audit of incidents.
9. It is also intended that regulations will require that the integration plan sets out the details of the clinical and care governance arrangements that will be used by the Integration Authority to provide assurance that services are delivered in line with current duties and responsibilities.

10. The Scottish Government will also provide guidance setting out matters that Ministers expect the Health Board and local authority to agree and put in place. Policy officials have set up a working group that is considering the guidance that will be provided to Integration Authorities, Health Boards and Local Authorities about the practical operation of clinical and care systems for the integrated functions and how they relate to those functions that have not been delegated to assure that there are common standards across all health and care services.

Financial Governance

11. The Health Board and the local authority need to make decisions and agreements about the resources that will be included within the integrated budget, and the arrangements that will provide assurance to the local authority section 95 officer and the Health Board Director of Finance to discharge their duties.

12. Ministers intend to make provision in regulations to require that the integration plan sets out the agreements that have been reached in relation to the financial management and performance monitoring of money paid to the integration authority.

13. Specifically, the following details should be agreed and set out in the integration plan:
   - Financial Monitoring and performance management arrangements for the integration authority;
   - Payment schedule;
   - Process for treatment of over/underspends;
   - Process for re-determining (in year) the allocations to the integration authority (to be used in extremis);
   - Arrangements for risk management;
   - Arrangements for information management;
   - Arrangements for asset management and capital;
   - Permitted use of reserves;
   - Process for sharing the net assets of the integration authority on winding up.

14. The Scottish Government will also provide detailed guidance for each of the areas specified above.

Liability arrangements

15. It is intended to amend the Bill so that it provides for liability to be attributed in line with normal legal principles, in particular the principle that the person liable for any claim is the person with actual control over the circumstances giving rise to the claim. This will have the effect that any of the parties involved in integrated
arrangements may, depending on the circumstances, be held liable for a claim arising from the exercise of delegated functions.

16. Ministers also intend to use regulations to require that the integration plan must include details of any agreement made in relation to liability by the Health Board and the Local Authority. The Scottish Government will provide guidance to partners on this matter.

Dispute resolution

17. The successful operation of integrated arrangements is predicated on Health Boards and local authorities reaching agreement about some fundamental aspects of those arrangements and maintaining an on-going working relationship.

18. Scottish Ministers believe that, as far as possible, decisions should be made and agreed locally, without Ministerial intervention. To aid this process, it is intended that regulations will provide that Health Boards and local authorities must include an agreed mechanism for ‘dispute resolution’ in the integration plan.

Data sharing

19. The integration authority, for the purposes of fulfilling their statutory responsibilities, require anonymised demographic information to determine how services should be delivered rather than the personal data that is held on clinical and care systems. In this way, the Health Board and the local authority remain the data controls for this personal information.

20. To effectively integrate services at a delivery level and plan a package of care for an individual, it is important that professionals have access to the relevant data. This can happen through close working and the establishment of multidisciplinary teams or through allowing different professionals to access different records held across health and care systems. This sharing of personal data is sensitive and needs to be closely managed to ensure that an individual’s privacy is respected.

21. As the data controllers for health and care information it is important that Health Boards and local authorities set out a process for how data sharing issues will be managed for integrated functions and teams, and how systems and databases will be aligned to aid professional decision making. Ministers will require in regulations that Health Boards and local authorities set out this detail within their integration plan.

Local measures and performance reporting

22. This requirement applies only to the integration model described in Section 1(4)(a).

23. Health Boards and local authorities have responsibility for delivering a wide range of targets, measures and improvements either at a national level or in response to local circumstance and need. Under the body corporate model of
integration they will delegate a significant amount of their resource and associated functions that would have been used to deliver, or impact upon these other local measures.

24. It is therefore important that the integration plan sets out the outcomes and targets that the integration authority might contribute to the wider delivery that Health Boards and local authorities are accountable for. It is important that a process is set out that would describe how the Integration Authority would take responsibility for any of these areas and the performance management arrangements that would need to exist to provide assurances to all parties.

25. Ministers intend to set out in regulations a requirement that Health Boards and local authorities include in their integration plan:
   • the outcomes and targets that integration authorities will be expected to contribute to; and
   • the expected performance management arrangements that would need to be put in place.

Integration Joint Board

26. This requirement applies only to the integration model described in Section 1(4)(a).

27. The regulations that underpin the creation of the Integration Joint Board (made under section 12) will give Health Boards and local authorities some flexibility to determine the governance arrangements of the integration joint board. Scottish Ministers will require that they set out these areas of local agreement within the Integration plan so that they are agreed before Ministers lay an order before Parliament to create the Integration Joint Board. Ministers intend that regulations under section 1(3)(e) will require that the following details are set out within the integration plan;

   • The number of members of the integration joint board that will be drawn from the Health Board
   • the number of members of the integration joint board that will be drawn from the Local Authority
   • The arrangements that have been made in relation to the Chair of the integration joint board.

28. also It is also intended that regulations will prescribe that, in the case where two or more Local Authorities wish to enter into a body corporate arrangement with a Health Board, the detailed arrangements that have been agreed for the integration joint board must be included in the integration plan.

Integration Joint Monitoring Committee

29. This requirement applies only to the integration models described in Section 1(4)(b-d).
30. The regulations that underpin the creation of the integration joint monitoring committee (prescribed under section 16) will give Health Boards and local authorities flexibility in determining much of the governance arrangements for the integration joint monitoring committee. Scottish Ministers intend to require that these local agreements are included within the integration plan so that they are agreed before the lead agency takes responsibility for integrated functions.

31. It is also intended that regulations under section 1(3)(e) will require that the following details are set out within the integration Plan;

- The number of members of the integration joint monitoring committee that will be drawn from the Health Board;
- The number of members of the integration joint monitoring committee that will be drawn from the local authority;
- The arrangements for administrative support of the Integration Joint Monitoring Committee;
- The arrangements for and financing of the integration joint monitoring committee;
- Additional non statutory members that will be added to the integration joint monitoring committee.

32. Ministers also intend regulations to prescribe that, in the case where two or more local authorities wish to enter into a lead agency arrangement with a Health Board, the detailed arrangements that have been agreed for the integration joint monitoring committee must be included in the integration plan.

The Scottish Government
January 2014
Policy Statement – Integration Plan Consultation
Section 6(2)(a)

Introduction

1. This statement summarises Scottish Ministers’ intention in relation to the regulations that will be made under 6(2)(a) of the Public Bodies (Joint Working) (Scotland) Bill (referred to in this statement as the Bill). This gives Scottish Ministers the power to make regulations that prescribe such persons or groups of persons that the Health Board and the local authority must consult in the development of the integration plan. The power is;

Section 6 - Consultation

6 (2) Before submitting the integration plan for approval under section 7, the local authority and the Health Board must jointly consult –

   a) Such persons or groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed
   b) Such other persons as the local authority and the Health Board think fit.

By virtue of section 48(1) of the Bill “prescribe” means prescribed by regulations. By virtue of section 49(4) of the Bill, regulations under this section will be subject to the negative procedure.

Consultation on the integration plan

2. Section 1 of the Bill requires Health Boards and local authorities to jointly prepare an integration plan for the area of the local authority. The purpose of the integration plan is to establish the context and provide the necessary clarity for the arrangements in which the integration authorities will operate. It will set out the governance arrangements for the integration authority, functions and budgets to be delegated; outcomes to be achieved; the model of integration to be implemented; and a range of other topics that Ministers will specify.

3. It is essential that the local authority and the Health Board share the proposed integration plan widely with those who have an interest in the delivery or receipt of health and social care within the geographic boundaries of the proposed integration authority. This would include other integration authorities or local authorities whose resident populations access services primarily through the same Health Board.

4. Ministers intend to consult on the basis that regulations will specify that the following people or groups of people must be jointly consulted on the development of the integration plan;

   • Health professionals who operate within the boundaries of the proposed integration authority;
   • Staff of the Health Board who operate within the boundaries of the proposed integration authority;
• Users of health care who reside within the boundaries of the proposed integration authority;
• Carers of users of health care who reside within the boundaries of the proposed integration authority;
• Commercial providers of health care who operate within the boundaries of the proposed integration authority;
• Non-commercial providers of health care who operate within the boundaries of the proposed integration authority;
• Social care professionals who operate within the boundaries of the proposed integration authority;
• Staff of the local authority who they see as relevant who operate within the boundaries of the proposed integration authority;
• Users of social care who reside within the boundaries of the proposed integration authority;
• Carers of users of social care who reside within the boundaries of the proposed integration authority;
• Commercial providers of social care who operate within the boundaries of the proposed integration authority;
• Non-commercial providers of social care who operate within the boundaries of the proposed integration authority;
• Local authorities or integration authorities who operate within the geographic boundaries of the same Health Board;
• Non-commercial providers of social housing who operate within the boundaries of the proposed integration authority;
• Recognised representative bodies, representing the interests of specific age, condition or illness groups who operate within the boundaries of the proposed integration authority.

The Scottish Government
January 2014
Introduction

1. The Public Bodies (Joint Working) (Scotland) Bill (referred to in this statement as the Bill) gives Scottish Ministers the power in section 32(4) to make regulations that prescribe such persons or groups of persons that the integration authority, Health Board and the local authority must consult and take account of the views of, for decisions that may significantly affect services in a locality. The relevant provision of the Bill is as follows:

32 Carrying out of integration functions: localities

(1) This section applies where a person carrying out an integration function for the area of a local authority proposes to take a decision which the person considers might significantly affect the provision in a locality of the area of a service provided in pursuance of the function.

(2) In subsection (1), “locality” means a locality of an area as set out in the strategic plan in pursuance of section 23(3) (a).

(3) The person must take such action as the person thinks fit with a view to securing that the groups mentioned in subsection (4) are involved in and consulted on the decision.

(4) The groups referred to in subsection (3) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

2. Section 32(4) provides a power for Ministers to prescribe the groups which must be consulted.

3. By virtue of section 48(1), “prescribed” means prescribed by regulations. Section 49 sets out additional provisions in relation to subordinate legislation under the Bill. By virtue of section 49(4), regulations under this section will be subject to the negative procedure.

4. Ministers therefore require to prescribe by regulations a list of persons who must be consulted before a decision is taken under section 32(1).

Locality Consultation

5. The development of locality planning arrangements is an essential part of the integration reform agenda. By virtue of section 23(3), all strategic plans prepared under the Bill require to make provision about localities. A locality is a defined ‘natural community’ that is primarily brought together because the resident population have similar health and social care needs. Considering the area of an
integration authority in this way allows for better planning of services as they are better aligned to the needs of communities.

6. It is also the best place for engaging and involving health and social care professionals in the planning and delivery of services, because the areas are small enough that those planning for the community that they are serving whilst having an understanding of their needs. It draws together those professionals that work alongside each other on a regular basis to allow, frontline staff to discuss and plan for tangible changes to service provision, something that is essential to keeping the majority of professional staff engaged.

7. Evidence shows, however, that the most effective services are those that are developed and designed in partnership with local communities. Local communities, users and their carers are best placed to know what services they actually want, and what benefit they derive from the existing arrangements. This intelligence will be essential for integration authorities if they are to deliver improved outcomes.

8. The Scottish Government intends to consult on the basis that the regulation will stipulate that the following people or groups of people must be consulted when a decision is proposed to be taken under section 32(1):

- General Practitioners;
- General Practitioner practice managers;
- Social Workers;
- Mental Health Officers;
- Nurses;
- Allied Health Professionals;
- Pharmacists;
- Dentists;
- Opticians;
- Scottish Ambulance Service;
- Public Health professionals;
- Local authority Councillors;
- Users of services;
- Unpaid carers of the users of services;
- Non-commercial providers of health or/and care services;
- Commercial providers of health or/and services;
- Non-commercial providers of social housing.

The Scottish Government
January 2014
Policy Statement – Consultation Group  
Section 26(2)

Introduction

1. This statement summarises Scottish Ministers’ intentions in relation to the Regulations that will be made under section 26(2) of the Public Bodies (Joint Working) (Scotland) Bill. These regulations will prescribe such persons or groups of persons that the Health Board and the local authority must consult in the development of the strategic plan. The power conferred on Scottish Ministers, underlined within the wider section, as introduced is:

Section 26 - Establishment of consultation group

(1) For the purpose of preparing a strategic plan, an integration authority in relation to the area of a local authority is to establish a group comprising—

(a) where the integration authority is an integration joint board, one person nominated by each of the local authority and the Health Board which prepared the integration plan in pursuance of which the integration authority was established,

(b) where the integration authority is a Health Board, one person nominated by the local authority with which the integration authority prepared the integration plan in pursuance of which the integration authority acquired its functions,

(c) where the integration authority is a local authority, one person nominated by the Health Board with which the integration authority prepared the integration plan in pursuance of which the integration authority acquired its functions,

(d) one person in respect of each of the groups mentioned in subsection (2), being a person who the integration authority considers to be representative of that group, and

(e) such other persons as the integration authority considers appropriate.

(2) The groups referred to in subsection (1)(d) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

(3) The procedure of the group is to be such as the authority determines.

(4) The integration authority may pay to members of the group such expenses and allowances as the authority determines

2. By virtue of section 48(1), “prescribed” means prescribed by Regulations. Section 49 sets out additional provisions in relation to subordinate legislation under the Bill. By virtue of section 49(4), Regulations under this section will be subject to the negative procedure.

3. An amendment to the Bill at stage two is proposed which would have the effect of re-naming the consultation group the “strategic planning group”.

Strategic Planning

4. Section 23 of the Public Bodies (Joint Working) (Scotland) Bill requires the integration authority to prepare a strategic plan for the area of the local authority. A strategic plan is a document that sets out the arrangements for carrying out the integrated functions, and also explains how these arrangements are intended to achieve the national outcomes. Each strategic plan should last for a minimum three years, although the actual planning period of each plan can be longer (so an integration authority can set out a five or ten year plan but must review it at least every three years). The plan should be subject to a continual cycle of analysis and review.

5. Depending on the model of integration chosen, the group must involve members nominated by the local authority or the Health Board, or both, as set out in subsection (1)(a), (b) and (c). In effect, this provides for the partners who prepared the integration scheme and are party to the integrated arrangements to be involved in the development of the strategic plan. In addition, once a draft strategic plan is prepared, the integration authority will be required to seek the views of a range of relevant stakeholders, to be prescribed by Scottish Ministers as having an interest. The integration authority can appoint others as it feels appropriate. The integration authority is to determine the procedure of the group and may pay members of the group expenses and allowances.

6. In order to gain an understanding of local need and demand, integration authorities must take account of the views of those that provide services and of those that use services. The Policy Memorandum that accompanies the Bill makes clear that, as part of the strategic planning process, integration authorities will be required to:

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

7. The regulations will specify the groups that must be represented in the consultation group. Subject to discussion within the National Steering Group on Joint Strategic Commissioning, these groups may include:

- Health professionals who operate within the boundaries of the proposed integration authority;
- Users of health care who reside within the boundaries of the proposed integration authority;
- Carers of users of health care who reside within the boundaries of the proposed integration authority;
- Commercial providers of health care who operate within the boundaries of the proposed integration authority;
- Non-commercial providers of health care who operate within the boundaries of the proposed integration authority;
• Social care professionals who operate within the boundaries of the proposed integration authority;
• Users of social care who reside within the boundaries of the proposed integration authority;
• Carers of users of social care who reside within the boundaries of the proposed integration authority;
• Commercial providers of social care who operate within the boundaries of the proposed integration authority;
• Non-commercial providers of social care who operate within the boundaries of the proposed integration authority;
• Representative of recognised bodies representing the interests of specific age, condition, or illness groups;
• Neighbouring Health Boards, local authorities and integration authorities that may be affected by the strategic plan;
• Housing providers;
• Representatives of localities as provided for in proposed amendment to s26.

8. It is expected that the groupings themselves will agree representative nominees for appointment by the integration authority. It will remain up to each integration authority as to the actual numbers appointed, which might be single or multiple representation.

9. The Scottish Government will issue extensive guidance on the development of strategic plans to ensure consistency of approach across Scotland.

The Scottish Government
January 2014
Introduction

1. This statement summarises Scottish Ministers' intentions in relation to the regulations that will be made under section 1(6)(a) of the Public Bodies (Joint Working) (Scotland) Bill 2013.

Power as introduced –

1(6) The Scottish Ministers may by regulations prescribe—

(a) Functions of local authorities that must, may or may not be delegated under an integration plan,

(b) functions of Health Boards that must, may or may not be delegated under an integration plan,

(c) functions of local authorities or Health Boards—
   (i) that must be delegated under an integration plan other than in prescribed circumstances,
   (ii) that may be delegated under an integration plan only in prescribed circumstances,
   (iii) that may not be delegated under an integration plan in prescribed circumstances,

(d) functions of local authorities or Health Boards that may be delegated under an integration plan only if other prescribed functions are also delegated to the same person under the plan.

Ministers intend to propose a significant revision of section 1 by amendment at stage 2. This would remove the above power and substitute a new section 1(4) as follows:

1(4) The integration models are—

(a) delegation of functions by the local authority to a body corporate that is to be established by order under section 9 (an “integration joint board”) and delegation of functions by the Health Board to the integration joint board,

(b) delegation of functions by the local authority to the Health Board,

(c) delegation of functions by the Health Board to the local authority,

(d) delegation of functions by the local authority to the Health Board and delegation of functions by the Health Board to the local authority.

(4A) A local authority may delegate a function under an integration scheme only if the function is conferred by an enactment listed in schedule (Enactments conferring on local authorities functions which may be delegated).

(4B) A Health Board may delegate a function under an integration scheme only if the function is prescribed.

(4C) The Scottish Ministers may by regulations prescribe which of the functions conferred by enactments listed in schedule (Enactments conferring on local authorities functions which may be delegated) local authorities must delegate under an integration scheme so far as the functions are exercisable in relation to persons of at least 18 years of age where the integration model mentioned in subsection (4)(a) or (b) is to apply under the scheme.
(4D) The Scottish Ministers may by regulations prescribe functions of Health Boards which Health Boards must delegate under an integration scheme so far as the functions are exercisable in relation to persons of at least 18 years of age where the integration model mentioned in subsection (4)(a) or (c) is to apply under the scheme.

(4E) If the integration model mentioned in subsection (4)(d) is to apply under an integration scheme either—
(a) the local authority must delegate the functions prescribed under subsection (4C) so far as the functions are exercisable in relation to persons of at least 18 years of age, or
(b) the Health Board must delegate the functions prescribed under subsection (4D) so far as the functions are exercisable in relation to persons of at least 18 years of age.

(4F) The Scottish Ministers may by regulations prescribe functions of Health Boards that a Health Board—
(a) must delegate under an integration scheme other than in prescribed circumstances,
(b) may not delegate under an integration scheme in prescribed circumstances.

(4G) The Scottish Ministers may by regulations prescribe which of the functions conferred by enactments listed in schedule (Enactments conferring on local authorities functions which may be delegated) local authorities may not delegate in prescribed circumstances.

(4H) The Scottish Ministers may by regulations remove an enactment from schedule (Enactments conferring on local authorities functions which may be delegated).

2. Section 1 of the Bill requires a Health Board and a local authority to enter into an integration plan and provides for a number of models of integration including the delegation of functions by a local authority to a Health Board, by a Health Board to a local authority or by a Health Board and local authority to an integration joint board. The Bill as introduced provides for regulations to prescribe any function of a local authority as a function which must may or may not be delegated.

3. Scottish Ministers intend bring forward amendments to section 1 at Stage 2. By virtue of these, it is intended to restrict the range of local authority functions that can be delegated under the Bill to specific “social care” functions. By virtue of the amendment, a list of enactments which may be delegated will be set out in a Schedule of the Bill.

4. It is intended at Stage 2 to further restrict Scottish Ministers’ powers in prescribing local authority social care functions in so far as those set out in the schedule, so that Scottish Ministers can only require the delegation of social care functions insofar as they relate to adults. It is proposed that the age limit of 18 be used to define “adults”.

5. Thus, the Bill would provide that –

(a) Ministers are only able to permit a local authority to delegate social care functions, from a list of enactments as set out in the Bill and
Ministers are only able to require a local authority to delegate those functions insofar as they relate to adults.

**Background**

6. The legal framework which confers “social care” functions on local authorities can be found across a wide range of different pieces of legislation. These functions are considered key to the establishment and promotion of a comprehensive and integrated health and social care service across Scotland.

7. Local authorities, with partner organisations, purchase and provide a wide range of social work and social care services in order to carry out their legal functions. These services include services to children, young people, adults and families, promoting empowerment, independence, safety and protection. Services are provided for people of all ages and their carers, who have a range of care and support needs. Across all care groups, while some individuals receive a service voluntarily, others will have social work involvement as a result of statutory responsibilities.

8. Central to this for social work services is the Social Work (Scotland) Act 1968 which places a duty on all local authorities to “promote social welfare” and governs their duties in this area. Although most duties are given to local authorities some roles are allocated to specific staff, such as, Mental Health Officers (MHO’s) who are social workers specialising in mental health issues.

9. Access to services is based on an assessment of need, which is carried out by local teams. These teams include, Children and Families, Criminal Justice, Adult Mental Health or Learning Disability Assessment and Care Management Teams. The teams are responsible for carrying out assessments or investigations and for developing appropriate care and support plans as a response to identified need. They also carry out the on-going monitoring and review of care and support, providing a response to changing needs. In addition, the teams offer carers’ assessments and care management services to carers.

10. Teams can be staffed by social Workers and community care assistants or integrated with other professionals, who work in partnership, with other agencies and with service users and their carers to ensure that the support and care services provided are as person centred and flexible as possible.

11. The Scottish Social Services Council’s Code of Practice States that Social service workers must:

- Protect the rights and promote the interests of service users and carers;
- Strive to establish and maintain the trust and confidence of service users and carers;
- Promote the independence of service users while protecting them as far as possible from danger or harm;
- Respect the rights of service users whilst seeking to ensure that their behaviour does not harm themselves or other people;
- Uphold public trust and confidence in social services;
- Be accountable for the quality of their work and take responsibility for maintaining and improving their knowledge and skills.
12. Scottish Ministers intend to make regulations under section 1(4B) to prescribe that the following functions must be delegated by a local authority where the model of integration is that set out in section 1(4)(a), (b) or (d).

- Social Work Services for adults and older people;
- adults with physical disabilities, learning disabilities,
- mental health problems,
- drug and alcohol problems;
- adult protection; and domestic abuse, (including carers) covering: community care assessment teams,
- support services,
- care home services,
- adult placement services,
- health improvement services,
- housing support services,
- day services,
- local area co-ordination,
- respite provision,
- occupational therapy services,
- re-ablement services, equipment and telecare.

The Scottish Government
January 2014
**Appendix (a) functions that must be delegated:**

Local authority functions which must be delegated, as they relate to, or support, adult social work, social care services.

<table>
<thead>
<tr>
<th>Act</th>
<th>Section/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Assistance Act 1948</td>
<td>Sections 22, 26, 45 and 48</td>
</tr>
<tr>
<td>Disabled Persons (Employment) Act 1958</td>
<td>Section 3</td>
</tr>
<tr>
<td>Social Work (Scotland) Act 1968</td>
<td>Sections 1, 4, 5, 8, 10, 12, 12A, 12AZA, 12AA, 12AB, 13 to 14, 27ZA, 28, 29, 59, 86 and 87</td>
</tr>
<tr>
<td>Local Government and Planning (Scotland) Act 1982</td>
<td>Section 24</td>
</tr>
<tr>
<td>Health and Social Services and Social Security Adjudications Act 1983</td>
<td>Sections 21, 22 and 23</td>
</tr>
<tr>
<td>Disabled Persons (Services, Consultation and Representation) Act 1986</td>
<td>Sections 2, 3, 7 and 8</td>
</tr>
<tr>
<td>Housing (Scotland) Act 1987</td>
<td>Sections 4, 5 and 5A and Part II</td>
</tr>
<tr>
<td>Adults with Incapacity (Scotland ) Act 2000</td>
<td>Sections 10, 12, 37 and 39 to 45</td>
</tr>
<tr>
<td>Housing (Scotland) Act 2001.</td>
<td>Sections 1, 2, 5, 6, 8 and 92</td>
</tr>
<tr>
<td>Community Care and Health (Scotland) Act 2002</td>
<td>Sections 5, 6 and 14</td>
</tr>
<tr>
<td>Mental Health (Care and Treatment) (Scotland) Act 2003.</td>
<td>Sections 17, 25 to 27, 33, 34, 228 and 259</td>
</tr>
<tr>
<td>Housing (Scotland) Act 2006.</td>
<td>Section 71</td>
</tr>
<tr>
<td>Adult Support and Protection (Scotland) Act 2007</td>
<td>Sections 4 to 11, 14, 16, 18, 22, 40, 42 and 43</td>
</tr>
<tr>
<td>Social Care (Self-Directed Support) (Scotland) Act 2013</td>
<td>Sections 3, 5 to 13, 16 and 19</td>
</tr>
</tbody>
</table>
Policy Statement - Strategic Plan Consultation
Section 27(5)

Introduction

1. This statement summarises Scottish Ministers’ intention in relation to the regulations that will be made under section 27(5) of the Public Bodies (Joint Working) (Scotland) Bill. These regulations will prescribe such groups of persons that the integration authority must consult having developed a draft strategic plan. The power, underlined within the wider section, at introduction is:

Section 27 Steps following establishment of consultation group

(1) Having established a group under section 26, an integration authority in relation to the area of a local authority is to—
(a) prepare proposals for what the strategic plan should contain, and
(b) seek the views of its strategic planning group on the proposals.

(2) Taking account of any views expressed by virtue of subsection (1)(b) the integration authority is then to—
(a) prepare a first draft of the strategic plan, and
(b) seek the views of the group on the draft.

(3) Taking account of any views expressed by virtue of subsection (2)(b), the integration authority is then to—
(a) prepare a second draft of the strategic plan,
(b) send a copy to—
   (i) the persons mentioned in subsection (4), and
   (ii) such other persons as it considers appropriate, and
(c) invite the recipients to express views (within such period as the integration authority considers appropriate) on the draft.

(4) The persons referred to in subsection (3)(b)(i) are—
(a) where the integration authority is an integration joint board, the local authority and the Health Board which prepared the integration plan in pursuance of which the integration joint board was established,
(b) where the integration authority is a local authority, the Health Board with which the local authority prepared the integration plan in pursuance of which the integration authority acquired its delegated functions,
(c) where the integration authority is a Health Board, the local authority with which the Health Board prepared the integration plan in pursuance of which the integration authority acquired its delegated functions, and
(d) persons who the integration authority considers to be representative of each of the groups mentioned in subsection (5).
(5) The groups referred to in subsection (4)(d) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

(6) In finalising the strategic plan, the integration authority must take account of any views expressed by virtue of subsection (3)(c).

2. By virtue of section 48(1), “prescribed” means prescribed by regulations. Section 49 sets out additional provisions in relation to subordinate legislation under the Bill. By virtue of section 49(4), regulations under section 27 will be subject to the negative procedure.

Background

3. Section 23 of the Public Bodies (Joint Working) (Scotland) Bill requires the integration authority to prepare a strategic plan for the area of the local authority. A strategic plan is a document that sets out the arrangements for carrying out the integrated functions, and how these arrangements are intended to achieve the national outcomes. Each strategic plan should last for a minimum of three years, although the actual planning period of each plan can be longer (so an integration authority can set out a five year or a ten year plan but must review it after every three years). The plan should be subject to a continual cycle of analysis and review.

4. Section 26 puts an obligation on the integration authority to establish a strategic planning group. Under section 27(1) and (2), the integration authority must seek and take account of the views of this group in preparing a strategic plan. Having sought and taken account of these views, section 27(3)(b) sets out that the integration authority is to send a draft of the strategic plan to other interested stakeholders. Section 27(4) (d) and (5) together allow the Scottish Ministers to prescribe certain groups whose views should be taken account of in the strategic planning process. Representatives of each prescribed group must be provided with a copy the draft strategic plan. The integration authority may also consult more widely if it feels this is appropriate. Any views on the draft expressed by the persons who are consulted must be taken account of by the integration authority, by virtue of section 23(6).

5. The Policy Memorandum that accompanies the Bill makes clear that as part of the strategic planning process, integration authorities will be required to:

- Embed patients/clients and their carers in the decision-making process;
- Treat the third and independent sectors as key partners; and
- Involve GPs, other clinicians and social care professionals in all stages of the planning work, from the initial stages to the final draft.
6. It is essential that the integration authority shares the draft strategic plan widely with those who have an interest in the delivery or receipt of health and social care within the geographic boundaries of the integration authority. This would include other integration authorities or local authorities whose resident populations access services primarily through the same NHS Board.

7. Scottish Government officials are discussing the groups that should be included in this process with the National Steering Group on Joint Strategic Commissioning. Subject to the views of the Group, it is envisaged the regulation will specify the following groups that should be included within the consultation –

- Health and social care professionals who operate within the boundaries of the proposed integration authority;
- Users of health and/or social care who reside within the boundaries of the proposed integration authority;
- Carers of users of health and/or social care who reside within the boundaries of the proposed integration authority;
- Commercial providers of health and/or social care who operate within the boundaries of the proposed integration authority;
- Non-commercial providers of health and/or social care who operate within the boundaries of the proposed integration authority;
- Recognised representative bodies, representing the interests of specific age, condition or illness groups;
- Other Health Boards, local authorities and integration authorities that might be affected by the strategic plan;
- Housing providers.

8. This list would be the core groups that should be consulted. Integration authorities would be able to consult with such other local groups as they consider to have an interest.

The Scottish Government
January 2014
Policy Statement – Performance Reports

Section 33(3)

Introduction

1. The Public Bodies (Joint Working) (Scotland) Bill (referred to in this statement as ‘the Bill’) gives Scottish Ministers the power in section 33(3) to make regulations that prescribe the form and content of performance reports. The relevant power in the Bill as introduced is as follows:

33 (3) The Scottish Ministers may by regulation prescribe –

   a) The form and content of performance reports,
   b) The period during which performance reports must be published.

2. By virtue of section 49(4) of the Bill, regulations under this section will be subject to the negative procedure.

3. Ministers intend to propose an amendment to this section of the Bill which would remove (b). Instead the Bill will set out that an performance report must be published within four months of the end of the reporting year. Regulations will therefore not be made in relation to the period during which performance reports must be published.

The power as proposed to be amended is:

33 (3) The Scottish Ministers may by regulation prescribe –

   a) The form and content of performance reports,

Background

4. Integration authorities will have responsibility for the planning and resourcing of a significant proportion of health and social care services within Scotland. It is important that the integration authority reports and accounts for their activities so the public are able to assess the progress made to improve outcomes by the integration authority that serves them.

5. Whilst the duties and responsibilities that come with the management of public finances will require local performance management arrangements to be put in place and external audit by scrutiny bodies, it is important that there is a robust public reporting mechanism which includes the key information that will allow the public to assess performance and provide the transparency and openness required of public agencies.

6. The performance report needs to provide a basis for national comparison between different integration authorities, whilst retaining flexibility for integration authorities to reflect on their local circumstance and particular population needs. It needs to report on the key elements of the reform.
Form and content of performance reports

7. It is intended that regulations made under this power will require that the performance report is to include consideration of all the functions that are set out within the integration plan and the associated budget.

8. Ministers also intend to provide in regulations will that the report must include an assessment of the following elements:

- Progress against the national health and wellbeing outcomes;
- Progress against a suite of key measures and indicators that will be noted in statutory guidance;
- Progress against the integration delivery principles with particular reference to strategic and locality planning;
- An overview of the integrated budget and the proportional changes within it;

In addition where the integration plan provided that an integration model set out in section 1(4)(b)(c) or (d) would be used, it is intended that regulations will require the performance report to include:

- Details of correspondence with the integration joint monitoring committee during the reporting year.

The Scottish Government
January 2014
Introduction

1. This policy statement relates to the power of the Scottish Ministers to make regulations under the Public Bodies Joint Working (Scotland) Bill to prescribe functions of a Health Board which must, may or may not be delegated to an integration authority under an integration plan. The relevant powers in the Bill as introduced are set out in section 1(6), which provides:

1(6) The Scottish Ministers may by regulations prescribe—

(a) Functions of local authorities that must, may or may not be delegated under an integration plan,

(b) functions of Health Boards that must, may or may not be delegated under an integration plan,

(c) functions of local authorities or Health Boards—
(i) that must be delegated under an integration plan other than in prescribed circumstances,
(ii) that may be delegated under an integration plan only in prescribed circumstances,
(iii) that may not be delegated under an integration plan in prescribed circumstances,

(d) functions of local authorities or Health Boards that may be delegated under an integration plan only if other prescribed functions are also delegated to the same person under the plan.

A proposed amendment to Ministers’ powers to prescribe functions for delegation under section 1 would replace the above section with the following provisions:

<(4A) A local authority may delegate a function under an integration scheme only if the function is conferred by an enactment listed in schedule (Enactments conferring on local authorities functions which may be delegated).

(4B) A Health Board may delegate a function under an integration scheme only if the function is prescribed.

(4C) The Scottish Ministers may by regulations prescribe which of the functions conferred by enactments listed in schedule (Enactments conferring on local authorities functions which may be delegated) local authorities must delegate under an integration scheme so far as the functions are exercisable in relation to persons of at least 18 years of age where the integration model mentioned in subsection (4)(a) or (b) is to apply under the scheme.

(4D) The Scottish Ministers may by regulations prescribe functions of Health Boards which Health Boards must delegate under an integration scheme so far as the functions are exercisable in relation to persons of at least 18 years of age where the integration model mentioned in subsection (4)(a) or (c) is to apply under the scheme.

(4E) If the integration model mentioned in subsection (4)(d) is to apply under an integration scheme either—
(a) the local authority must delegate the functions prescribed under subsection (4C) so far as the functions are exercisable in relation to persons of at least 18 years of age, or
(b) the Health Board must delegate the functions prescribed under subsection (4D) so far as the functions are exercisable in relation to persons of at least 18 years of age.

(4F) The Scottish Ministers may by regulations prescribe functions of Health Boards that a Health Board—

(a) must delegate under an integration scheme other than in prescribed circumstances,
(b) may not delegate under an integration scheme in prescribed circumstances.

(4G) The Scottish Ministers may by regulations prescribe which of the functions conferred by enactments listed in schedule (Enactments conferring on local authorities functions which may be delegated) local authorities may not delegate in prescribed circumstances.

(4H) The Scottish Ministers may by regulations remove an enactment from schedule (Enactments conferring on local authorities functions which may be delegated).

2. Health Boards will be required to delegate certain functions, depending on the integration model that is used under their integration plan. The integration models are set out in section 1(4), which provides:

1 (4) The integration models are—

(a) delegation of functions by the local authority to a body corporate that is to be established by order under section 9 (an “integration joint board”) and delegation of functions by the Health Board to the integration joint board,
(b) delegation of functions by the local authority to the Health Board,
(c) delegation of functions by the Health Board to the local authority,
(d) delegation of functions by the local authority to the Health Board and delegation of functions by the Health Board to the local authority.

Delegation of Functions

3. The main purpose of the integration plan is to set out the major considerations and areas of agreement that must be reached before formally integrating functions and resources. Scottish Ministers intend to prescribe a list of functions of Health Boards that ‘must’ be delegated and also to prescribe those functions that a Health Board ‘may’ delegate under an integration plan. Any functions not listed in the ‘must’ or ‘may’ lists are by default not delegable under an integration plan.
4. The Scottish Government proposes to require that a Health Board must delegate all of its functions as they relate to adult primary and community health services and the proportion of acute sector provision that will be part of integrated arrangements. Scottish Ministers intend to make regulations under Section 1 providing that functions in this class must be delegated.

5. The Scottish Government proposes to require that those functions of a Health Board that may be delegated under an integration plan are those functions that may be delivered alongside adult primary and community care, such as primary and community care for children and young people. Scottish Ministers intend to make regulations under Section 1 providing that functions in this class may be delegated.

6. The functions of a Health Board that are not to be available for delegation will include matters such as the provision of regional and national services, functions relating to education and research facilities of Health Boards and some specific duties, such as the registration of professionals. These will not be listed in regulations. Instead the functions which will not be delegable will be those which do not appear in the Regulations as functions which a Health Board may delegate.

7. Annex A provides an illustrative list of the types of functions which Ministers are considering prescribing that must be delegated. The Scottish Government intends to informally consult with Health Boards about the content of this list and it is likely, therefore, that the annexed list be altered to reflect these discussions to ensure that the delegation of functions of Health Boards is properly provided for in legislation.

8. The list of functions that Health Boards ‘may’ delegate is under development. The Scottish Government intends to informally consult with Health Boards about the content of this list once a draft has been developed.

The Scottish Government
January 2014
Annex A

List 1 – Functions which must be delegated
This list is comprised of those functions which Ministers intend to prescribe as functions that must be delegated in their entirety in as far as they relate to primary and community health care and the proportion of acute sector provision that will be part of integrated arrangements.

National Health Service (Scotland) Act 1978

<table>
<thead>
<tr>
<th>Section</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A(1)</td>
<td>Duty of Health Board, Special Health Board, the Agency and HIS to promote health improvement</td>
</tr>
<tr>
<td>2B(1)</td>
<td>Duty to encourage public involvement</td>
</tr>
<tr>
<td>2C(1)</td>
<td>Functions of Health Boards: primary medical services</td>
</tr>
<tr>
<td>2D(1)</td>
<td>Equal opportunities</td>
</tr>
<tr>
<td>12H</td>
<td>Duty of quality.</td>
</tr>
<tr>
<td>12J(1)</td>
<td>Health Boards: co-operation with other Health Boards, Special Health Boards and the Agency</td>
</tr>
<tr>
<td>13</td>
<td>Co-operation between Health Boards and other authorities.</td>
</tr>
<tr>
<td>13A(1)</td>
<td>Co-operation in planning of services for disabled persons, the elderly and others.</td>
</tr>
<tr>
<td>16</td>
<td>Assistance to voluntary organisations.</td>
</tr>
<tr>
<td>16A</td>
<td>Power to make payments towards expenditure on community services</td>
</tr>
<tr>
<td>16B</td>
<td>Financial assistance by the Secretary of State to voluntary organisations.</td>
</tr>
<tr>
<td>17C(1)</td>
<td>Personal medical or dental services.</td>
</tr>
<tr>
<td>17I</td>
<td>Use of accommodation.</td>
</tr>
<tr>
<td>25.(1)</td>
<td>Arrangements for provision of general dental services.</td>
</tr>
<tr>
<td>26.(1)</td>
<td>Arrangements for provision of general ophthalmic services.</td>
</tr>
<tr>
<td>27.(1)</td>
<td>Arrangements for provision of pharmaceutical services.</td>
</tr>
<tr>
<td>27A(1)</td>
<td>Arrangements for providing additional pharmaceutical services.</td>
</tr>
<tr>
<td>28 A</td>
<td>Remuneration for Part II services.</td>
</tr>
<tr>
<td>36.(1)</td>
<td>Accommodation and services.</td>
</tr>
<tr>
<td>37.</td>
<td>Prevention of illness, care and after-care.</td>
</tr>
<tr>
<td>38.</td>
<td>Care of mothers and young children.</td>
</tr>
<tr>
<td>38A</td>
<td>Breastfeeding</td>
</tr>
<tr>
<td>41.</td>
<td>Family planning.</td>
</tr>
<tr>
<td>42.</td>
<td>Health education.</td>
</tr>
<tr>
<td>43.</td>
<td>Control of spread of infectious disease.</td>
</tr>
<tr>
<td>64</td>
<td>Permission for use of facilities in private practice.</td>
</tr>
<tr>
<td>75A</td>
<td>Remission and repayment of charges and payment of travelling expenses.</td>
</tr>
<tr>
<td>98</td>
<td>Charges in respect of non-residents.</td>
</tr>
</tbody>
</table>

Disabled Persons (Services, Consultation and Representation) Act 1986

<table>
<thead>
<tr>
<th>Section</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Persons discharged from hospital</td>
</tr>
</tbody>
</table>
### Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13)

<table>
<thead>
<tr>
<th>Section</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>17(1)</td>
<td>Duties of Scottish Ministers, local authorities and others as respects Commission</td>
</tr>
<tr>
<td>23</td>
<td>Provision of services and accommodation for certain patients under 18</td>
</tr>
<tr>
<td>24</td>
<td>Provision of services and accommodation for certain mothers with post-natal depression</td>
</tr>
<tr>
<td>31</td>
<td>Assistance from Health Boards and others</td>
</tr>
<tr>
<td>34</td>
<td>Inquiries under section 33: co-operation</td>
</tr>
<tr>
<td>228</td>
<td>Request for assessment of needs: duty on local authorities and Health Boards</td>
</tr>
</tbody>
</table>

### Protection of Vulnerable Groups (Scotland) Act 2007

<table>
<thead>
<tr>
<th>Section</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Information held by public bodies etc.</td>
</tr>
<tr>
<td>92</td>
<td>Meaning of “protected adult”</td>
</tr>
</tbody>
</table>

### Certification of Death (Scotland) Act 2011

<table>
<thead>
<tr>
<th>Section</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Duty to co-operate</td>
</tr>
</tbody>
</table>

### Adults with Incapacity (Scotland) Act 2000

<table>
<thead>
<tr>
<th>Section</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>1(5)</td>
<td>General principles and fundamental definitions</td>
</tr>
<tr>
<td>35</td>
<td>Application of Part 4(MANAGEMENT OF RESIDENTS’ FINANCES)</td>
</tr>
<tr>
<td>37</td>
<td>Residents whose affairs may be managed</td>
</tr>
<tr>
<td>39</td>
<td>Matters which may be managed</td>
</tr>
<tr>
<td>42</td>
<td>Authorisation of named manager to withdraw from resident’s account</td>
</tr>
<tr>
<td>44</td>
<td>Resident ceasing to be resident of authorised establishment</td>
</tr>
<tr>
<td>45</td>
<td>Appeal, revocation etc.</td>
</tr>
<tr>
<td>81</td>
<td>Repayment of funds</td>
</tr>
<tr>
<td>82</td>
<td>Limitation of liability</td>
</tr>
</tbody>
</table>
Local Government and Regeneration Committee

Committee Memorandum on the Children and Young People (Scotland) Bill and the Public Bodies (Joint Working) (Scotland) Bill

26 September 2013
## CONTENTS

**Remit and membership**

**Memorandum** 1

**Introduction** 1

**Committee Interest** 1

**Findings and Recommendations** 2
- Is there a consistency of approach across legislation? 2
- System issues 4
- The role of GPs 5
- Role for the Housing Sector [Public Bodies (Joint Working) (Scotland) Bill] 6
- Measuring outcomes, costs and benefits 7
- The role of CPPs 8
- Consultation with service users and role of third sector 9
- Transition arrangements for children to adult services 10
- Named Person provision [Children and Young People (Scotland) Bill] 10

**Annexe A: Extract of Minutes** 11
Local Government and Regeneration Committee

Remit and membership

Remit:
To consider and report on a) the financing and delivery of local government and local services, and b) planning, and c) matters relating to regeneration falling within the responsibility of the Cabinet Secretary for Infrastructure and Capital Investment.

Membership:
Richard Baker
Cameron Buchanan
Stuart McMillan
Anne McTaggart
Stewart Stevenson
Kevin Stewart (Convener)
John Wilson (Deputy Convener)

Committee Clerking Team:

Clerk to the Committee
David Cullum

Senior Assistant Clerk
Fiona Darwin

Assistant Clerk
Seán Wixted

Committee Assistant
Fiona Sinclair
Local Government and Regeneration Committee
Committee Memorandum on the Children and Young People (Scotland) Bill and the Public Bodies (Joint Working) Scotland Bill

INTRODUCTION

The Committee reports to the Education and Culture Committee and the Health and Sport Committee as follows—

1. The Local Government and Regeneration Committee agreed to take evidence at Stage 1 on the Children and Young People (Scotland) Bill and the Public Bodies (Joint Working) (Scotland) Bill in relation to the delivery of local government services. Both bills include proposals for joint working between local government and public bodies. Our main focus of interest in the Bills is the proposals for integrating and sharing public services. The proposals for the integration of public services are inextricably linked to issues covered in recent and ongoing inquiry work, particularly the public service reform inquiry.

COMMITTEE INTEREST

Introduction
2. The Children and Young People (Scotland) Bill (“the CYP Bill”), aims to put children and young people at the heart of planning and delivery of services and ensure that their rights are respected across the public sector. Part 3 of the CYP Bill aims to improve the way in which services support children and families by promoting cooperation between planning children’s services, placing the child at the centre of this process.

3. The Public Bodies (Joint Working) (Scotland) Bill (“the PBJW Bill”), provides the framework which will support improvement of the quality and consistency of health and social care services through the integrated delivery of health and social care in Scotland. This framework permits integration of other local authority services with health services.

4. Our interested is in how the Bills, with related key aims, complement each other and work together to help deliver and support the Public Service Reform agenda.

Approach
5. We agreed to consider those parts of the Bills relevant to its remit. We did not issue its own call for evidence but included questions in the Health and Sport Committee call for evidence, as lead committee for the PBJW Bill. For the CYP Bill, we considered evidence submissions received by the Education and Culture Committee, the lead committee for this Bill.
6. We targeted specific organisations to supply written evidence given the Bills may have an impact on them. Written submissions were received from—

- Association on Directors of Education in Scotland;
- Argyll and Bute Council;
- Audit Scotland on behalf of the Auditor General for Scotland and the Accounts Commission;
- Coalition of Care and Support Providers (CCPS);
- Children in Scotland;
- Childrens Hearings Scotland;
- COSLA;
- GPs at the Deep End;
- Housing Coordinating Group;
- Midlothian Community Planning Partnership;
- NHS Ayrshire and Arran;
- Police Scotland;
- Royal College of General Practitioners;
- Scottish Fire and Rescue Service (SFRS);
- UNICEF UK, and
- West Lothian Community Planning Partnership.

7. We took oral evidence from relevant witnesses in a single evidence session on Wednesday 4 September 2013—

- NHS Ayrshire and Arran;
- GPs at the Deep End;
- East Ayrshire Council;
- North Ayrshire Council, and
- Housing Coordinating Group.

8. Finally, we then took oral evidence from the Cabinet Secretary for Health and Wellbeing, Alex Neil MSP (“the Cabinet Secretary”) and the Minister for Children and Young People, Aileen Campbell MSP (“the Minister”) jointly, on both Bills.

9. Our findings and recommendations are reported to the respective lead committees, and to the Parliament, in this memorandum.

FINDINGS AND RECOMMENDATIONS

Is there a consistency of approach across legislation?

10. Our recent inquiry into Public Services Reform in Scotland had a strong focus on partnership, joint working and shared services in line with the Christie Commission recommendations. A significant part of that work was looking at Community Planning Partnerships (“CPPs”) which are a key delivery agent in driving forward public service reform. During that inquiry we were informed that the forthcoming Community Empowerment and Renewal Bill (“CER Bill”) will include

---

provisions strengthening relationships and responsibilities of partners in CPPs in order to improve accountability and ultimately enhance joint working.

11. We expect to be the lead committee for consideration of the forthcoming CER Bill and have noted that the provisions requiring joint or integrated working in the PBJW Bill and the CYP Bill are inextricably linked. They all share the overarching purpose of public sector reform.

12. Evidence taken by us generally acknowledges the desirability of better integration of services while ensuring that the approaches taken to integration across the public sector remain compatible. Evidence highlighted actions that need to be undertaken to ensure that links and relationships between the new partnerships, CPPs and Single Outcome Agreements work.

13. Consultation responses on Part 3 of the CYP Bill referred to the need for a linkage to other legislation, in particular the PBJW Bill, the forthcoming CER Bill and recent legislation on self-directed support. There was concern that between the CYP Bill and the PBJW Bill, two processes for service planning were being established. The Royal College of Nursing suggested that this showed ‘little strategic thinking’2. Disability groups highlighted their particular concern for well integrated systems of service provision across age groups, policy areas and geographical areas.

14. Both the Cabinet Secretary and the Minister in evidence stated similar aims for their Bills, principally ‘improving outcomes for service user’ while recognising that the approach taken differed. The Bills, we were told, “complement one another”3 and “will streamline structures and make it easier to see the focus for partnership working”4.

15. The Cabinet Secretary in evidence told us that—

“...the umbrella for all of this is the Government’s guiding principles and strategic objectives, which include not only community empowerment and renewal but public sector reform, to ensure that better-quality services are delivered more cost effectively and timeously; patient-centred healthcare and social care; and, indeed, person-centred education. Those underlying principles are not restricted to my bill, Aileen Campbell’s bill or Derek Mackay’s community empowerment bill; they are universal and part and parcel of our broad principled agenda for changing Scotland for the better.”5

16. COSLA noted clear links between the PBJW and the integration of adult health and social care services and suggested that it was possible “some local partnerships may wish to consider the inclusion of children’s services in those arrangements.”6

---

2 Royal College of Nursing written submission to the Education and Culture Committee on the Children and Young People (Scotland) Bill (Submission 83): http://www.scottish.parliament.uk/S4_EducationandCultureCommittee/Children%20and%20Young%20People%20(Scotland)%20Bill/RoyalCollegeofNursingScotland.pdf [Retrieved 19 Sept 2013].
3 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2526.
5 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2535.
6 COSLA written submission:
17. We support the drive for public services reform and recognise the desirability of taking a flexible approach, endeavouring to identify an approach which fits the particular policy.

18. Argyll and Bute Council noted—

“...implementation of joint working will require a major culture change for both the Local Authority and our NHS colleagues, there will need to be changes in behaviours and attitudes and a willingness to overcome obstacles, driven by strong and enthusiastic leadership. We need to improve on staff and community involvement and overcome risk aversion to achieve truly customer-led service delivery. We also face financial and logistical challenges, particularly given the rurality of our environment; however it is clear that unless we achieve both economies of scale and economies of skill, through this opportunity for joint working, we will not be able to meet the demographic-demand challenges of the future.”

19. We agree with the sentiments expressed in that comment. We would like to see a mechanism put in place to monitor and review the approaches taken to ensure that lessons can be learned across portfolios and best practice identified across the boards. We note the submission by Audit Scotland which states that “it is essential that services are able to work well together to respond to needs whilst making the best use of existing resources and delivering high quality services.”

20. In the following section we consider specific system issues raised in evidence.

System issues

21. A number of ‘system’ issues were raised in evidence which were categorised by one witness as “strategic planning systems”. These included the necessity for processes to communicate well with each other and about duplication of statutory frameworks requiring multiple plans for children.

22. We heard from NHS Ayrshire and Arran that—

“A significant amount of work needs to be done to resolve the systems that we have and to ensure that we are working to a common system and a common language. In Ayrshire and Arran we have AYRshare; we hope that that will take us some way down that road, but there is still a need for the organisations that we work with—education, social work and health—to have their own systems underneath all of that. That is an industry in itself and they all have different reporting mechanisms that work within that.”
23. In our recent work we have increasingly been hearing about benefits accruing from co-location of buildings and people. East Ayrshire indicated that “co-location of certain services has been a really positive move”. Although it was made clear that while co-location is helpful, the key is improved information sharing. This is true for both electronic communications, but better yet, and more simple, by professionals talking to one another. Co-location can of course assist this process, but is not a prerequisite for conversations and information sharing to take place.

24. Written evidence from GP’s at the Deep End noted that—

“Our faith in the instrumental efficacy of technology and proliferation of process-orientated tasks should not displace what is essential to effective integration working practices, namely sustained professional relationships that are built on mutuality and trust.”

25. Collaboration between GPs and other partners exists on many different levels. Working collaboratively promotes a collective determination to reach objectives where sharing information and experiences contributes to a more detailed local knowledge of individual patients and their families. This is vital to planning effective support services for patients, addressing their unmet health needs and anticipating when they will need to access specialized services.

26. The Cabinet Secretary indicated that he “would not like to prescribe that co-location is always a prerequisite to approving any delivery plan” before adding that “in the examples that I have seen, co-location is definitely very advantageous.”

27. We welcome all moves towards co-location of services recognising local solutions are required to meet local needs. We agree with the evidence of NHS Ayrshire and Arran that—

“good communication and professionals talking to professionals to ensure that we are talking the same language and that we understand the issues will be critical to the whole process.”

The role of GPs

28. The evidence we received from GPs at the Deep End highlighted the central and critical role that doctors can, and do, have with those affected by these Bills—

“General practice is the main public service that is in regular contact with virtually the whole of the general population, with substantial cumulative knowledge and experience of people’s problems and consistently reported high levels of public trust. 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{16}

29. In evidence the Cabinet Secretary was keen to stress the role that the health sector will play under the PBJW Bill and referenced work that had been commissioned by government to look at where the public health function would sit in future. **We encourage this approach and urge that the role of GPs as key partners is embedded into development, planning and delivery under both Bills.\textsuperscript{17}**

**Role for the Housing Sector [Public Bodies (Joint Working) (Scotland) Bill]**

30. In evidence to us the Housing Coordinating Group made an eloquent plea for greater recognition and inclusion on the face of the PBJW Bill as a partner within integrated authorities. Suggesting that the success of the new integrated authorities—

“...will largely depend on effective joint strategic commissioning to which the housing sector can make a crucial contribution. The current arrangements for involving the housing sector have not produced a consistent nor 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{18}

31. Going on to say that—

“Housing providers offer varying levels of care and/or support to vulnerable adults and older people, and have long been committed to working with colleagues in health and social care to enable people to continue living in the community rather than institutional settings. There are examples where this has happened already and the Bill could promote this approach more widely across the country. The housing sector has much to contribute to this agenda.”\textsuperscript{19}

32. The Housing Coordinating Group expressed concerns that they may not be involved by new integrated authorities at the strategic level stating that “proper engagement with the housing sector in both planning and delivery will be required.”\textsuperscript{20}

\textsuperscript{16} GPs at the Deep End written submission: http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/GPs_at_the_Department_end.pdf [Retrieved 19 Sept 2013].

\textsuperscript{17} Local Government and Regeneration Committee, *Official Report*, 4 Sept 2013 Col 2527.

\textsuperscript{18} Housing Coordinating Group written submission: http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/Housing_Coordinating_Group.pdf [Retrieved 19 Sept 2013].

\textsuperscript{19} Housing Coordinating Group written submission: http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/Housing_Coordinating_Group.pdf [Retrieved 19 Sept 2013].

\textsuperscript{20} Ibid.
33. The Cabinet Secretary agreed it was essential that the housing sector be involved, noting that there is a stream of work ongoing—

“...to best ensure that the housing function is involved at grass-roots level in the partnerships. It may not necessarily be the case that housing bodies are separately represented on partnership boards, but I think that the most important element is what happens in the localities underneath the partnership board area. That is where the close working relationship between health, social work and housing is vital.”

34. The Minister also emphasised the specific requirement to consult social landlords at section 10 of the CYP Bill when preparing a children’s plan.

35. We agree that the housing sector need not be represented on partnership boards in all cases, but would expect that in situations when housing is likely to be central to the delivery of successful partnership working, they are involved at board level.

Measuring outcomes, costs and benefits

36. Both Bills seek to set in place policies which have the aim of improving outcomes for users, carers and their families. The PBJW Bill seeks to plan and deliver quality and sustainable care services. Similarly the CYP Bill through early intervention and preventative spend is also intended to produce benefits both in the short and also increasingly the long term.

37. This has challenges in measuring outcomes and benefits as Jim Carle eloquently described—

“Public organisations are quite used to looking for short-term gains over one, two or three years, but we are not used to looking at someone who will be born today and the benefits for them or the reduction in their uptake of services in later life.”

38. Children in Scotland suggested “that current performance and reporting requirements are linked to earlier, specific policies and strategies and they may not reflect the shift of focus towards prevention, early intervention and the early years.”

39. Audit Scotland in their submission on behalf of the Auditor General for Scotland and the Accounts Commission suggested that looking ahead—

“Any outcome measures must be transparently reported and available to the public and this information should be used to drive improvement. National measures are useful but partners also need a mechanism for

---

22 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2524.
24 Children in Scotland written submission, paragraph 21: [http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/ChildreninScotland1.pdf](http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/ChildreninScotland1.pdf) [Retrieved 19 Sept 2013].
ensuring local needs and priorities are met and for measuring the
difference that specific services are making to the individual.  

40. We explored how outcomes and benefits can be measured. Witnesses agreed that numbers are available but that they focus on costs, are generally short term measuring the impacts of existing services. It is “harder to look at less tangible issues such as wellbeing in communities and longitudinal things”.

41. The Cabinet Secretary in response noted that outcomes are not on the face of the PBJW Bill for two reasons—

“One is that outcomes change. The outcomes that you would set today would be very different from the outcomes that you would have set, say, five years ago. I suspect that they would also be very different from what they would be in five or 10 years’ time as service provision changes—how we do things in these fields changes continually. Therefore, if you put the outcomes in the bill, you would need to introduce primary legislation every time you wanted to amend them. The national outcomes will be set out in secondary legislation.”

42. We are content that outcomes should not be placed on the face of either Bill for the reasons given. We draw the Scottish Government’s attention to the Audit Scotland submission and we will, as part of our ongoing work in scrutinising benchmarking by local authorities, look closely at the measures introduced and crucially how they are used to learn from others and improve performance.

The role of CPPs

43. Since we published our original report on Public Services Reform the Scottish Government have advised that community planning has been significantly strengthened. Recent review work by the Accounts Commission for Scotland and Auditor General for Scotland, together with internal quality assurance processes, have identified a range of key strengths as well as some key areas for development which chime with some of our findings.

44. CPPs will have key roles to play if the overarching aims of these Bills are to be realised. We note the views of Audit Scotland, on behalf of the Auditor General for Scotland and the Accounts Commission for Scotland in their submission that—


25 Audit Scotland submission on behalf of the Auditor General for Scotland and the Accounts Commission, paragraph 17: http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/Audit_Scotland.pdf [Retrieved 19 Sept 2013].
26 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2508.
27 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2533.
“There is a need for a clear articulation of how these new arrangements fit with CPPs given the significant leadership and co-ordinating role for local public services that the Scottish Government/COSLA see for CPPs in their Statement of Ambition for Community Planning and Single Outcome Agreements.”

45. We heard in evidence how well the North Ayrshire Council CPP works with their integrated children’s services partnership. We note that the forthcoming CER Bill will seek to strengthen further the roles and responsibilities of partners in CPPs. In the meantime we consider it important that the Scottish Government provide clarity around implementation of the Bills and how they fit with the role of CPPs in the new partnerships and arrangements.

Consultation with service users and role of third sector

46. In our recent work we have taken a close interest in the extent to which service users are consulted and the methods used to engage them. We have been critical of engagement practices, in particular tendencies towards doing things to people as opposed to undertaking meaningful consultation. We note that neither Bill requires consultation at the level of individual service users although we were told by the Cabinet Secretary that for the PBJW Bill—

“The planning and delivery principles in the bill encapsulate the Christie commission’s principles by putting the person at the centre of service planning and delivery and require a focus on prevention and anticipatory care planning.”

47. We acknowledge that both Bills require levels of consultation and were pleased to be told that “it is essential that we have real engagement with local communities” and of the need “for communities to inform professional practice”.

48. The Minister indicated that guidance will make the role of the child and family “explicitly clear”.

49. The Cabinet Secretary responded to criticisms we received from the third sector, for example the Coalition of Care and Support Providers in Scotland, about the lack of community involvement in the PBJW Bill at the planning, design and delivery stages. He indicated that he envisaged the third and independent sector being represented on boards in every case. Adding that involvement in service redesign and consultation exercises “will be required”.

50. We note the determination of the Scottish Government to involve service users and the third sector at every stage, we recognise this need not be set out on the face of the Bills and expect guidance to make the roles of

---

30 Audit Scotland submission on behalf of the Auditor General for Scotland and the Accounts Commission, page 2: http://www.scottish.parliament.uk/S4_LocalGovernmentandRegenerationCommittee/Inquiries/Audit_Scotland.pdf [Retrieved 19 Sept 2013].
31 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2501.
32 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2521.
33 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2525.
34 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2550.
35 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2510.
36 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2529.
all parties clear. We are interested in what role the National Community Planning Group will have in the preparation of guidance.

Transition arrangements for children to adult services

51. Consultation responses on the CYP Bill from both Capability Scotland and For Scotland's Disabled Children highlighted the need for good planning when young people move from children's services to adult services, or move between local authority boundaries. Young disabled people will use services planned under the CYP Bill and under the PBJW Bill.

52. We asked the Minister how the quite different mechanisms for integrating services will improve children’s transition to adult services. In response she suggested that the transition will in future be “far smoother” adding—

“I believe that there are two big differences between dealing with children and dealing with adults. First, there is the very crucial role that the education system plays with children and for which there is no equivalent for adults, particularly older people. Secondly, children by definition do not legally have the capacity to make decisions for themselves. However, adults do and I note that there are special arrangements for adults with incapacity. The fact that these two bills cross-reference each other means that we are singing from the same hymn sheet—and that is very important.” 37

Named Person provision [Children and Young People (Scotland) Bill]

53. Although not a matter falling within our remit, we received evidence in relation to Part 4 of the CYP Bill, the Named Persons provision. We draw to the attention of the Education and Culture Committee the exchanges which took place on the Named Persons provision at our meeting on 4 September.38 In particular we highlight the concerns raised around time, burdens and resources on both health and education professionals in undertaking this role as well as questions around continuity of provision. We also draw attention to the outstanding issue of who should be the named person for children being home educated.

54. In drawing this to attention we are not expressing any view on the substantive issue.

37 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Col 2534.
38 Local Government and Regeneration Committee, Official Report, 4 Sept 2013 Cols 2511, 2513, 2517 and 2523.
ANNEXE A: EXTRACT OF MINUTES

19th Meeting, 2013 (Session 4), Wednesday 12 June 2013

Public Bodies (Joint Working) (Scotland) Bill (in private): The Committee considered its approach to the scrutiny of the Bill at Stage 1, and agreed that it wished to consider those parts of the Bill relevant to its remit. The Committee also agreed not to issue its own call for written evidence, but to ask to include questions in the call for evidence being issued by the Health and Sport Committee, as the lead committee for Bill. Furthermore, the Committee agreed to take oral evidence on the Bill, after the summer recess, and to report its findings and recommendations to the lead committee, by way of a memorandum.

Children and Young People (Scotland) Bill (in private): The Committee considered its approach to the scrutiny of the Bill at Stage 1, and agreed that it wished to consider those parts of the Bill relevant to its remit. The Committee also agreed not to issue its own call for written evidence, but to consider relevant submissions received by the Education and Culture Committee, as the lead committee for Bill, in response to that committee’s call for written evidence. Furthermore, the Committee agreed to take oral evidence on the Bill, after the summer recess. Given the parallels in policy between the Bill and the Public Bodies (Joint Working) (Scotland) Bill - in relation to issues such as joint working and the development of shared services - the Committee agreed to take oral evidence from relevant witnesses, jointly, on both Bills. Finally, the Committee agreed to take evidence from the relevant Scottish Ministers on both Bills, and to report its findings and recommendations to the lead committee, by way of a memorandum.

22nd Meeting, 2013 (Session 4), Wednesday 4 September 2013

Children and Young People (Scotland) Bill and the Public Bodies (Joint Working) (Scotland) Bill: The Committee took evidence on the Bills from—

Jim Carle, Child Health Commissioner, NHS Ayrshire and Arran;
Dr Anne Mullin, GPs at the Deep End;
Eddie Fraser, Head of Community Care, East Ayrshire Council;
Carol Kirk, Corporate Director (Education and Skills), North Ayrshire Council;
Mary Taylor, Chief Executive, Scottish Federation of Housing Associations, and Member of the Housing Coordinating Group;
Alex Neil, Cabinet Secretary for Health and Wellbeing, Aileen Campbell, Minister for Children and Young People, Kathleen Bessos, Deputy Director Integration and Reshaping Care, John Paterson, Divisional Solicitor (Food Health and Community Care), Alison Taylor, Team Leader Integration and Reshaping Care, Philip Raines, Head of Child Protection and Children's Legislation, and Magdalene Boyd, Solicitor (Communities and Education), Scottish Government.
Children and Young People (Scotland) Bill and the Public Bodies (Joint Working) (Scotland) Bill (in private): The Committee considered the evidence received.

24th Meeting, 2013 (Session 4), Wednesday 25 September 2013

Children and Young People (Scotland) Bill and the Public Bodies (Joint Working) (Scotland) Bill (in private): The Committee considered a draft memorandum to the lead committees on the Bills. Subject to various amendments, the memorandum was agreed to.
Children and Young People (Scotland) Bill and Public Bodies (Joint Working) (Scotland) Bill: Stage 1

The Convener: Agenda item 5 is an oral evidence-taking session on two bills that are currently undergoing parliamentary consideration: the Public Bodies (Joint Working) (Scotland) Bill and the Children and Young People (Scotland) Bill. The bills are being considered by the Health and Sport Committee and the Education and Culture Committee, respectively.

Although this committee is not a formal secondary committee for the consideration of the bills, each of the bills might have a significant impact on the functions of local government in Scotland in relation to the delivery of adult and children’s services. In keeping with the Presiding Officer’s agenda for more focused and joined-up working by committees, we have decided to hold this one-off evidence-taking session on both bills with some key witnesses and to report our findings to the lead committees.

The aim of the session is to ensure that the bills are scrutinised from a local government perspective as well as to deliver joined-up scrutiny of cross-cutting legislation by the committees of the Parliament. This session will also inform the committee’s on-going work on the implementation of the Christie commission principles across the public sector in Scotland.

The witnesses have made written submissions, which members have before them. We have also received a further 13 written submissions from other organisations, and we have had regard to the written submissions that were given to the lead committees.

I welcome Jim Carle, the child health commissioner with NHS Ayrshire and Arran; Dr Anne Mullin, from the general practitioners at the deep end group; Eddie Fraser, the head of community care in East Ayrshire Council; Carol Kirk, the corporate director for education and skills at North Ayrshire Council; and Mary Taylor, the chief executive of the Scottish Federation of Housing Associations and a member of the housing co-ordinating group.

We are rather short of time, but do any of our witnesses wish to make a short statement?
Mary Taylor (Scottish Federation of Housing Associations and Member of Housing Co-ordinating Group): I would welcome the opportunity to do so. I will try to be brief.

It is clear that housing seems to be absent from the debate about the integration of health and social care, so we are delighted to have an opportunity to speak to the committee today. The housing sector—on whose behalf I am speaking; I am not here solely on behalf of the SFHA—supports the broad aims of joined-up working and improved outcomes in relation to health and wellbeing. We see ourselves as already making significant contributions to outcomes around healthy living and independent living, and positive outcomes for individuals and communities.

We support the broad thrust of what is happening, but the focus on the institutional and structural aspects of integration without reference to housing creates a risk that, in our view, this committee could do something to address. For example, in the papers for today’s meeting, there is virtually no mention of housing, other than in the paper from the housing co-ordinating group. That might be what you would expect, but I am here to make the case for revising the proposals as they stand in order to allow better strategic engagement with the housing sector, from strategic commissioning down to locality planning at whatever scale that turns out to be.

Unless the housing sector, which has experience of strategic planning and has the practical capacity and appetite to make a contribution on the ground, is involved, there is a risk that there will be poorer-quality and more expensive outcomes than might have been achieved with housing involvement at an earlier stage. That is not what we want for ourselves or for our older generations and relatives.

The Convener: That was an extremely useful contribution, so I will begin by following it up.

In the past, there were moves to create homes for life. However, we have seen various welfare reform changes, with more to come, which kind of impede that ambition—I am thinking of the bedroom tax and so on. Of course, this Parliament does not have powers to address those issues at the moment, which is probably an impediment to what you would like to see. Do you wish to comment on that?

Mary Taylor: I am not going to elaborate on the bedroom tax, in the interests of time. I could go on at great length, but all that I would say is that it does not completely undermine the sector’s capacity, although it certainly erodes it and we are working to address that.

There are all sorts of issues, particularly in the engagement of the housing sector in strategic planning through the local housing strategy and housing contribution statements, and, as I said earlier, it would be a risk to the objectives and goals of the integration exercise to miss the opportunity to involve housing in those things.

The Convener: Would it be fair to say that those changes do away with the concept of homes for life?

Mary Taylor: Not necessarily. There are a number of people affected by the bedroom tax, but there are also a number of people who are not affected by it, and there is no requirement on anybody to move as such. The English regime for housing policy is quite different from the Scottish one, and Alex Neil, when he was Minister for Housing and Communities, made it quite clear that there was no suggestion that the homes for life notion was going to be done away with.

I point out that, in speaking for the housing sector, I am speaking not only for social housing providers. Our housing co-ordinating group involves people who work right across the spectrum, including care and repair projects that help elderly owner-occupiers to undertake repairs to their homes and to engage the services that they need to keep them living independently in their homes. This is not just about social housing.

The Convener: Thank you. There are obviously high expectations for both bills and for what services can be expected to achieve. People are obviously looking for improvements once the bills come into place. When do you think that the benefits will start to be demonstrated?

Jim Carle (NHS Ayrshire and Arran): I believe that the benefits are already becoming manifest and have been for some time. Children’s services, in the broadest sense, have been working towards a similar integration agenda, understanding that by working together we can produce better outcomes for children and young people.

The challenge for us is measuring the impact of, for example, the early years collaborative over a longer period of time. Public organisations are quite used to looking for short-term gains over one, two or three years, but we are not used to looking at someone who will be born today and the benefits for them or the reduction in their uptake of services in later life. Children’s services have been working hard on that agenda, and we hope that the two new bills will go some way to supporting that new process.

Dr Anne Mullin (GPs at the Deep End): From a general practice perspective, working in deprived areas we have not seen benefits yet.

We are looking from a slightly different standpoint from other services that are represented on the panel. The deep end group
thinks that there is potential in the legislation, and we would like to explore some of that potential with the Scottish Government. We have outlined specific proposals in areas where we feel we could and should make a difference, but that needs to be supported with all the things that we have suggested in our proposals, such as the additional time for consultations that we need when working with very comorbid people in deprived areas; support for serial encounters in general practice, which are key to people’s holistic and long-term care; attached staff who are specifically named social workers, addiction workers and health visitors; and a nationally enhanced service for vulnerable children. The list goes on.

We have outlined those proposals, and members can access those documents. If the proposals are incorporated and recognised, we feel that general practice can play its part with our other partners in primary care.

The Convener: Having visited some doctors’ surgeries during the recess—everybody thinks that we take long holidays, but it is actually more work—I am aware of the need for increased consultation times. Surgeries that I visited made a plea for that, but I believe that your contract is governed by a deal with the UK Government. Is that correct?

10:30

Dr Mullin: There is perhaps some scope for that now. I am not involved in contract negotiations, which are for the British Medical Association, but there is some appetite to revisit the contract and consider what could be more appropriate for the national health service up here. The primary care services in Scotland and England bear no resemblance to each other any more. We feel that primary care is far more protected up here and we want to develop the role of general practice, particularly in the equalities agenda. We feel that it is very important for us to get involved.

The Convener: You would say that it would be best for the BMA to negotiate with the Scottish Government rather than the Westminster Government over many of these things.

Dr Mullin: That is my opinion, yes.

Carol Kirk (North Ayrshire Council): I concur with Jim Carle that we are already seeing a lot of the benefits. I chair our integrated children’s services partnership, which has representatives from the police, health, social services, housing and the voluntary sector. Over the years—particularly the past two years—we have seen a significant coming together in specific actions in relation to children. Before that, we would come together much more around a project.

The situation has now changed and we are looking at significantly different ways of working together. We are considering the co-location of health visitors within our early years establishments and we have established a multi-agency domestic abuse team, which is having a major impact on the number of children who are referred to the children’s panel. There is a lot of good joined-up working on specific issues such as those, and it is beginning to bear fruit.

Within the North Ayrshire community planning partnership, we are considering putting our children’s services into the health and social care partnership along with adult services. With my other hat on, I am the director of education and skills, and it does not cause me anxiety that health is no longer going to be part of the council as such. I think that the networks and the work on the ground are solid enough that it does not matter what headings we have on the management structures. If there is working together in an integrated and effective way, it matters less where the budget sits and where the managers and the reporting structures are.

Our partnership reports directly to the CPP, which takes a very active role—as does the chief officers group—in monitoring the outcomes for children. As Jim Carle said, that proves a challenge, as some of the short-term measures are not easy to define. In some of the work that we are doing, particularly with our youngest children, we are seeking long-term societal change and there is a challenge in that. I am happy to see the focus on integrated children’s services in the bill, but we need to be careful that we are not creating additional planning structures instead of refining the planning structures that we have both at the corporate level and at the level of the individual child.

The Convener: Thank you. It is refreshing to hear that a CPP seems to be working well in that regard. Getting it right for every child has played a part. Can you outline the importance of what that programme has achieved? Has there been any resistance within the CPP to a move to preventative spend?

Carol Kirk: GIRFEC has been a catalyst in changing a lot of the thinking. We have established local resourcing groups, which have been in place for four or five years. That has meant that multi-agency teams can provide a very quick response for children who need additional support but who are not at the level at which the reporter is approached and compulsory measures of care are sought. That has served us well both in keeping children out of compulsory care and in preventing situations whereby they are either out of school or out of the local authority. We have seen significant change around that.
A significant piece of work around GIRFEC has been carried out across the three Ayrshire councils. The information-sharing project, which is called AYRshare, started in South Ayrshire and has been rolled out to North Ayrshire. In essence, the three integrated children’s services planning groups came together to take things forward. We think that the approach will help all the agencies that are involved to get a handle on issues much more quickly and to be able to share information at that level.

GIRFEC has significant strengths and I think that people are signed up to it. There are issues to do with the planning around GIRFEC. We still have additional support needs planning, so there is sometimes an issue for us and for people in health about which plan to have for a child. There is still a bit of a cluttered landscape, but that will probably change over time.

I have not detected a reluctance in relation to preventative spend. However, there is significant difficulty in disengaging in relation to costs that are incurred for children who require a residential placement or intensive support, in order to invest in support further down in the early years.

Our joint chief officers and the CPP have made significant investment. We have put more than £1 million into preventative spend for young children, which meant that hard decisions had to be made elsewhere. There is not an unwillingness to spend in that way; it is just that there are groups of young people at the upper end of the spectrum who need continuing support, and it is difficult to disengage the money that is being spent on them so that it can be diverted elsewhere.

The message is beginning to get out that preventative spend is having an impact. It is having an impact on the number of exclusions from school and the number of young people whom we place outwith the authority, and there are fewer referrals to the reporter. There is hard evidence that spend is effecting change.

Mary Taylor: The convener asked when the benefits will materialise. As other people said, to some extent the benefits are already materialising.

That is true even in relation to housing planning and the development of new services that are preventive in essence and that aim to be low cost. That can happen where there are good relationships such as my colleagues on the panel have described. However, for every area where there are good working relationships there is an area—if not many areas—where working relationships are not necessarily good.

In particular, I cite the experience of the reshaping care change fund. Change fund plans have often been developed without reference to housing and without recognition that housing can achieve a huge amount upstream, at costs that are relatively low in the context of health budgets. Until relatively recently, people had not even got to the point at which they had the opportunity to sign off change fund plans—and that has happened only after a lot of pushing.

That is part of the argument for stronger recognition of the role that housing can play and for not leaving things to chance and the accident of good relationships.

Eddie Fraser (East Ayrshire Council): As members might have anticipated, I concur with most of what other witnesses have said. I emphasise the need for continued partnership working with housing in the new health and social care partnerships. We all know that there will be demographic change and that the number of older people will grow. Older people need appropriate housing so that they can continue to live in the community.

In my area, the focus of the council house building programme has been on houses for older people and how we can build houses that can support adults who have complex needs—that is the other area in which close partnership working with housing is needed.

We absolutely support de-institutionalisation and people living in their communities, but the fact is that we have individual support packages costing £200,000 dotted all over a town instead of some way of delivering them effectively through a type of core and cluster model. The issue is very much to do with the link between care and housing, and we in East Ayrshire have been able to deliver some successes in that respect.

I also agree that through housing we can get some early wins not just for organisations but for individuals. If by working through care and repair we can get simple things such as handrails installed without the need for elaborate assessment processes, people get what they need quickly and it proves cost effective. Indeed, one of our major successes has been the ability to put money into such areas through the change fund.

We have also been able to give money to the voluntary sector in order to give people practical support. Older people get depressed if they have to sit and look at an overgrown garden, and providing money to certain voluntary organisations that get young people into work and to do Scottish vocational qualifications while, at the same time, giving older people some practical support has proved to be a big success for us.

As for other early wins, co-location of certain services has been a really positive move. We have a number of good examples where such co-location has helped to increase communication. For example, the co-location of all our mental
health and learning disability services has given us immediate wins.

We have also been able to develop our intermediate care and enablement services to support early discharge from hospital and prevent admissions. Indeed, our statistics show how successful we have been in consistently improving the delayed discharge situation and, most important, in helping older people stay at home.

One of the positives of the proposed changes is that everyone will be clearer about how to access services. It will certainly help if, instead of general practitioners making referrals to a whole range of different people, we have clarity about who they can refer to. Having quicker decision making instead of decision making by committee will also make things clearer for us.

We also have to look at locality working, because we cannot have separate approaches to that issue in the various bills that are around at the moment. We have single communities, and we have to consult those communities together; after all, the priorities for those communities and how they want some of the national priorities to be implemented should come from them.

In that respect, it is essential that we have real engagement with local communities and that our local GPs are involved in that process. With the development of community health partnerships, we have lost the engagement of GPs in local healthcare co-operatives. We need GPs to come back into the process in a meaningful way that allows them to see the changes that are being made and to influence what is going on in communities.

The bills contain many opportunities, but it only makes sense to do this together on the front line at community level.

Anne McTaggart: Do our health colleagues foresee any practical issues for local authorities and health boards in trying to implement both bills together?

Jim Carle: Yes, there are a number of issues. Aligning both processes will be problematic and what could be regarded as strategic planning systems will give us issues. However, we are not going to run away from them; instead, we are going to grab and make the best of them.

There will be problems in ensuring that the two processes communicate well with each other. In planning for the implementation of the Children and Young People (Scotland) Bill, we need to be conscious of actions that are being taken on the other side. The recognition of the need to work better together did not come as early in the process as we would have wished, but it is now there and we are starting to build from that basis.

However, the fact that we are dealing with two separate processes that come from slightly different perspectives has been problematic, and it would have been much more helpful had they been brought together much earlier in the process.

An awful lot more could have been learned from the experience of children and young people’s services under GIRFEC and the processes that we have had to go through. Carol Kirk mentioned a number of gains. Under GIRFEC, we have had to look at culture, systems and practice. What we have done well is to change our culture and move away from our silo working practices towards having, on occasion, large meetings at which we work through all of our issues, recognise that we have more than one audience for anything that we are trying to deal with and move forward from that. However, we see the potential hurdles and are working towards dealing with them.

10:45

Dr Mullin: We could have a long discussion on where things could again go very badly wrong in Glasgow, as happened last time, so it is important to get it right this time. Purely from a GP perspective, one of the biggest lessons is on the need to engage directly with general practice. There are different models in Glasgow’s community health partnerships but, in Glasgow south, where I am from, we have a large established GP committee that engages with senior management to discuss policy and to consider local initiatives. That committee has minuted meetings, we report back to local colleagues and we have set up learning events and so on, so the situation is progressing. We feel that that should be built on, because it is a good way of implementing stuff that comes to us that sometimes seems very hierarchical and full of bureaucratic speech.

For example, we just want to know whether, if a GP identifies that someone has an unmet need, there is actually a service that the patient can be put into. At the moment, there is a mismatch. In our anticipatory care planning, we go out and visit housebound elderly people, who were traditionally chopped out of the QOF, or quality and outcomes framework. We now identify a lot of unmet need, but we do not have the resources to match the need. The discussion needs to be linked into the experience of children and young people’s services under GIRFEC and the processes that have been brought together much earlier in the process. An awful lot more could have been learned from the experience of children and young people’s services under GIRFEC and the processes that we have had to go through. Carol Kirk mentioned a number of gains. Under GIRFEC, we have had to look at culture, systems and practice. What we have done well is to change our culture and move away from our silo working practices towards having, on occasion, large meetings at which we work through all of our issues, recognise that we have more than one audience for anything that we are trying to deal with and move forward from that. However, we see the potential hurdles and are working towards dealing with them.

At the moment, there is a mismatch. In our anticipatory care planning, we go out and visit housebound elderly people, who were traditionally chopped out of the QOF, or quality and outcomes framework. We now identify a lot of unmet need, but we do not have the resources to match the need. The discussion needs to be linked into the views of those experienced professionals who can inform the process about what needs to happen in parallel as the work progresses. We realise that that is not quick work—it is slow work—but it has to be a two-way thing.

Carol Kirk: There have been particular issues for health colleagues, who have some very complex arrangements. For example, I know that health representatives on our group often have
complex reporting arrangements that they need to go through. The two chief officers in the CPP have managed to cut through some of that, but a considerable amount of work is required. Therefore, there is potential to simplify a lot of what we do. We need to learn from the work on integrated children's services in taking forward integration of health and social care, but we also need to learn from the work that has been done in adult services on how we create the momentum to make some of the changes. Perhaps a bit of joined-up learning still has to happen on that.

The Convener: Ms Taylor, do you want to comment?

Mary Taylor: We did not comment on the Children and Young People (Scotland) Bill at all. All that I would say is that, in the consultation on the integration of health and social care, children's services and housing services were lumped together. Given that, in this committee, a focus on children's services tends to exclude a focus on housing services, my only plea is that, in the absence of housing provisions in the Public Bodies (Joint Working) (Scotland) Bill, the committee should still pay attention to the housing dimension of the argument.

The Convener: I think that you have got that message across, Ms Taylor.

Eddie Fraser: We need to be careful that we do not lose anything in the changes. Community health partnerships currently have a responsibility for people from cradle to grave—for children, adults and older people. If we move to health and social care partnership committees that have a responsibility only for adults and older people, we need to be careful that children's services are not left sitting without an easy strategic voice in community planning partners such as councils and health boards. In taking the agenda forward together and planning across both bills, we need to ensure that the change is for betterment and that there is no loss of strategic planning.

The Convener: Does Anne McTaggart want to respond to any of those comments?

Anne McTaggart: No, that is fine. Thank you.

Margaret Mitchell: Dr Mullin mentioned that GPs are doing good things but they sometimes run out of resources. One way of addressing that—I put this point to all the panel—would be to ensure that positive outcomes are assessed and logged. Particularly for local authorities, will the new requirements be integrated into benchmarking? How do you assess the outcomes—both positive and negative, as you can learn from the negatives, too—and then do things differently? Perhaps we can go round the panel and ask people about that.

We have heard positive things this morning about how people are sharing and integrating services, which is welcome news. Equally, we have heard good things from CPPs in the past that have not then materialised in local communities. It would be helpful to have a little more detail on how you will pin this down.

Eddie Fraser: We can evidence that through numbers. Sometimes, that is about the number of hospital admissions for people over 75. We can also evidence it through measures such as the number and proportion of our elderly population who stay at home. It is much harder to look at less tangible issues such as wellbeing in communities and longitudinal things. If we do preventative spend, we need to do it so that people do not need certain health and social care services in 20 years’ time. That applies to everything from the 50-year-old male with an alcohol problem to unborn children. We must look at how we do that, but it is sometimes difficult to do and it will be longitudinal.

We can use indicators. One issue is the extent to which we put together anticipatory care plans. I accept that, unless we follow those up, we have gone through a process without improving someone’s life but, if we can put such plans in place, we can show that we have improved someone’s life. We currently have indicators that show what the situation is, but it is much harder to capture the positive and tangible things that we will see as we take the approach forward.

Mary Taylor: First, some of our colleagues in the housing co-ordinating group are actively working with the outcomes group on the definition of the outcomes and on the targets and indicators that go with all of that. Our general view is that wellbeing is not sufficiently addressed and that there is still too much focus on the costs and impacts of existing services rather than on the services that there might be in future, but I do not want to rehearse that in greater detail now.

Secondly, some members of the SFHA have undertaken social return on investment studies into the impact of the benefit of services and those have shown the value of the services concerned. I can send you details of a project done by Link Housing Association, which showed that, for every pound that it invested in an advice and information service, it got £27 of value back. A study by Hanover (Scotland) Housing Association, Bield Housing Association and Trust Housing Association looks at the value of adaptations for older people. I can send you details of those studies.

The Convener: I think that we have seen them before, but we would be happy to see them again.

Carol Kirk: An issue with benchmarking is that it tends to be done against individual services and
individual parts of the service. For example, it is easy for me to benchmark in education and we are benchmarked to the hilt across other services. Schools benchmark against other schools and benchmarking is embedded in the system.

We are also good at benchmarking against children at the acute end, if you like. We are good at benchmarking around looked-after children and children who come into the child protection world. Benchmarking around children when there are issues of wellbeing or neglect is quite difficult and we tend to rely on input measures—on what we are doing to address the issue—as there is a conceptual difficulty in benchmarking the impact that we have. However, we have done quite a lot of work to try to identify indicators and we think that we are getting there by looking at the stretch aims of the early years collaborative. We are working back to establish how we get there and which measures tell us that we are getting there.

We have taken forward an investment in the Solihull approach to parenting jointly with East Ayrshire Council, South Ayrshire Council and NHS Ayrshire and Arran. We can measure how many people are using the approach and what impact they feel that it is having on their clients or the families that they deal with, but it is difficult to develop hard measures of what it is saving us and what difference it makes to the wellbeing of children. A lot of work is going on in that area, but it is still in its infancy.

Margaret Mitchell: Previously, you gave us a good example of something tangible when you referred to the number of exclusions from school going down, but I take the point that it is not always possible to give such examples.

Dr Mullin: We could look at the epidemiology of the statistics that are being collected on issues such as unscheduled admissions to hospitals and the number of days that elderly people spend in hospital before they get moved to a nursing bed. I agree that some of the more qualitative outcomes take longer to develop, because we often need to involve the patient or client in the research agenda, and that work requires commitment.

There are a lot of short-term measure outcomes, but there are not a lot of long-term measure outcomes. A lot of our evidence on early interventions comes from the Olds study, which is on-going. We have nothing similar to that here, but we were prepared to look 20 years down the line at what happened earlier, and how we prevented something from happening. Social return on investment was mentioned. Action for Children published an interesting report about a family intervention project in Northampton and the money that was saved if it intervened early on.

There are ways of pulling together research strands into an integrated proposal. The GPs at the deep end group is working on that. We are very keen to do that research, but it would need to be resourced to give us the staff and the ability. At the moment, there is very little evidence to show for all the work that is going on.

Jim Carle: The question is excellent and quite difficult to answer for a number of reasons, but I agree with what my colleagues have said.

GIRFEC gives us the model for change and a common language so that we can communicate with one another. However, we need to develop a number of areas in a much more integrated way. We need to develop better systems for looking at contribution and developing the contribution analysis that looks at all the different systems that contribute to the wellbeing of a child, at how we measure or quantify the benefits that those systems can bring together and the impact that they have on the child.

We need to move away from looking at children in the sense of talking about what we do with a five-year-old, for example, and pick up on the life-course approach. What do we do when we are preparing young people for parenthood? What do we do to help new parents to develop? How can the issues that were identified during the early years be carried forward into primary and secondary school? How do we measure that across the life course of the child? There needs to be some sort of longitudinal analysis of the benefits of the different contributions that are made across the different systems.

One key benefit of joint working is that we all come to the table with a number of different skills. A public health approach to the issues would be extremely beneficial and helpful. As a science, public health has the skills to enable us to develop a proper contribution analysis. We need to ensure that, once we have established an agreed way forward, we stick to it over a long enough period of time to see the benefits coming from the process in which we engage just now. For example, the early years framework is helpful and positive. It gives us a good focus on prevention and the early identification of issues and it gives us the opportunity to engage positively with parents.

One of the key things that has been missing from our discussion so far is the contribution that communities can make to the process. How many of the answers to the questions that the professionals are asking lie within communities? They can inform professional practice.

The combination of approaches from the different disciplines and sciences that are involved will help to take us forward. However, we do not yet have systems that can measure the total
contribution to an individual child over their life course, and that is very much what we want to have a look at and start to develop.

**Margaret Mitchell:** Finally, I want to ask about the implications of the provision in the Children and Young People (Scotland) Bill that every child should have a named person. Do the witnesses have concerns about that? Is it necessary? Sadly, some children have chaotic lifestyles, so many different public bodies might have to share information. It would be helpful if you could give us your views on that.

**Jim Carle:** In Ayrshire and Arran, systems are well advanced. We know that our health visiting team will pick up the role of named person for the under-fives. Our midwifery service will be working hard to take that forward.

If we are to do more than just implement the wording of the bill and instead try to achieve the bill’s aim of a much better society in Scotland, and if we are to improve our culture, we have to consider the amount of time that it will take to engage with more difficult families. We believe that that is a significant burden that will, I admit, build up over a period of time for our midwifery and health visiting services.

11:00

We have time to meet our statutory obligations and we are doing that fairly well, but if we are to have a conversation with a new mum around alcohol, how it relates to foetal alcohol syndrome and the impact that that could have on her, her children and her family over the later life course, that requires the development of a relationship. The current systems do not allow for that on every occasion. That approach also requires the development of good communication skills and the ability to raise difficult issues and agendas, which will be problematic.

We are asking the health visitor, as the named person, to co-ordinate all the information that comes from a number of services and pull it together to adopt a basic analysis to identify whether there are issues for the particular family, and then to pass on those issues. However, that will take a significant time, and we are not confident at present that the resources are there in those services to enable that.

We will be able to perform our services according to the word of the legislation, but that is not our issue. If you really want us to get behind the issues that exist and find resolutions for them, that will take time and resources, and at present they are not there. We expect to see investment being recycled, if you like, from the money that is being put into the early years collaborative later in the life course. We hope to see a reduction in the number of children who are looked after and accommodated, for example. However, we do not have systems that can identify where those savings have been made, because that will perhaps happen 10 to 15 years later. Then there are questions about how to recycle that funding back into the early years to continue the process and build on it.

There are a number of challenges in the issue that Margaret Mitchell asked about.

**Dr Mullin:** I agree with a lot of what Mr Carle has said. For the under-fives—pre-schoolers—it is logical to have health visitors as the named person. For schoolchildren, there is a massive gap. If a child becomes vulnerable at four or five, they will probably still be vulnerable at six, seven and eight, but I do not believe that there is enough capacity for that work to be on-going in a meaningful way in the education system.

I am quite relaxed about the named person idea. Most people have a named general practitioner, and GPs are often the source of referral for many different agencies that are looking for bits of information or have something to tell us about a family or individual. I would like the GPs—and GPs at the deep end have stated this desire strongly—to have far more involvement with vulnerable children and families. There needs to be something more substantive in general practice.

**Carol Kirk:** There is a challenge for a lot of services. We have discussed whether, given that probably more than 98 per cent of three to five-year-olds are in early years provision where they are seen every day by nursery practitioners, the named person would have been better situated in that place. We have raised that on a number of occasions.

We have been operating with GIRFEC and the GIRFEC guidance for some time, but it is not easy. In primary schools, the headteacher or the additional support needs co-ordinator, who is often either a depute or a principal teacher, usually gathers information from a range of agencies. That can be quite complex and time-consuming, even before the information is looked at. The issue is not that there is a lack of willingness but that the capacity that is required to do that is a strain on the system.

However, that is perhaps not as much of an issue as that of looking at a young person with more complex needs and the transfer from that approach to someone being the lead professional. That tends to sit with social services, but that is not necessarily where it should sit. In some cases, it would be better for it to sit with the school or with a health professional. A bit more work is needed.
on that to free up the time for the appropriate professionals to take that role.

In our consultation on the issue with parents, we had quite a kickback about the term “named person”. A number of our parent councils expressed significant concern about it, with people saying, “I should be my child’s named person.” When we explained the concept behind it, they were fine with it, but their initial reaction to the name was not one of unqualified approval. That is a challenge. We need to be explicit about what the role is and how it will be implemented. Some of the things around information sharing and the shared systems that will be used will make the process less onerous, but there is still an issue about how that comes together.

We are also concerned about the issue of who the named person is for children who are home educated. Local government education departments have no locus in that regard. With regard to health, who would take that forward for young people of primary and secondary school age? That is not explicit in the legislation. If we want to have a net to catch every child, we should be aware that there is a group of children that could slip through that net.

The Convener: Miss Taylor, this is not really your field.

Mary Taylor: That is correct. I have nothing to add.

Eddie Fraser: I concur with Carol Kirk. There is a difference between the most vulnerable children, who have a lead professional and multi-agency involvement, and the wider population of children, in relation to whom the concept involves allowing easy, named access to that world and enabling proportionate access to professionals rather than having people who are involved with them every day of their lives and who take over some of the role of parents.

Margaret Mitchell: Miss Taylor, do you have no locus in this? Some information about housing and what is going on in a home can be very pertinent. I would imagine the SFHA might have something to say in that regard.

Mary Taylor: A social landlord might have an understanding of what is going on in a home—that occurred to me as I listened to the responses. However, we have opted not to make any formal comment in that regard, and I do not want to simply react to things today. I think that the important point is that the landlord’s relationship is primarily with the householder, who will always be an adult, even if they are 16, 17 or 18.

The Convener: It would be fair to say that housing assistants throughout the country play a major role in finding difficulties and pointing them out, but they are unlikely to be the named person in this regard. That is the key thing. That is why I said that this was not really your field. I am sure that housing assistants and housing visitors will continue to do what they have been doing in this regard for many years.

Mary Taylor: It is not because we are not aware of chaotic lifestyles or whatever. I could elaborate on that, but this is not the place.

Richard Baker: Carol Kirk said that there was a potential to simplify structures to benefit services, which is something that we would all support. She also said that we need to be careful that we do not just create additional structures rather than simplify the structures in a way that will make the process easier.

Will the Scottish Government get that balance right? Obviously, we are also considering the Public Bodies (Joint Working) (Scotland) Bill. Is the balance right as the proposals stand, or does it need to be worked on further?

Carol Kirk: It possibly needs to be worked on further. Even in the Children and Young People (Scotland) Bill there is much more of a statutory imperative around children’s services planning, which I think that people would welcome, but I would ask why we need a plan on corporate parenting that sits outwith that. I cannot see why that would not be merged into the same plan, given that the plan is concerned with a range of vulnerable children.

With regard to issues around the individual children, there is a complex framework, not only for local government but for parents. GIRFEC provides a structured and helpful way of planning for a child, in the round, and I am supportive of that. However, it crosses over with, for example, a co-ordinated support plan for a child who has complex needs. The additional support needs legislation does not sit entirely comfortably with the guidance around GIRFEC. It is possible to merge them, but it would still involve having two statutory frameworks, which does not make sense to professionals working in the area and probably makes less sense to parents.

The Convener: I return to a point about GIRFEC. I mentioned that I visited some doctors’ surgeries during the recess. I am interested in systems that do not talk to one another and which complicate the spread of information. What are your experiences of that? Could a bit of common sense and a bit of gumption be applied to deal with some of that? Do we overly complicate such systems?

Jim Carle: Yes, it is a real issue. The professionals are good at communicating with one another, but if we want to deal with the issues that are on the table, we need to have a better look at
that issue. I will pronounce this really carefully, but the Scottish Government needs to GIRFEC itself; it needs to look at the interrelationship between different bits of legislation, how they cut across each other and the number of demands that have been put on different aspects of professional organisations.

We do not need conflicting legislation. We do not need legislation that tells us to report to 16 different organisations, all on the same subject. A number of issues that we are dealing with in local authority and health board areas come from that source.

A significant amount of work needs to be done to resolve the systems that we have and to ensure that we are working to a common system and a common language. In Ayrshire and Arran we have AYRShare; we hope that that will take us some way down that road, but there is still a need for the organisations that we work with—education, social work and health—to have their own systems underneath all of that. That is an industry in itself and they all have different reporting mechanisms that work within that.

Somebody who sits in my position frequently answers the same questions to a number of different aspects of the Scottish Government. Again, that is about public money and public time that could be used better and more effectively on the issues that we have to deal with—issues that the other members of the panel have outlined so well.

The Convener: The term GIRFEC has to be said very carefully—I nearly did not say it the right way there.

Dr Mullin: Sensitive data sharing is a real issue for general practice and other agencies: how you filter what you talk about informally, in corridor chat and various other ways, and what you are prepared to put down on paper.

With child protection issues, it is fairly straightforward. I do not think that many GPs wring their hands over that. If they suspected anything, they would divulge that information quite readily. However, we are talking about the majority of vulnerable children in this country—probably about 20 per cent of 1 million children—who have unmet needs. The sharing of information around the subtleties of parenting and all the issues around deprivation and so on is a big piece of work that still needs to go on because some parents are very reluctant—naturally enough—for you to speak to other agencies about their own personal, private lives because that impacts on their parenting skills.

The only way round that is for extensive work to be done between the front-line GPs and social work, which is probably the main referral agency if you are talking about catapulting into the child protection system or legislative intervention. Otherwise, the majority of children who are vulnerable in general practice will just be signposted to other services for support; they are not being signposted into prosecuting the parents because they are battering their children. We are talking about parents who are not coping, for whatever reason.

A lot of such information comes into the consultation and the issue is how that is filtered. It is about experience—having experienced GPs who have met a lot of children and families in their lifetime—but it is also about having the work supported within the GP contract.

The Convener: I ask everyone to be brief, because I am hoping to get another question in. Ms Kirk, please.

Carol Kirk: That is right. The particular issue is not at the child protection end; it is the very large group of children for whom poverty and difficult home circumstances are impacting. We need to get much better at direct communication around that issue that possibly does not involve social services.

With AYRshare, one thing that we have considered—in fact, we had a meeting about it yesterday—is how GPs can have automatic access to the system. They might have a wee concern because they do not feel that some information can be shared of its own right but, if they have access to what other professionals have put on the system, that maybe builds a picture and allows them to say that they have a real concern. Achieving that level of shared information as easily as we can is a real issue for us.

11:15

Eddie Fraser: One of my responsibilities is to run out-of-hours social work services across Ayrshire. Working with three social work systems and trying to get out-of-hours health information is a difficult challenge. Improved information sharing, whether it be electronic or, better still, just talking to each other, would be a real move forward. That is where co-location comes in. I mentioned some of the services that we have co-located, such as mental health and learning disability services. In that situation, a social worker will just go along to the learning disability nurse and say, “Will you come out with me today and see this?” That communication happens and it works. On another level, we need to consider how to develop electronic information systems. I know that, through the Public Bodies (Joint Working) (Scotland) Bill, some money is being made available to move that on, but that has been a challenge for us for at least the past decade.
John Wilson: I want to follow up on a point that Mr Fraser made earlier, although my question has been partly answered in the previous round of answers. Mr Fraser referred to the fact that GPs are not as actively involved in the community health partnerships as they could be. My concern about the named person and protecting vulnerable young people is about how we ensure a smooth transition from pre-school to the school period and that the appropriate professional is the named person. For pre-school, that person could be the health visitor, but when the child starts school, it could be a social worker, a teacher or someone else. Might that give rise to issues? We must ensure that every child has a named person who can not only gather information but give it to other professionals to ensure that the child is protected.

Eddie Fraser: At a very basic level, one measure of success is that the child and family know who the named person is. Sometimes, in my service, when someone is asked whether they have a social worker, the answer will be yes, but they will give the name of somebody who left two years ago. Sometimes, the answer will be no, but we know that the person has a social worker. There are real issues about whether the role of named person will fulfil its function. You are right that children move through systems. If the approach is to be successful, who the named person is must be clearly communicated to the child and family. Families continually tell us that the lack of continuity in the people who support them is a real issue. I know that GP colleagues will say that, a lot of the time, the continuity comes through the practice.

Carol Kirk: The key to the issue is good relationships between early years establishments and health visitors. Health visitors will have a huge case load of children for whom they are the named person. When those children transit from the early years establishments to school, the named person will become someone in the school although, if the child is very vulnerable, the health visitor might retain that role until an appropriate time for handover. The key issue is to ensure that transition meetings take place and transition plans are produced for any children about whom a health visitor has a concern. Linking the health visitors directly to the early years establishments and involving them in the transition to primary 1 is the key way of ensuring that that happens. Another key issue is ensuring that, when a child moves into primary 1, the parents know who the named person is.

Mary Taylor: I wanted to come back on the previous question, but I am happy to wait until the end if you want.

The Convener: Fine. Dr Mullin?

Dr Mullin: I do not want to go into too much detail about the named person for over-fives. That is still something that has to be worked out. We are still often the referral point for older children, because agencies have withdrawn for whatever reason, because they do not need help any more, or because they have become vulnerable again. Because most people have a named GP, services or people will come to the GP. There is a big schism between education and general practice; there is not enough dialogue there.

The deep end has talked about integrated working and attached workers, but the only way to make any of the systems work is to have integration of communication. It is about professionals being able to communicate with and understand one another, and child health in general practice has been peripheral to many of those developments, although we are often the central point of referral for many agencies. The deep end has a clear view on that, which is outlined in our proposals.

Jim Carle: I agree 100 per cent with what Carol Kirk said. We need to align health visitors carefully with early years establishments, and a good relationship needs to be built and maintained in that process. My concern for health visitors is about the resource requirements and the additional burden that that will bring. GPs are the critical partners in most of what we do in children’s and young people’s services. They are the pivotal point around which families revolve, so communication systems must be developed well to support their practice. If there is a hierarchy within the system, they are among the most valuable partners.

Our difficulty is in assessing what happens with health visitors beyond the age of five, when the burden of being the named person is placed on our education colleagues, who must have good support systems in place. We are new to the whole process. We do not yet have a huge amount of experience of those transition arrangements, but good communication and professionals talking to professionals to ensure that we are talking the same language and that we understand the issues will be critical to the whole process. The strength behind that is that we have well-established communication frameworks where we can raise those issues, and we will find shared resolutions. However, the problems should not be underestimated, either in terms of the additional resource required or in terms of the critical nature of the relationship between health visitor and early years establishments.

The Convener: Miss Taylor, I shall let you come back very briefly.

Mary Taylor: On the general issue about systems not talking to one another, there is an
operational dimension, which we have spent a lot of time talking about, and a strategic dimension. The operational dimension intersects with the housing system in the sense that, for example, someone who is leaving care and who may have had a history of social work interventions as a child may then be at risk of homelessness and may enter the housing system as a social tenant through the homeless route. There is an interesting issue there about how much information passes with that person to the people who take him or her on as a landlord, to enable them to understand what interventions have worked and who has been involved in the past. Operational practice is much patchier than it really should be.

With regard to the other side of the operational information, I know that there are projects in Glasgow where housing associations are actively working with police and fire services to ensure that they get effective data sharing, information sharing and knowledge sharing at a local scale, so that they can tackle problems on a preventive basis. They have been able to document the extent to which they have saved lives and extensive budgets on vandalism, fire damage and other things.

However, I return to the point that I made at the beginning, about strategic information. There is a whole lot of information around strategic planning that relies on decent data sharing and integration of practice around strategy, and that is where housing can make a significant contribution—but only if it is required.

John Wilson: I have no further questions.

The Convener: I thank the witnesses for their evidence, which has been useful.

11:24

Meeting suspended.

11:33

On resuming—

The Convener: We move to our final panel. I welcome from the Scottish Government Alex Neil, the Cabinet Secretary for Health and Wellbeing; Aileen Campbell, the Minister for Children and Young People; Kathleen Bessos, deputy director for integration and reshaping care; John Paterson, divisional solicitor for food, health and community care; Alison Taylor, team leader for integration and reshaping care; Philip Raines, head of child protection and children’s legislation; and Magdalene Boyd, solicitor for communities and education.

I ask the cabinet secretary to make opening remarks.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): Thank you for inviting Aileen Campbell and me to make statements and answer questions. I will confine my remarks to the Public Bodies (Joint Working) (Scotland) Bill, which deals with the integration of adult health and social care. The bill’s purpose is to provide a framework for the integration of health and social care, with the aim of improving outcomes for service users, carers and their families. That is at the heart of our policy.

We are legislating for national health and wellbeing outcomes that will underpin the requirement for health boards and local authorities to plan effectively together to deliver quality and sustainable care services for their constituent populations. It is important that the bill aims to bring together the substantial resources of health and social care to deliver joined-up, effective and efficient services for the increasing number of people with longer-term and often complex needs, many of whom are older.

The bill requires health boards and local authorities to establish integrated arrangements through partnership working and it requires statutory partners to integrate via one of two models—delegation to a body corporate that is established as a joint board, or delegation to each other as a lead agency, which involves three possible models. Health boards and local authorities will be required to delegate functions and budgets to the integrated partnerships, and secondary legislation will set out such matters and will cover adult primary care and community care, adult social care and aspects of acute hospital services.

Integrated partnerships will be able to include other services, such as children’s services, when a local arrangement is made to do so. That already works well in areas across Scotland, such as West Lothian and Highland.

Each partnership will be required to establish locality planning arrangements, which will provide a forum for local professional leadership of service planning. Integrated partnerships will also be required to prepare and implement strategic commissioning plans that will use the totality of resources that are available across health and social care to plan for local populations’ needs. It is important that professionals, service users, GPs and the third and independent sectors will be embedded in that process as key decision makers.

The bill is in the context of public service reform. Alongside the Children and Young People (Scotland) Bill, which Aileen Campbell is leading, it is part of the Government’s broader agenda to
deliver public services that better meet the needs of people and our communities. The Public Bodies (Joint Working) (Scotland) Bill provides a legislative framework for partnership working at strategic and local levels that involves professionals, service users and partners. The planning and delivery principles in the bill encapsulate the Christie commission’s principles by putting the person at the centre of service planning and delivery and require a focus on prevention and anticipatory care planning.

As for why we need to legislate, my predecessor, the Deputy First Minister, proposed to Parliament in December 2011 the introduction of the bill, which had cross-party consensus. We are all aware of attempts in the past to integrate the services, with greater or lesser success. Underpinning the process with a legislative requirement is essential to achieving our objective.

We are not starting with a blank sheet. In many areas across Scotland, bodies are already working in partnership to deliver integrated services. We have considered the evidence from across the UK and we are mindful about applying it in Scotland. However, I am clear that, to achieve consistent progress, it is necessary to set out in legislation a framework that is not too prescriptive and will deliver the necessary changes to meet the future demand on services. I welcome the opportunity to provide further clarity on the bill to the committee.

The Convener: Does the minister have anything to add?

The Minister for Children and Young People (Aileen Campbell): Yes. Good morning and thank you for inviting me to give evidence on part 3 of the Children and Young People (Scotland) Bill—on children’s services planning—which was introduced in Parliament on 17 April. The bill is fundamental to securing the Scottish Government’s aim of making Scotland the best place in the world to grow up in. Through the bill, the Scottish Government aims to ensure that children’s rights properly influence the design and delivery of policies and services. The bill aims to improve how services support children and families, to strengthen the role of early years support in children’s and families’ lives and to ensure better permanence planning for children and their families.

The report of the Christie commission on the future delivery of Scotland’s public services highlighted that services must better meet the needs of the people and communities that they serve. In welcoming the report, we set out a vision of reform through early intervention and preventative spending, greater integration and partnership locally, workforce development and a sharper and more transparent focus on performance.

The Children and Young People (Scotland) Bill will be fundamental to our achieving those ambitions on rights and services. It aims to put Scotland at the forefront of providing services that give children, young people and their families what they need and deserve, and find better ways of offering better life chances to each and every child in Scotland.

I am delighted to have an opportunity to speak to the committee about part 3 of the bill, which is on children’s services planning. In recent years, there has been increasing integration in how public bodies develop, plan and operate services to support children and young people. However, unless services work together, there is a danger that something important will be missed and a child or young person’s wellbeing will suffer. Children and young people need not just co-ordinated services but services that share an holistic approach to wellbeing and early intervention. Children deserve services that routinely and consistently consider the full spectrum of their needs.

Part 3 sets out the duty of local authorities and health boards, with the assistance of other public bodies and third sector organisations, to work together to develop joint children’s services plans every three years. The intention is that bodies that are responsible for expenditure and for planning and delivering services will work together to improve the wellbeing of all children and young people in their area.

Currently there is no requirement for public bodies to report collectively on how the lives of children and young people are improving. To give the public and children and young people a full picture of how wellbeing is being promoted, supported and safeguarded, local authorities and health boards will report each year on the extent to which they have achieved the aims of their children’s services plan. That will enhance the implementation of getting it right for every child and make a direct and accountable link for the public between local services and outcomes for children and young people.

I hope that I have given the committee some useful background information. I will be happy to take questions from the committee on part 3.

The Convener: Thank you, minister. The evidence that we heard today on the difference that GIRFEC has made was mainly positive. However, a few things cropped up, one of which was the perennial question about communication and systems that do not talk to one another. How will we tackle the issue, which causes great difficulty sometimes?

Another interesting issue that was raised was how we deal with named persons for children who
are home educated, given that an educationist would normally be the named person for a child of school age. Will you respond to those points, minister?

Aileen Campbell: It is good to hear that you had such a positive session on GIRFEC. As you know, GIRFEC has been around for a while. The bill provides the opportunity to embed the approach further, putting the child at the heart of the design and delivery of services.

You asked about communication. Part 3 is about ensuring that joint working happens. I think that this morning the committee heard good examples of joint working and the strong relationships and good communication that are crucial to the delivery of services that a child or family needs.

There is the joint services element of the bill, and we want a reporting mechanism that brings together local authorities and health boards. We will ensure that such an approach is standardised and embedded in the bill, to ensure that there is an holistic approach that reflects the child’s holistic needs and promotes the child’s wellbeing.

As the bill progresses through the Parliament, I know that the Education and Culture Committee, which is the lead committee, will take a strong interest in the named person aspect, because of the issues that have arisen in that regard. From our point of view, the named person is a big part of the GIRFEC approach. It is about ensuring that services are delivered consistently, that families have a point of contact and that support is in place.

We are well aware of the issues that have arisen in relation to home-educated children. We are working with stakeholders to ensure that, through guidance for example, procedures are put in place to reflect the parental choice to educate a child at home—it is right that there is such a choice, because the parent is the person who knows the child best. We will ensure that that is reflected in the bill and in the guidance.

The Convener: Mary Taylor, the chief executive of the Scottish Federation of Housing Associations, told us this morning that the housing sector is not really taken into account in either bill. She thinks that the sector has a major part to play in integration. Will you comment on that, cabinet secretary?

11:45

Alex Neil: Absolutely. I agree with Mary Taylor that it is essential to involve the housing sector, particularly the social housing sector. Many of the issues that we are dealing with, whether delayed discharge, aids and adaptations or a range of other issues, clearly require the involvement of housing associations and local authority housing departments. We have a stream of work going on, which I commissioned a few months ago, to see how we can best ensure that the housing function is involved at grass-roots level in the partnerships. It may not necessarily be the case that housing bodies are separately represented on partnership boards, but I think that the most important element is what happens in the localities underneath the partnership board area. That is where the close working relationship between health, social work and housing is vital. Both the ministerial steering group and the bill steering group are looking at how best to achieve that.

The Convener: Minister, do you want to follow up on that?

Aileen Campbell: Yes. Section 10(1)(b)(ii) in part 3 of the Children and Young People (Scotland) Bill explicitly refers to consulting “such social landlords as appear to provide housing in the area of the local authority”.

when the local authority is preparing a children’s services plan, so there is explicit recognition of the role that housing can play in a child’s wellbeing.

The Convener: Thank you.

Margaret Mitchell: Good morning. It is clear from the very comprehensive opening statements from the cabinet secretary and the minister that both bills contain provisions that require consultation on their respective shared services provision. Section 6(2)(a) of the Public Bodies (Joint Working) (Scotland) Bill requires consultation to be with “such persons or groups of persons appearing to the Scottish Ministers to have an interest”.

Section 10(2)(a) of the Children and Young People (Scotland) Bill requires consultation with organisations that “represent the interests of persons who use or are likely to use any children’s service”.

However, neither bill appears to require consultation with individual service users.

Despite your emphasising that the provisions are based on the Christie commission recommendations and that we are putting children at the heart of the process, the fact of the matter is that, as you have explained it so far, there does not seem to be a requirement to consult the child or the young person.

Aileen Campbell: As Margaret Mitchell correctly notes, the ethos of the bill is getting it right for every child and putting the child at the centre of service design and delivery. The bill mentions setting out guidance on how consultation might take place on potentially bringing into the
planning process third sector providers and whoever else is appropriate, which will include the child and the families. However, as we develop the guidance, we can certainly make it explicitly clear that consultation should recognise the role of the child and the family and ensure that they have a full and active role in the service design and delivery that is going on around them.

Margaret Mitchell: May I put a specific, quite technical question to you, minister? You will be aware that the Children (Scotland) Act 1995 drew everything affecting children into a single act. The act had three overarching principles, but the key one was to require the child to be given the opportunity to express their views. Obviously, their welfare is required to be a paramount consideration and there is the requirement that the minimum proportion of state intervention be preferred over disproportionate intervention in family life. Subsequent legislation affecting children and young people—for example, on children's hearings and adoption—has ensured that those requirements are incorporated, but that is not the case with the Children and Young People (Scotland) Bill. Why is that?

Aileen Campbell: Again, the bill takes appropriate account of the child and the family. That is the ethos of GIRFEC, which is about ensuring that services provide support to families when they need it and that such intervention is appropriate and timely, and is delivered at the right point to avoid crises, given that intervention is most effective when it is done as early as possible.

It is worth recognising that the 1995 act is still in place and that our aim is to ensure that we make the bill as good as it can be, that we can work things through in consultation with stakeholders and that our guidance reflects the points that you have raised as much as it can.

Philip Raines (Scottish Government): Section 9, which relates to the aims of the children's services plan and sets out many of the principles that we want to underpin the planning of children's services—and, by extension, the way in which children's services are carried out—makes it clear that planning should take place in a way that "best safeguards, supports and promotes the wellbeing of children in the area concerned ... is most integrated from the point of view of recipients, and ... constitutes the most efficient use of available resources".

We wanted to make many of those principles explicit in the bill to ensure that they underpin the planning that takes place. As the minister has said, we will work with stakeholders on the detail of that and how that will work in practice as we develop guidance.

Margaret Mitchell: The fact that the issue is not implicit in the bill as it has been in other bills has led some to comment that this is a duty on public services rather than anything in particular to do with the rights of the child. That, I think, is the technical point.

Do you wish to comment on the suggestion made by an earlier witness that, in view of this legislation and potentially competing legislation, the Scottish Government should GIRFEC itself?

Aileen Campbell: Should what itself?

The Convener: GIRFEC itself.

Margaret Mitchell: They were referring to getting it right for every child. The suggestion was that the Scottish Government should look at the various bits of legislation that might compete with, conflict with or duplicate one another.

Aileen Campbell: The bills complement one another; in fact, a lot of work has been done to ensure that not just these two bills but all the bills that we introduce complement one another. From my point of view, the Children and Young People (Scotland) Bill is about ensuring that the United Nations Convention on the Rights of the Child is taken far more into account in the work that we as a Government do. That applies not just to this bill but to all our work across Government, regardless of whether we are talking about legislation. The Government has been working in a joined-up way to ensure that the bills are complementary and that the work of Government in future dovetails and provides the good outcomes that we expect to emerge from the bills that we are presenting today.

Margaret Mitchell: Did you hear the previous panel's evidence?

Aileen Campbell: I did not catch it all. Did you wish to raise a specific issue?

Margaret Mitchell: I simply refer you back to the specific examples of conflicting legislation and duplication that were highlighted and suggest that the previous panel's evidence on that specific point might be worth looking at.

The Convener: I am sure that, as per usual, the minister will do so.

Richard Baker: Although the previous panel was very enthusiastic about the potential for integrating and improving services through legislation, the witnesses asked that, in pursuing this agenda, we were careful not to create new and additional structures instead of simplifying things. How would you allay such concerns?

Alex Neil: To some extent, the legislation will streamline structures and make it easier to see the focus for partnership working. We have clearly specified that one of two models must be adopted:
the lead agency model that has been adopted in the Highland area or the joint corporate body model, which I think will be adopted in most if not by all of the rest of Scotland. As a result, there is scope for many existing committees to be streamlined. For example, one of the consequences of the enactment of the Public Bodies (Joint Working) (Scotland) Bill will be that there will be no need for separate CHPs because their work will in effect be incorporated into the partnership. Moreover, with the introduction of a more formal structure, the many formal and informal organisations involving health boards and local authorities at local level can be collapsed. In that way, the legislation will simplify the structure.

The role of the chief officer in the partnership will also be crucial because they will do two things: first, report to the partnership board—or the lead agency, if a lead agency model has been adopted—but, secondly, report to the respective chief executives of the local authorities. For example, such an approach has been up and running very successfully in West Lothian for eight years now and integration and co-ordination at parent organisation level have been substantially enhanced as a result of the partnership’s work.

I should stress that, from day 1, we want the acute health sector to be actively involved in the partnerships. When we involve acute care in the community, many of the barriers that exist between the primary care sector and social care, and between the primary and secondary care sectors, start to get broken down. A good example of that is the hospital at home programme that NHS Lanarkshire initiated, which is now being rolled out across the country. I think that that will remove barriers and bureaucracy, cut red tape and lead to much more localised provision.

In addition, we have commissioned—jointly with our colleagues in the local authorities—some work to look at where the public health function would sit in future. In the post-war situation, the public health responsibilities were given exclusively to local authorities. Under Ted Heath, they were transferred exclusively to the new health boards. South of the border, they have been split up between the health boards or their equivalents and the local authorities. My view is that a successful public health policy requires the health boards and the local authorities, with their respective remits, to work in an integrated fashion. I think that an opportunity exists, particularly in public health, not just to enhance the service, but to break down the barriers that have traditionally existed between the different sectors and to streamline the entire process.

Richard Baker: That is helpful, but there is still a concern about the details of what is proposed and how it will work in practice. In its submission to the committee on the two bills, Audit Scotland said:

“Significantly, the relationship between CPPs and the new integrated health and social care arrangements ... and changes to children’s services ... are not clear.”

Will greater clarity be provided on some of the working arrangements before the bills are finalised?

Alex Neil: I am surprised by that comment, because I believe that Audit Scotland is represented on the group that is chaired by Pat Watters, the former leader of the Convention of Scottish Local Authorities, which is looking specifically at enhancing the role of the CPPs in relation not just to health and local authorities, but to the entire public sector operation at local level.

It is likely that the output from that group, which includes representatives from a wide range of organisations including COSLA and the Society of Local Authority Chief Executives and Senior Managers, will take forward in a substantial way greater co-ordination and integration of services across the board at local level. In particular, I know—because I am a member of the group—that it has had serious and in-depth discussions about the need for bodies such as health boards and local authorities, and others, to discuss annually their strategic budget proposals before they agree to implement those proposals, in an effort to ensure that across the public sector, in each local authority area, we maximise the impact of the public pound. Therefore, I am surprised that Audit Scotland has made that comment.

Richard Baker: Well, it has made it, so—

Alex Neil: I draw your attention to the work of the group that is chaired by Pat Watters.

Richard Baker: I am sure that you and Pat will discuss the matter—

Alex Neil: Absolutely.

Richard Baker: I do not want to labour the point, but it is worth reflecting on the fact that Audit Scotland raised the issue specifically in relation to CPPs.

Alex Neil: Pat’s group is looking specifically at the role of CPPs and how there can be much greater integration and co-ordination across the public sector in each local authority area.

The Convener: I am sure that the committee will talk to Mr Watters again shortly, because we said that we would.

Stuart McMillan: Good morning, panel.

My question is directed mainly at the cabinet secretary. The Public Bodies (Joint Working) (Scotland) Bill is, obviously, about public bodies; it is not about other organisations. Prior to the
summer recess, the committee concluded the latest instalment of its inquiry into public services reform. An issue that came up in all three of the stages of the inquiry that we undertook was community and third sector involvement in the shaping and delivery of public services.

During one of the visits that I undertook over the summer, a council of voluntary services made the point that the Public Bodies (Joint Working) (Scotland) Bill appears to make no mention of community involvement. Now, I accept that the bill is about public bodies rather than about communities per se, but it appeared to that CVS that the bill is about something that is being done to people rather than in conjunction with the community. Should there be a wider discussion with communities to provide that involvement?

Alex Neil: Let me make it clear that, as should be evident from the policy memorandum and from the bill itself, we see the third and independent sectors as having a very important role not just in the delivery of services but in the design and architecture of services.

I think that there is a bit of a misconception here, and let me explain why. Because the health board and the local authority are the public fund holders, only they have a vote on the partnership board. However, as we have seen in West Lothian and elsewhere, the third and independent sectors are represented on the boards. We would envisage that happening in every case because the third and independent sectors clearly have a major role to play. Obviously, we need to ensure that there is no conflict of interests, because we cannot have people who are competing in a tender for service delivery simultaneously sitting on the board. However, those governance issues are not new and have been with us for a long time.

You just need to look at West Lothian, which is a kind of exemplar for the joint corporate body model in Scotland, to see that the third and independent sectors have a role not only in terms of board membership but—more important, actually—in designing and delivering services at the locality level. They are heavily involved in that. Also, where there are any proposals for service redesign, the third and independent sectors are involved in the process and in the consultations on the redesign of services. I would take West Lothian as a very good example. We would expect that kind of standard of consultation with, and standard of involvement of, the third and independent sectors to be followed. Indeed, we will require that, and we will incentivise the use of the third and independent sectors where that is appropriate.

Stuart McMillan: That is helpful, thank you.

The Convener: Cabinet secretary, you have mentioned that West Lothian is probably the exemplar for this kind of work. In the evidence from East Ayrshire Council earlier today, we heard that co-location can help a lot in that regard. Obviously, West Lothian Council has its new civic building, where teams from across the public sector can work side by side at desks next to one another. That seems to make joint working easier. In your opinion, is co-location required to ensure that all these things work properly?

Alex Neil: I would not like to prescribe that co-location is always a prerequisite to approving any delivery plan, but I must say that, in the examples that I have seen, co-location is definitely very advantageous. In the East Ayrshire Council headquarters building on London Road in Kilmarnock, the co-location of services there is definitely a huge advantage in providing for integrated delivery.

I draw your attention to a pilot project that is being run in the mining village of Dalmellington in East Ayrshire. That joint project, which involves the third sector as well as the local authority and the health board, is using telehealth to help older people with co-morbidities. Over the 21 months that the pilot has been running, the GP in charge says that, for the 20 older people with co-morbidities who are involved in the pilot, there has been a reduction in hospitalisation of that cohort group that has been of the order of 70 per cent. That is a very practical example.

Similarly, in your part of the world, convener, in Aberdeen and Aberdeenshire, social workers are co-located in some of the NHS Grampian community hospitals. In Fife, although the partnership boards have not yet been set up formally—they are still prototypes—there is already co-location of health and social workers, for example in Dunfermline, and there is no doubt that it adds great value to the quality and efficiency of service delivery.

The Convener: We have heard your Dalmellington story before, cabinet secretary, and I am glad to hear it again, as I have been telling it elsewhere.

Minister, do you have anything to add on co-location?

Aileen Campbell: The cabinet secretary said co-location is not a prerequisite for greater integration, but the anecdotal evidence from the service user's point of view is convincing. If someone needs a bit of extra support, they can go to a service that is co-located with social workers, GPs or whoever and they do not face the stigma that is attached to seeking help from that service because they are entering a building in which a
variety of different services are provided. People can be a bit more proactive in seeking help and can feel reassured that there will not be any stigma attached to that and that people will not start talking about them. The anecdotal evidence from the point of view of the service user is compelling regarding how they feel when they enter a place where different services are co-located. They find that a good experience for them.

The Convener: Thank you very much.

John Wilson: Good afternoon, cabinet secretary and minister. Cabinet secretary, you have spoken about integration measures. According to our Scottish Parliament information centre briefing, there will be two broad models of integration, which will be broken down into four different models. The first model is the body corporate model, under which local authorities and health boards will come together to form a joint board that will be separate from the local authorities and health boards and will be led by a chief officer. Do you see that chief officer being separate from the health board and the local authority, and will that require the creation of a new post?

Alex Neil: It will be a statutory post after the bill has been passed. That said, we must be pragmatic. Again I refer to West Lothian, where the chief officer has come from a health board background but is on the senior management team of both the local authority and the health board. The important thing is that the chief officer reports primarily to his or her own board but also has a line of responsibility to the chief executive of the local authority and to the health board. In West Lothian—and, indeed, in other areas where it is earlier days than in West Lothian—that arrangement has worked very well.

John Wilson: What I am trying to get at is whether we will see the creation of a new administrative structure for the delivery of services. If we create a new administrative structure, how will that be paid for?

Alex Neil: By definition, the partnership board is a new administrative structure because such boards do not exist at present, and the role of the chief officer is a new position in that sense. The important thing in paying for that is the integrated budget. I will give you a good example. I have been encouraging local authorities and health boards up and down the country to follow the example of West Lothian and establish a step-up, step-down centre as one way of improving the transition from hospital back into the community. The centre has also contributed to the elimination of delayed discharges in West Lothian. If West Lothian did not have a partnership board, the health board’s and the local authority’s respective shares of the funding for the project would have to go through separate decision-making processes within both the local authority and the health board, through the committee structure and all the rest of it.

When you have integrated budgets, that is decided internally, within the partnership board. The decisions can be made quicker but, more important, they will be taken in the context of the strategic plan that is laid down and agreed by the partnership board, which would obviously have to be endorsed by both the health board and the local authority. You get much quicker decision making and much more co-ordinated and integrated approaches. The evidence from north and south of the border—from Torbay, for example—is that the quality of the decision making is far better. Most important, not only do you end up with far better outcomes, but those outcomes are delivered far more cost effectively, which is a big prize.

John Wilson: I welcome what you said about West Lothian, but you are not promoting the West Lothian model throughout Scotland; four different models of integration can be taken from the proposals that are before local authorities and health boards. Would it not have been better to have applied the West Lothian model of integration throughout Scotland, so that a uniform model would be adopted by all local authorities and health boards?

Alex Neil: From day 1, including under my predecessor, Nicola Sturgeon, this has been an iterative process of discussion between us, the local authorities, which have been represented by COSLA and SOLACE, and the third and independent sectors. My approach to the development of the models, and indeed to the whole bill, has been to try to get consensus among the local authorities, the health sector, the Scottish Government and the third and independent sectors. On the basis of those bodies’ experience, track record and expertise in delivering the services, they are all pretty much of the opinion that there should be a degree of choice so that each area can decide how best to deliver in their area. Highland has decided on a particular variation of the lead-agency model and all the indications are that it is beginning to work well and to deliver substantially improved services and outcomes.

We have said all along that it would be inappropriate for us to sit in Edinburgh and prescribe every detail of the arrangement in each of the 32 local authority areas. How you would structure services in Glasgow, where you have one health board and six local authorities, is completely different from how you would structure them in the Borders, where you have one local
We are saying that the principles that matter to us are that there is a statutory underpinning to the integration of adult health and social care and that there is an integrated board, budget and strategic plan. That is why the bill sets out the framework. Within that framework, we are saying to local people, “You decide what’s best for your area, because politicians and civil servants sitting in Edinburgh don’t know enough about what’s happening in your local area to dictate to you how all the i’s are dotted and all the t’s are stroked.”

John Wilson: Having said that, can you assure us that the reporting and monitoring regime carried out by the Scottish Government will be consistent across all models of integration used by health boards and local authorities?

Alex Neil: Absolutely. We have said clearly that, in measuring success, the key thing that we are interested in is the national outcomes. You might ask why the outcomes are not on the face of the bill. They are not there for two reasons. One is that outcomes change. The outcomes that you would set today would be very different from the outcomes that you would have set, say, five years ago. I suspect that they would also be very different from what they would be in five or 10 years’ time as service provision changes—how we do things in these fields changes continually. Therefore, if you put the outcomes in the bill, you would need to introduce primary legislation every time you wanted to amend them. The national outcomes will be set out in secondary legislation.

Secondly, I am not going to take a unilateral decision on what those outcomes will be. All along, we have proceeded on a partnership basis with our friends in the local authorities and the third and independent sectors, and I think that this will work much better if we can get agreement on what the national outcomes should be and on how we measure success. We are more likely to achieve success if from day 1 everyone is signed up to what has been defined as success.

12:15

John Wilson: I am well aware that outcomes should not be set out in the bill. After all, you will know from your own constituency, cabinet secretary, that things can change dramatically with one report.

Alex Neil: They have improved enormously in the past two years.

John Wilson: I am glad that you have friends in local government throughout Scotland.

Anne McTaggart: Now that we are into the afternoon, I wish the cabinet secretary and minister good afternoon.

I have two quick questions. How will the quite different mechanisms for integrating services that are set out in each bill improve children’s transition to adult services?

Alex Neil: I will let Aileen Campbell take the lead on this question, but I point out that the Public Bodies (Joint Working) (Scotland) Bill, which deals with adult health and social care, does not make a statutory requirement with regard to the integration of health and social care per se. However, coming back to the examples of the Highlands and West Lothian, I note that, in both cases, even with their different administrative arrangements it was agreed almost from day 1 that they needed to integrate their children’s health and social care services.

I believe that there are two big differences between dealing with children and dealing with adults. First, there is the very crucial role that the education system plays with children and for which there is no equivalent for adults, particularly older people. Secondly, children by definition do not legally have the capacity to make decisions for themselves. However, adults do and I note that there are special arrangements for adults with incapacity. The fact that these two bills cross-reference each other means that we are singing from the same hymn sheet—and that is very important.

Aileen Campbell: Some of the consultation responses to the lead committee have acknowledged that the transition from children’s to adult services can be challenging. The two bills allow for greater planning in both services; the Public Bodies (Joint Working) (Scotland) Bill will help to provide far more planning in adult services, while the Children and Young People (Scotland) Bill will require improvements in children’s services to recognise the breadth of different people and services involved in a child’s life. The fact that the two systems will improve planning will give us the ability to make the transition far smoother than might have been the case in the past. Indeed, that is the benefit of having these two approaches; greater emphasis on planning and improvement from children’s point of view to reflect the breadth of services involved in a child’s life will enable a better transition to adult services, which will also be improved through better planning.

Anne McTaggart: With regard to CPPs, how do these bills tie into the proposed community empowerment and renewal bill?

Alex Neil: Obviously, the community empowerment and renewal bill has a wider remit; it is not entirely about, but very much has an
emphasis on, physical assets, how the community obtains such assets and such matters. However, the umbrella for all of this is the Government’s guiding principles and strategic objectives, which include not only community empowerment and renewal but public sector reform, to ensure that better-quality services are delivered more cost effectively and timeously; patient-centred healthcare and social care; and, indeed, person-centred education. Those underlying principles are not restricted to my bill, Aileen Campbell’s bill or Derek Mackay’s community empowerment bill; they are universal and part and parcel of our broad principled agenda for changing Scotland for the better.

Aileen Campbell: I echo the cabinet secretary’s comments. When we seek to help families and children, we must ensure that we build from an asset-based approach—indeed, the chief medical officer is keen to promote approaches that build from a family’s strengths—and I think that that dovetails very nicely with the community empowerment work that Derek Mackay will be taking forward.

Local authorities already publish children’s services plans and West Lothian, for example, sets out very clearly how such plans integrate with the wider CPP family. The fact that structures are already in place to reflect community planning needs will also be reflected in how we move forward on this issue, with CPPs no doubt playing a crucial role in making the improvements that we expect to emerge from the Children and Young People (Scotland) Bill. I also imagine that our approach will reflect the single outcome agreements that local authorities will be finalising.

I hope that that covers your question.

The Convener: Thank you very much for that useful evidence.

Before I move the meeting into private session, I ask for everyone’s co-operation in clearing the room quite quickly. We need to get through a lot of business before we meet the European commissioner at 1 o’clock.

12:21

Meeting continued in private until 12:45.
WRITTEN EVIDENCE TO THE LOCAL GOVERNMENT AND REGENERATION COMMITTEE

Written evidence associated with oral evidence

NHS Ayrshire and Arran
GPs at the Deep End
North Ayrshire Community Planning Partnership
Housing Co-Ordinating Group

Other written evidence

Association of Directors of Education in Scotland
Argyll and Bute Council
Audit Scotland
Children in Scotland
Children's Hearings Scotland
Coalition of Care and Support Providers in Scotland
COSLA
Midlothian Community Planning Partnership
Police Scotland
Royal College of General Practitioners
Scottish Fire and Rescue Service
UNICEF UK
West Lothian Community Planning Partnership
1. The potential benefits which might accrue from shared working arrangements, both for the organisations involved and for those in receipt of services;

In June 2013 Ayrshire and Arran NHS Board approved the following:

- The adoption of the body corporate model for the integration of health and social care, between Ayrshire and Arran Health Board and each of the three Ayrshire Local Authorities
- The creation of a Transition Integration Board and thereafter a Shadow Integration Board in each Local Authority area to plan for the establishment of formal Health and Social Care Partnerships in North, South and East Ayrshire under the direction of Integration Joint Boards
- The establishment of the post of Chief Officer for the North, South and East Ayrshire Health and Social Care Partnerships
- The appointment process for the Chief Officer to each Health & Social Care Partnership.

This process was mirrored by each of our Local Authority Partners through their own systems. It should be noted that Ayrshire and Arran Health Board has three Councils within its boundaries.

A requirement of this model is the establishment of an Integration Joint Board in each partnership area. To progress this, arrangements are being made for a Transition Integration Board to be in place as soon as practicable followed by a Shadow Integration Board from 1 April 2014 with the Integration Joint Board being established by 1 April 2015, or in line with the timetabling as set out in the final legislation.

As we progress we will continue to build upon our positive and well established relationships with our Local Authority partners. We anticipate that the establishment of the joint management teams will result in a number of benefits.

Efficiencies and benefits are anticipated to arise as follows:

- The focus on outcomes (providing this is reflected in performance regimes)
- The introduction of locality planning – this should streamline community engagement across the four sectors and maximise the opportunities for
an assets based approach while engaging local users, carers and professionals in an agenda which is real for them. It should also bring a sharper focus on tackling health inequalities

- The principle of joint and equal responsibility – this should help reduce “hand offs” between the statutory agencies
- The engagement of the third and independent sectors as strategic partners – this is already helping to shape effective plans in services for older people
- A logical framework reflected in the flow of the Bill from the model of integration to the integration plan to the strategic plan with consistent integration planning principles throughout – this will bring a much higher level of consistency and focus to joint endeavour
- Stronger working relationships with adult services resulting in a more family focused approach
- Enhanced working relationships with our third sector partners
- Improved information sharing.

2. The rationale for having a separate approach in both Bills to establishing joint working arrangements.

Although the subject matter of the Bills is different, there are significant similarities in the approach taken to achieve the underlying aim of integrated or shared services. Both Bills have implications for the development of shared services involving local government, the health service and other parts of the public service. We would accept that it is necessary to have two separate Bills given the subject matter but it would have had a number of advantages if the approaches could have been more closely aligned.

3. In what area potential savings might arise?

It is difficult to offer a definitive statement as children’s services in implementing GIRFEC (Getting It Right for Every Child) and the Early Years Collaborative have had a clear focus on integration and better joint working for a number of years, and we would anticipate that the implementation of the Children and Young People (Scotland) Bill and Public Bodies (Joint Working) (Scotland) Bill would further enhance this process. We can however reasonably anticipate that savings would result from the following:

- An improved approach to making investment and disinvestment decisions based on a clear process and evidence base and best use of integrated resources
o Greater potential to reduce costs through a joint strategic commissioning process which is based on improving outcomes at both a strategic and individual level, supports effective service change and views issues from a user’s perspective

o Enhanced processes for early identification and intervention for example:

Effective and secure sharing of information within and between agencies is fundamental to the protection of children. AYRshare is a mechanism for sharing information across partner agencies will lead to a more effective integrated approach to assessment, single child’s plan and common chronology ensuring we are compliant with the GIRFEC transformational change programme. It will link current computer systems and support business processes. Enabling coordinated and efficient support, well informed personnel working in partnership, enhancing our ability to achieve appropriate and timely interventions leading to improved outcomes.

o Better outcomes for our Children and Young People

o Enhanced information sharing (Specifically between Adult and Children’s services)

o A more integrated strategic approach

o More effective use of current resources (reducing any overlap in service delivery)

o Significant potential to streamline services that are currently delivered by both the LA and Health.

4. Whether there are any issues around the proposals covering consultation on, and development of, strategic plans/service plans between the respective areas involved?

There is a need to ensure that staff are fully engaged and consulted in the decision making process leading to implementation, with regard to both Bills. A consistency of approach across all staff groups is critical as is gaining commitment from staff which should be regarded as a marker for success.

NHS Boards will require, in strategy, policy and performance to make explicit children’s rights and steps taken to comply with this section of the legislation. This will require a culture shift across health services and whilst it is welcomed, it poses certain challenges. Further guidance on implementation and monitoring performance would be welcome and this would also help to support a consistent approach across the country.
It is suggested there will be particular challenges for those who work in services where the adult is the primary receiver of care and their understanding as to compliance with children’s rights in practice is crucial to the implementation of the legislation. In addition, health practitioners may face conflict in balancing the rights of adults receiving care with those of the adult’s children.

NHS Boards will require clarity on the role of the corporate parent and the implications of this. Consideration will need to be given to the role of adult health services in particular in relation to those 16-25 years and action taken to ensure they understand the legislation and the interface with vulnerable adult legislation.

Concern about possible duplication of effort e.g., preparing a children’s services plan and a corporate parenting plan. We will be required under the new bill to produce individual children’s plans which will bring together all of the relevant information and resulting actions but we still have a requirement under the Education (Additional Support for Learning) (Scotland) Act 2004 for individual support plans.

The Children and Young People’s Health Strategy for Ayrshire and Arran, sets out the broad vision for improving and promoting health, developing health services and addressing inequalities for children and young people in Ayrshire and Arran. This document forms the health chapter of each of our Local Authority partners Integrated Children’s Services Plans. This supports an equitable approach to meeting and addressing the health needs of our children and young people. Our plan for the establishment of three Health and Social Care Partnership’s in North, South and East Ayrshire has the potential to result in a significant variance in agreed priorities which may result in an inequitable approach.
Local Government and Regeneration Committee

Children and Young People (Scotland) Bill

Submission from NHS Ayrshire and Arran - Paper 2

Background information

<table>
<thead>
<tr>
<th>1.</th>
<th>Do you agree with the general principles of the Bill and its provision?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes. The general principles and provision are welcomed and follow on from the previous consultation on the Scottish Government’s proposals, responses made, and the Scottish Government’s subsequent response to these.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.</th>
<th>To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?</th>
</tr>
</thead>
</table>
|    | The Bill sets out a coherent framework within which integration can be progressed but leaves room for local partnerships to develop “best fit” solutions within statutory boundaries. It is felt that this strikes a good balance and it is believed will help to achieve the stated policy objectives.  

The extent to which the stated policy objectives will be achieved will be largely determined by two factors: (1) moving from a focus on outcomes at a high strategic level to personal outcomes for individuals to ensure seamlessness at point of service delivery (2) effective locality plans which link to, and heavily influence the Integration Authority strategic plans. |

<table>
<thead>
<tr>
<th>3.</th>
<th>Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths.</th>
</tr>
</thead>
</table>
|    | The coherence of the policy objectives is a key strength. They will have to be followed through at a personal and locality level supported by an approach which values enablement and coproduction.  

Aspects of the policy memorandum are welcome reminders:  

- “Integration is not an end in itself – it will only improve the experience of people using services when partner organisations work together to ensure that services are being integrated as an effective means for achieving better outcomes”;  
- “legislation alone will not achieve the scale or improvement that is required . . . Leadership is key, locally and nationally . . .” |
4. Please provide details of any areas in which you feel the Bill’s provisions could be strengthened.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>It may be that the following will be picked up in regulations etc but as it stands, the Bill could be strengthened in the following areas:</td>
</tr>
<tr>
<td>a)</td>
<td>public accountability arrangements – section 33 mentions a performance report. It may be helpful to link this to a focus on outcomes for avoidance of doubt;</td>
</tr>
<tr>
<td>b)</td>
<td>statutory public engagement responsibilities – for instance it would be helpful to clarify the position of Public Partnership Forums (PPFs). In Ayrshire, the PPFs have proven to be very effective support to public engagement arrangements across the totality of health provision;</td>
</tr>
<tr>
<td>c)</td>
<td>consultation arrangements – various references are made to issues such as the preparation of the integration plan but there is a substantive issue to be addressed concerning any implications for consultation arrangements in relation to proposals for service change made by the Integration Authority;</td>
</tr>
<tr>
<td>d)</td>
<td>following on from this, it may be helpful to clarify approval processes in instances where a strategic plan proposes major service change. In particular whether the Cabinet Secretary will continue to hold what would effectively be veto powers over the Integration Authority’s plans;</td>
</tr>
<tr>
<td>e)</td>
<td>whilst it is helpful that the Bill makes consistent reference to integration planning principles these are silent on the need to ensure effective clinical / care governance;</td>
</tr>
<tr>
<td>f)</td>
<td>staff governance is a statutory requirement of NHS Boards and the Bill is fairly silent on what arrangements (if any) Integration Authorities will be required to put in place.</td>
</tr>
<tr>
<td>g)</td>
<td>there is a need to be more explicit about how the Integration Authority will be scrutinised jointly, by external scrutiny agencies;</td>
</tr>
<tr>
<td>h)</td>
<td>in terms of analytical review of the Bill as a whole, there may be a case for considering whether the balance between what is on the face of the Bill and what will be in regulations could be improved. For instance while regulations will define the scope of integration, it is on the face of the Bill that the responsibilities of a Chief Officer are subject to the agreement of Scottish Ministers.</td>
</tr>
</tbody>
</table>
5. What are the efficiencies and benefits that you anticipate will arise from your organisation from the delivery of integration plans?

Efficiencies and benefits are anticipated to arise as follows:

- the focus on outcomes (providing this is reflected in performance regimes);

- the introduction of locality planning – this should streamline community engagement across the four sectors and maximise the opportunities for an assets based approach while engaging local users, carers and professionals in an agenda which is real for them. It should also bring a sharper focus on tackling health inequalities;

- the principle of joint and equal responsibility – this should help reduce “hand offs” between the statutory agencies;

- the engagement of the third and independent sectors as strategic partners – this is already helping to shape effective plans in services for older people;

- a logical framework reflected in the flow of the Bill from the model of integration to the integration plan to the strategic plan with consistent integration planning principles throughout – this will bring a much higher level of consistency and focus to joint endeavours;

- an improved approach to making investment and disinvestment decisions based on a clear process and evidence base and best use of integrated resources;

- greater potential for a joint strategic commissioning process which is based on improving outcomes at both a strategic and individual level, supports effective service change and views issues from a user’s perspective.

6. What effect do you anticipate integration plans will have on outcomes for those receiving services?

Integration plans will bring a rigour to setting out what the Partnership is responsible for and how it will be funded. Coupled with the strategic plan setting out how the Partnership will deliver its responsibilities it will give greater transparency to how all of this directly relates to improving outcomes. Crucially, however, it must also link to effective locality plans which should capture how refreshed relationships between the statutory, third and independent sectors and local communities can also improve outcomes.
### 7. Other Comments

There will be a need to ensure that there is sufficient Non-Executive Director capacity within NHS Boards to support the effective running of the Integration Authorities. This may be a particular challenge for NHS Boards with several Local Authorities within their Board area.
General comments concerning General Practice and the Two Bills from A Deep End Perspective

As a GP the barriers that prevent me working more closely in partnership are excessive workload, uncertainty and anxiety over job security, high turnover of staff, short life span of community projects, bewildering array of services and pathways, lack of time and difficulty in getting hold of people, dysfunctional and overly large planning committees, incomprehensible and verbose communications from on high, abstract rationalist planning that disparages experience and organically developed systems, a remorseless rise in demand and expectations, a self-defeating emphasis on measurable factors that undermines the quality of interpersonal relationships and care.

Deep End GP

General practice is the main public service that is in regular contact with virtually the whole of the general population, with substantial cumulative knowledge and experience of people’s problems and consistently reported high levels of public trust. 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.

The Deep End Report 18 on Integrated Care (Annex A) lists the essential ingredients of an integrated care approach. Attached workers, lay link workers and protected time are keys to joint working. Local leadership needs respect, support and representation (not consultation) within locality planning and acknowledgement of practitioners’ experiential knowledge to develop an ‘ecology of practice’ (Fisher & Owen, 2008).
In front line care the two main barriers to integrated care are firstly, the inverse care law, whereby practices serving the most deprived areas are insufficiently resourced to meet patients' needs, and secondly, poor links between general practices and many other area-based health and social services. These challenges are clearly stated in Deep End Report 12 on Vulnerable Children and Families (Annex B). This report highlights the frustration of practice teams who remain limited in their ability to deal with children with unmet needs in vulnerable family settings. Current policies aimed at family support unfortunately often fail to explicitly outline the contribution of General Practice to child safeguarding.

The policy memorandum for the Children and Young People Bill makes no reference to General Practice, while the memorandum for the Public Bodies only refers to General Practitioners as a group to be consulted. There is no recognition of general practice as the natural hub of local health systems, based on its intrinsic features of population contact and coverage, continuity, cumulative knowledge and trust.

Although many services are involved in caring for children, practice teams often have additional substantial contact with and knowledge of a child’s family, including the health of parents and carers, which is relevant to understanding child well-being on a case by case basis. Most GPs recognize and value the continuity with families and possible opportunities for early intervention that should define universal child health care within the primary care structure. This remains an unrealized aspiration at present because the system does not support the full potential of General Practice’s contribution towards safeguarding children.

General Practitioners at the Deep End address this concern in Report 20 What can NHS Scotland do to prevent and reduce health inequalities?, which advocates for a National Enhanced Service for Vulnerable Families (Annex C), providing a more explicit role and additional pro rata support for general practices serving vulnerable families in very deprived areas.

**Working Outside A Managerialist Framework**

Locality planning is not just about commissioning and budgetary planning but about organically growing trust, relationships and local systems that make integrated working and smoother decision-making possible. Front line staff and volunteers are the people who will or will not work as partners to make services more integrated and seamless for patients. However, they need to be given the resources to be able to do this, and not loaded with endless targets developed remotely. I hope this legislation will not be another missed opportunity to create the kind of organisational environment which makes it possible to grow this kind of trust and people-based system of care that patients expect and deserve. Deep End GP

General Practitioners at the Deep End welcome the different approach in Scotland, from the rest of the UK, which encourages localism, favouring less central control
and trusting professionals to work with and shape policy development (Greer, 2005). However, the Joint Bodies Bill appears concerned mainly with a second attempt at the structural integration of current local health and social care organizations. Policy consolidation is not a linear process, as the recent attempt at Community Health Partnerships has shown, resulting in ineffective integrated care for patients and widespread professional scepticism about the new arrangements.

General Practitioners at the Deep End question any assumption that the budgetary and accounting arrangements of senior managers are the key factors in enabling or preventing partnerships. In reality this superstructure rests on a foundation of human factors that are not given sufficient weight in these proposals.

The Joint Bodies Bill only mentions general practice in terms of how general practices working in localities should be represented within the new joint working arrangements. It is also important to consider the essential ingredients of care arrangements providing integrated continuity of care for large numbers of people. At present the opportunities for GPs to engage directly with locality planning arrangements are limited, patchy and inconsistent.

References


Specific Questions

Q1. What benefits which might accrue from shared working arrangements, both for the organisations involved and for those in receipt of services?

- It is important to acknowledge that despite the consensus that collaboration within health and social care is more effective than single agency approaches there are substantial problems associated with the adoption of this principle.

- Documented problems include a lack of definitional clarity surrounding partnership, endless organisational restructuring and barriers between core and third sector agencies. A general lack of valid evidence of improvement to service delivery and user outcomes means that we know ‘relatively little about what works’ (Glasby & Dickinson, 2008, p.38)

- It is imperative to acknowledge that policy imperatives can lead to unintended consequences in the delivery of services. The increasing bureaucratisation of managerial systems has resulted, we believe, in fragmentation of health service provision.

- Services that Deep End GPs regard as attached and intrinsic to effective universal and targeted health provision (e.g midwifery services, pact teams and health visitors) are now professionally and strategically removed from General Practice, resulting in less opportunity to provide a coherent effective health service. There are additional barriers to effective working between primary and secondary that Deep End Report 18 on Integrated Care (Annex A) highlights, especially in relation to the provision of seamless care for the frail elderly population. Within the hospital setting, perverse waiting time targets and financial penalties result in difficulties for vulnerable children who often miss hospital appointments and are not offered second appointments.

- The Deep End Project has outlined how general practice can contribute to the conceptual and theoretical coherence of partnership working, by developing community based solutions, better use of support services and increased patient participation in their own health and well-being.

- Our proposals build on the work already taking place in General Practice where the serial encounter is key to developing holistic unconditional healthcare and where General Practice may be the most suitable setting to promote resilience in communities and empower patients and their carers in managing their health needs (Mola, 2013).

- Collaboration between GPs and other partners exists on many different levels. Working collaboratively promotes a collective determination to reach objectives where sharing information and experiences contributes to a more detailed local knowledge of individual patients and their families. This is vital to planning effective support services for patients, addressing their unmet health needs and anticipating when they will need to access specialized services.
The complexity of health issues that are a consequence of multimorbidity, beginning earlier in Deep End practice patients, requires informational continuity and continuity of care to ensure that services are best matched to the patient’s requirements. The Deep End believes that General Practice is the natural hub of such a health care system partly because of the serial encounter between GPs and their patients and the detailed health information that is held in patient records. If the ethical considerations to sharing sensitive information are explored at the outset of the integration agenda then it is more likely that professionals will be able to better plan patient care that is acceptable to patients.

We know a great deal about the psychosocial consequences of adverse early years experiences. We also know that a robust primary care health system is important to improving the wellbeing of vulnerable children and their families (Klevens & Whitaker, 2007; Scribano 2010). Given that almost all children and families have a named GP and will consult with their GP regularly we need to promote the role of general practice in supporting vulnerable children. The Deep End has provided a detailed proposal that both clarifies the role of GPs in child safeguarding and describes the structural process to allow this. The legislation if interpreted appropriately, can underpin this process and ultimately General Practice can contribute to better outcomes for vulnerable children.

If we are allowed to maintain organizational autonomy but promote mutuality between professionals then reciprocity and trust will become embedded into the process. This will build effective teamwork as professionals begin to mutually understand the concepts of ‘unmet needs’ and ‘vulnerability’. The principle underlying collaboration is to improve patient care. In order to do this requires a framework that provides the time required to develop formal and informal means of interaction between professional groups strengthens and stabilizes team working and also makes the lines of responsibility clearer when planning health and social care provision.

Q2 What is the rationale for having a separate approach in both bills to establishing joint working arrangements?

From a GP perspective this is not relevant. In GP consultations in practice or during houses visits we are presented with dilemmas that are resolved pragmatically with practical solutions. What is valuable is having an extensive network of readily accessible interagency contacts when planning the support of vulnerable patients and time to co-ordinate the support package. This may be required immediately or developed over time depending on the patient’s circumstances. Joint planning arrangements are strategic processes that should be guided by the frontline professionals and remain patient centred if we are to achieve the aims of the integration agenda.

Within the context of vulnerable children and families the strategic planning aspect of joint working arrangements should ensure that the
options to GPs are multifaceted. This should be encapsulated within the Children’s Plan and recognise that vulnerable children are often sign-posted by general practitioners to supportive services. Most vulnerable children do not reach thresholds of intervention that would trigger involvement of statutory services. The ‘targeted’ intervention is frequently embedded within the universal provision of child health care in general practice. It is incumbent on the relevant health authority to recognise this important gatekeeper role for general practice as it establishes its role as a ‘corporate parent’. The mechanism for GPs to inform this process as it is developed would require the contractual arrangement that the Deep End has suggested in its report.

- In respect of adult services the newly formed ‘Integration Authority’ must be prepared to canvas GP views widely on the implementation and evaluation of the integration agenda. There should be very direct lines of communication between this body and general practice, other professionals and patients as the changes are implemented.

Q3  **In what areas might potential savings arise?**

- The compelling arguments for greater integration of health are driven by rising demand for service and the need to reduce public expenditure. However, there is a lack of economic evaluation of cost effectiveness across studies (Ellis et al, 2006) therefore the savings remain theoretical and are yet to be realised.

- There are potential savings in adult services for example, if pooled budgets in health and social care genuinely result in less time spent in hospital for elderly patients who can be discharged into nursing homes. It remains unclear however how barriers to transferring savings in secondary into primary care will be removed.

- In children’s services savings may result from minimising the consequences of adverse childhood experiences that persist into adulthood. These might include time lost at work through illness and injury, absent school attendance in the short and long term, indirect costs of special education, adult mental health and other healthcare services and the costs to judicial system. Many of these costs savings would be indirectly related to interventions in childhood which would include the pro-active identification of vulnerable children in a primary care setting. This would require a different approach to the economic evaluation of such interventions.

- There are not only potential economic savings through the integration of health and social care services. There are intangible savings for example reducing mental anguish and social stigma and are applicable to both adult and children’s services.
Q4 What other issues are there around the proposals covering consultation on, and development of, strategic plans/service plans between the respective areas involved?

- In adult services irrespective of how the ‘integration authority’ is realised there should be robust mechanisms that ensure the engagement with frontline professionals who are tasked with implementing the policy. This is challenging to achieve in General Practice but having a GP lead for each locality/practice and an infrastructure to engage widely with colleagues through for example, protected learning events, would ensure that policy directives are meaningfully guided and influenced by local population needs.

- Governance and accountability processes need to be widely understood and transparent to uphold the integrity of the integration agenda and discourage professional scepticism about the contribution of integration of health and social care. There should be clarity about individual and collective accountability at all levels of strategic planning and during each stage of the implementation of the integration agenda.

- Integration of health and social care and its evaluation are long term processes. Both should be evaluated using a robust research approach specifically because there is a lack of a convincing evidence base for integration of health and social care (Cameron & Lart et al 2013). The Deep End in collaboration with the South Glasgow CHP has proposed such a project but this requires a sustained commitment from Government to support the work and allow frontline professionals and patients to participate in the development of the integration agenda.

- Well intentioned reforms must not exacerbate the margin of error when dealing with the complexity of family circumstances with respect to safeguarding children which are often attributed to deficient interagency working and a failure to share information. Standardisation and micromanagement of decision making in situations where evidence can often be ambiguous and contradictory defeats the purpose of having an integrated system because it cannot support complex decision making in its human, social and organisational context. The Deep End believes that a ‘light-touch’ system design is required whose purpose is not to intensify the bureaucracy of professional working but to free up time, support flexibility and intelligent professional discretion to cope with the contingencies of situations as they arise on a case by case basis. The professionals and patient experience should be driving the development of integrated services, not the system.

- Our faith in the instrumental efficacy of technology and proliferation of process-orientated tasks should not displace what is essential to effective integration working practices, namely sustained professional relationships that are built on mutuality and trust. The Deep End research proposal
outlines very clearly the importance of acknowledging the multifaceted aspects of vulnerability and how this maybe inculcated into an agenda that supports professional involvement in vulnerable patient groups in a meaningful way. For example biological, neurological and psychosocial factors may be relevant to the definition of the vulnerable adult or child but in the context of knowledge sharing between professionals this process is ‘slippery’ (difficult to codify) and ‘sticky’ (difficult to share across boundaries) (Reder & Duncan, 2003). Furthermore, acknowledging that non-electronic communication is a component of reaching sound inter-professional agreement (Saario, Hall & Peckover, 2012) is vital to avoid fallacious circular reasoning in complex decision making. If we are to achieve the aims of the integration agenda time must be given to professionals to have regular face-to-face meetings to discuss their own anxieties and share professional opinion in often emotionally and morally charged cases to sustain confidence in their decision making.
References


Dr Anne Mullin, Govan Health Centre

Professor Graham Watt, University of Glasgow

on behalf of the Deep End Steering Group

23rd August 2013
INTEGRATED CARE

This report and recommendations draw on research evidence, previous Deep End reports and discussion groups at the second national Deep End conference at Erskine on 15 May 2012.

- To avoid widening inequalities in health, the NHS must be at its best where it is needed most.
- The arrangements and resources for integrated care should reflect the epidemiology of multimorbidity in Scotland, including its earlier onset in deprived areas.
- Better integrated care for patients with multiple morbidity and complex social problems can prevent or postpone emergencies, improve health and prolong independent living.
- Policies to provide more integrated care must address the inverse care law, whereby general practitioners serving very deprived areas have insufficient time to address patients' problems.
- Patients should be supported to become more knowledgeable and confident in living with their conditions and in making use of available resources, for routine and emergency care.
- The key delivery mechanism for integrated care is the serial encounter, mostly with a small team whom patients know and trust, but also involving other professions, services and resources as needs dictate.
- The intrinsic features of general practice in the NHS, which make practices the natural hubs of local health systems, include patient contact, population coverage, continuity of care, long term relationships, cumulative shared knowledge, flexibility, sustainability and trust.
- Health and social care professionals working in area-based organisations (e.g. mental health, addiction and social work services) should be attached to practices, or groups of practices, on a named basis.
- Practices should be supported to make more use of community assets for health via a new lay link worker role.
- The quality and timeliness of hospital discharge information should be a consultant responsibility and audited as a key component of the quality of hospital care.
- Practices needed protected time to share experience, views and activities, to connect more effectively with other professions, services and community organisations, to develop a collective approach and to be represented effectively.
- Collective working between general practices is best achieved with groups of 5/6 practices, as shown by the Primary Care Collaborative and Links Project. Larger groupings are less likely to achieve common purpose.
- Locality planning arrangements should be based on representation (not consultation), mutual respect and shared responsibility.
81 practitioners and managers from Greater Glasgow and Edinburgh, including 19 Deep End GPs, met on Thursday 09 September 2010 at the Beardmore Conference Centre, Clydebank, for a discussion about policies and practices for children and families.

- Practitioners and managers agree that there are not enough resources to respond to need, resulting in a focus on fire fighting, raised thresholds for engagement and missed opportunities for early intervention.
- Local teams are often aware of vulnerable children and families before serious problems develop, but lack the resources to intervene and to make a difference. Investments are needed in home support, free nursery places and other ways of supporting families.
- The many suggestions made in this report can result in greater efficiency, especially via better joint working, but do not address the fundamental problem of resources.
- Hundreds of professional teams are involved in providing care for vulnerable children and families, and all need to work well, both individually and as components of an integrated system.
- The system needs accurate information on the numbers and distribution of vulnerable children and families, including but not restricted to children on child protection registers, as a basis for resource distribution, audit and review.
- Effective joint working depends on colleagues being well informed concerning each others’ roles, how they may be contacted locally and the constraints under which they work.
- Information about the progress of particular cases needs to be shared between professions and services, so that each is aware of what is happening. There is an urgent need for bespoke IT which links systems and professionals.
- Pregnancy is an important opportunity to demonstrate the integration of professionals and services working to identify and help vulnerable mothers and their families.
- Professionals and services should be accountable not only for their own contribution but also how this connects with the contributions of others. The “connectedness” of care should be a major policy, management and practitioner objective, concerned not only with joint working around crises, but also continuity of care as required throughout childhood.
- Professionals acquire local knowledge and develop trusted relationships with families that are crucial for long term preventive care. There is a need to support and retain such staff, to value the relationships they have developed and to use the information they acquire, via regular multidisciplinary meetings.
ANNEX C : From Deep End Report 20

WHAT CAN NHS SCOTLAND DO TO PREVENT AND REDUCE INEQUALITIES IN HEALTH?

Vulnerable children and families

Current thinking
It is uncontested that vulnerability in early years and beyond impacts adversely on child and adult physical and psychological dimensions of well-being. [1–2] A conservative estimate of the economic cost of the vulnerable child to society in the UK is £735 million annually [3].

Where is general practice?
The Deep End manifesto and reports on vulnerable families [4–5] clearly outlined the contribution that general practice can make to safeguarding children and families. GPs contribute to the process of ongoing family assessment and support [6–7] and are well placed to understand the specific challenges that result in the vulnerable family and the vulnerable child [8].

A skilled and long term professional relationship, built on trust, that provides a low-level of inquiry into the circumstances of the vulnerable family [9] is key because vulnerable parents are often avoidant and suspicious of supportive services [10]. Furthermore, the majority of vulnerable children will not meet sufficient thresholds of harm or endangerment that will trigger formal child protection proceedings [11].

The Deep End has consistently highlighted the ‘multiple jeopardy’ that economically poor and disadvantaged families face [12] with poverty an enduring characteristic of families who would be considered vulnerable. The Deep End recognises the clear association between disadvantage with social class and adverse effects on child health in the first 10 years of life [13] with increased mortality rates [14]. The impact of poverty and the accumulative effect of negative factors on health outcomes of vulnerable children are highlighted in the Deep End Austerity Report [15].

This publication contextualises current research concerns to real-life narratives of vulnerable families who are living within the constraints of swingeing cuts across health and social care budgets.

That said, knowing and stating our contribution to supporting children and families is of limited value if general practice does not have the strategic support within policy directives and contractual obligations to undertake this challenging area of health care.

Current policy – is it collective and inclusive?
Whilst we welcome the acknowledgement of the role of the GP in Scotland’s national child protection framework [16] and the RCGP child health strategy [17] this is not replicated in other important policy directives. For example GIRFEC, whose ethos is at the heart of government policy in ensuring that all children in Scotland are ‘safe, healthy, achieving, nurtured, active, respected, responsible and included’ [18–19] and the National Parenting Strategy [20], do not mention GPs. This is disappointing
given that the newly instated 30-month child development check will address issues of 'child development and physical health, parenting capacity and family matters including domestic abuse and parent-child relationships, along wider parental health such as smoking, alcohol or drug abuse, and mental and physical health' [20]. It is obvious to the Deep End group where the obligation to general practice provision lies in addressing this agenda.

Given that there has been a noticeable decline in preventative child health care in general practice since the implementation of 'Hall 4' [21], the Deep End have advocated for a National Enhanced Service for Vulnerable Families (NES). This approach will not diminish the reach of a universal child health care system but recognises the need to reduce disadvantage in vulnerable families by developing services according to the needs of the community.

How would the proposal work, both internally within practices, and externally in practices' relationships with others?
The NES is a collaborative model that promotes organisational learning where all involved professionals meet regularly to discuss their vulnerable children caseloads. It is hypothesised there would be immediate gains in terms of improved health outcomes and consistent support for vulnerable children.

The NES would build on the work that is already done in some GP practices where GPs have regular and minuted meetings with their health visitors but it remains 'unofficial' as there is no contractual requirement to do so. Across practices the NES could be the basis of a protected learning event to disseminate results (similar to the COPD pilot in the South Glasgow CHP) and would include other relevant professionals in the learning agenda.

The attached social worker is not a new idea for general practice and many practices have positive experiences of working with a named social worker across health and social care domains. It would seem axiomatic that the unmet needs of vulnerable children and families require that both professions collaborate but there is a paucity of evidence of effective practices in complex families where health and social care professionals have intervened [22].

The NES provides the mechanism to improve a positive working environment where professional roles are clarified and shared understanding of the language of vulnerability is achievable. It also begins to address a pressing need to meaningfully research the complexity of child welfare outcomes in ‘real world’ situations [23].

How would progress be consolidated, with practices learning from each other?
A rolling programme of protected learning events funded through the CHP structure. There is a learning coordinator within each CHP (these appear to be new posts but are welcome if they have this remit). Of equal importance is recording the long term outcomes of vulnerable children that would require substantial investment in preventative health care and would provide a robust research database.
**How would individual practices and groups of practices be accountable for the additional resource?**

At present there is no mechanism for GPs within CHPs to be directly responsible for monies spent. Financial sector spending would have to be carefully evaluated with appropriate management support and would require robust accountability and governance structures.

**Is the proposal for all practices, with each being resourced pro rata according to need, which could be taken forward within local areas; or something for Deep End practices only, requiring a network approach?**

This would not be exclusive to Deep End practices as the NES is embedded within the principles of universal health care for children. Realistically, it would be anticipated that the strong influence of poverty on child health outcomes and vulnerability would ensure a greater proportion of vulnerable children would be identified within Deep End practices. Nonetheless, the NES would be relevant to all practices in Scotland.

**Who are the significant partners/funders and how can they be influenced?**

SG, HBs, health and social care professions. There is an expectation that SGPC and the BMA will acknowledge the call for greater emphasis on child health matters within the forthcoming contract negotiations. This would reflect the profession’s aspiration for an improvement to the structure of child health care provision in general practice and primary care. This is envisaged under a broader approach of child safeguarding that at present remains patchy and inconsistent.

**References**

4. Deep End Report 3. The GP role in working with vulnerable families 2010


19. and


22. accessed 03/05/09


26. Thorburn J. *Effective interventions for complex families where there are concerns about or evidence of a child suffering significant harm—a research synthesis completed for C4EO Centre for Excellence and Outcomes in Children and Young People’s Services 2009.*


Local Government and Regeneration Committee
Children and Young People (Scotland) Bill
Submission from North Ayrshire Community Planning Partnership

1. The potential benefits which might accrue from shared working arrangements, both for the organisations involved and for those in receipt of services;

The Public Bodies (Joint Working) (Scotland) Bill requires local authorities and health boards to adopt formal partnership arrangements. In June 2013 the Council and the Health Board approved proposals to move forward with a “Body Corporate” model. A Chief Officer for the partnership will be jointly appointed in the Autumn, and a joint committee will be established to oversee the development of the partnership with a view to this taking operational responsibility from April 2014. We envisage there will be a joint management team established before this date. The immediate benefits will relate to shared management and accommodation. As we progress with our strategic plan we expect to identify agreed priorities for the partnership in relation to joint service delivery. This will result in the identification of further benefits for both organisations.

Public Sector and Third Sector partners should work together at a local level with the aim of realising an increased share of public sector expenditure for the Third Sector through engagement in service design, commissioning and procurement activities.

Strategic commissioning provides the basis for assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

By bringing other partners resources into the mix in a more meaningful way, this could improve CPPs more widely and would help pave the way for the Community Empowerment and Renewal Bill.

Within the Children and Young People (Scotland) Bill, the proposal is to strengthen children's planning and to reinforce the development of integrated service delivery across the range of partners. While we welcome an approach that streamlines planning for children we are concerned about possible duplication of effort e.g., preparing a children’s services plan and a corporate parenting plan (rather than incorporating the latter into the former). We are also concerned that any crossover with the ASN legislation needs to be dealt with if the landscape is to be clarified especially around the need for a separate child’s plan.

In terms of the benefits to those in receipt of service, we are clear that this is the main driver behind both pieces of legislation. In North Ayrshire we intend to place our Social Services children and families service within the Health and Social Care Partnership and we believe this will strengthen our service delivery to vulnerable children by working closely with services provided to their parents/carers e.g., mental health and substance misuse. At the same time we will ensure that the links between the universal services within health and education are strengthened and we
have a programme to deliver prevention and early intervention initiatives across the children’s services partnership. This involves social work and health staff being located with early years staff. We already have co-located services with Police Scotland.

We have identified a range of outcomes across all care groups and would intend to identify our priorities for development and implementation within both our HSCP integration plan and our Children’s Services Plan. For example,

**Older People**
- Through integrated teams working locally.

**Outcomes**
- Prevent hospital admissions
- Sustain people safely at home
- Maximise independence.
- Reduce social isolation.
- Support Carers.

**Vulnerable Children**
- Through co-located teams including social workers/health visitors/early years staff/teachers.
- Through specific joint initiatives.

**Outcomes**
- Sustain more children at home.
- Improve outcomes for children who are neglected.
- Reduce admissions to residential schools.
- Maximise independence for children with disabilities.
- Improve transition between child and adult services.
- Improve support to families and carers.

These are two examples of our current considerations. The key aspect will be how we implement our redesigned services to reduce barriers from the point of view of those who use the services.

2. **The rationale for having a separate approach in both Bills to establishing joint working arrangements.**

Presumably the difference in approach relates to the difference in the range of partners involved in adult and children’s services. There are particular issues about the need for clear partnership agreements between the universal services of health and education. The HSCP shares a common client/patient group within adult services and a common client/patient group of vulnerable children.

3. **In what area potential savings might arise?**

In relation to the Public Bodies (Joint Working) (Scotland) Bill, this is a difficult question to answer at this stage and is one of the difficulties within integration. Local authorities have made substantial savings over the past four years, while the NHS
has been protected. This is likely to mean the level of savings available without affecting operational capacity will be less for local authorities. It will be a challenge to maintain costs within existing budgets. Therefore our key benefit must come from integration through i) reducing duplication at the point of service delivery and streamlining some senior management, but mostly middle management; ii) improved deployment of resources as a result of better planning; iii) implementation of the neighbourhood planning approach so that services are focused on the areas where they will have the biggest impact; and iv) common priorities.

We are also considering how the range of ‘support services’ required by health and social services would be best delivered. At this stage it is not possible to say if this will lead to efficiencies or if in fact some may require additional initial investment ‘Support services’ include; Finance; Human Resources; Legal Services; IT and Property; Facilities Management.

Further savings or investment redirection will be achieved as the partnerships progress.

We have developed a range of initiatives to improve services to elderly people through the Older People’s Change Fund.

For the past two years we have also been funding a range of prevention and early intervention initiatives for children which we are tracking in relation immediate impact and efficiencies down the line.

We would be happy to provide further information if the committee was interested.

4. Whether there are any issues around the proposals covering consultation on, and development of, strategic plans/service plans between the respective areas involved?

The main issue in relation to consultation and development of plans will be around timing to ensure we do not duplicate effort or create consultation fatigue. There will be clear structures established within the HSCP to involve the full range of stakeholders and we will need to utilise these as far as possible. We have developed a “neighbourhood planning approach” within North Ayrshire which brings together all the Community Planning partners. We would see this as a key way of reducing disruption and maximising synergy. We believe this approach fits with the requirements of both Bills.
1 Introduction

1.1 The Housing Coordinating Group (HCG) welcomes this opportunity to contribute to the Committee’s stage 1 scrutiny of the Public Bodies (Joint Working) Scotland Bill.

1.2 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. Thus, this evidence comes from representative bodies of strategic housing authorities, social housing providers (councils, housing associations and co-operatives), the housing profession, and many third sector providers particularly Care and Repair services. To reflect our common views, in this response we use the collective term “the housing sector”.

1.3 Together we make a very significant contribution to national outcomes on health and well-being by:

- Co-ordinated strategic planning of the supply and quality of housing and related services across tenures and stages of life;
- Providing individuals with information and advice on housing options;
- Directly providing or facilitating, ‘fit for purpose’ housing for rent and for sale / part sale, that gives people choice and a suitable home environment;
- Providing local, personal, preventative services such as aids and adaptations, and care and repair or “handyperson” schemes;
- Building capacity in local communities.

This paper sets out a response to each of the committee’s questions.

1.4 In summary, 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. The success of the new ‘integrated authorities’ will largely depend on effective joint strategic commissioning to which the housing sector can make a crucial contribution. The current arrangements for involving the housing sector have not produced a consistent nor adequate approach and the Bill, as it stands, could result in an ‘integrated authority’ deciding not to involve the housing sector as a

---

1 The Joint Improvement Team has provided support and assistance to the Housing Coordinating Group
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.

2 How will the proposed legislation affect the ‘housing sector’?

2.1 Housing planning and housing services already play a fundamental role in providing ‘homes or a homely setting’ for those using health and social care services particularly as people face long term conditions.

2.2 Housing providers offer varying levels of care and or / support to vulnerable adults and older people, and have long been committed to working with colleagues in health and social care to enable people to continue living in the community rather than institutional settings. There are examples where this has happened already and the Bill could promote this approach more widely across the country. The housing sector has much to contribute to this agenda.

2.3 The Bill sets out a requirement on local authorities and health boards to set up new integrated authorities’ but leaves it to local areas to decide whether and how to involve the housing sector. The possibility that any ‘integrated authority’ could lack the involvement of the housing sector at a strategic level is of some concern. Whilst the need to maintain a focus on housing issues in order to achieve the outcomes of integration has been acknowledged, proper engagement with the housing sector in both planning and delivery will be required.

3 What do you see as benefits that can accrue from the proposed legislation?

3.1 The main efficiencies and benefits potentially arising from integration plans are likely to be improved living conditions for our tenants and residents rather than benefits accruing directly to housing organisations themselves. There is increasing recognition of the preventative benefits of housing investment such as keeping people safe at home longer through the timely provision of appropriate housing adaptations, or the reduction of respiratory illness through efficient modern central heating systems. The housing sector argues for an investment dividend arising from an established link between housing investment and a consequential reduction in other more expensive forms of provision such as hospital treatment or long term stays in care homes.

3.2 The ‘housing sector’ has much to contribute to achieving the objectives of integration but its contribution would be put on a more secure footing through a continued commitment to the Housing Contribution Statements (HCSs) and through Community Planning Partnership arrangements to ensure that housing issues and housing sector are properly tied in with Joint Strategic Commissioning plans (JSCPs) and the delivery of the national outcomes.
being developed – the first three of which are particularly pertinent to housing: Healthier Living; Independent Living and Positive Experiences and Outcomes.

3.3 The development of a set of national outcomes will be fundamental in pursuing this objective and we look forward to further opportunities to reflect on the way housing related issues are reflected in the national outcomes and indicators.

3.4 There are also efficiencies and benefits to be had for the housing sector to work with integrated authorities rather than separately with social care and health. Equally, it is important that integrated authorities work with the housing sector otherwise the opportunity joint working presents will be lost in some areas. One way to ensure that this joint working occurs is to require the new partnerships engage formally with the strategic function of housing in local authorities and delivery of housing more generally. This is too important to leave to chance.

3.5 A central policy objective of the Bill is to provide ‘joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so’. The requirement that integration authorities share a budget and that they develop JSCPs mark a real step change from previous aspirations about joint working and are key strengths of the Bill. The housing sector has much to contribute to the overall policy objective but its role and contribution needs to be strengthened, as set out below.

3.6 The policy memorandum (para 9) states, and we agree, that an aim of the legislation is to deal with the variations in quality across the country. The forthcoming review of National Care Standards provides a significant opportunity to explore the scope to align regulatory standards with the principles of the Bill and the associated national outcomes being currently being developed.

3.7 The policy memorandum, which suggests (paras 98 onwards) that the scope of Bill should extend to adults of all ages, creates an opportunity to offer more consistent approaches to people with similar conditions or situations irrespective of their age. This may particularly assist those living in areas of deprivation, especially those with long term conditions, who are likely to face poorer health outcomes.

3.8 The Bill requires an integration authority to consult with service users where it decides to change the arrangements for carrying out of integration functions. Consultation is required where an authority wants to make changes ‘significantly affecting provision of service in an area’. This could be interpreted to include large tendering exercises, in which case this new duty might provide a means of ensuring that there is a process of consultation with service users in relation to such exercises. This is to be welcomed in order to achieve better outcomes for those using services.

4 Are there any concerns that you have around the proposed legislation?
4.1 The success of the new partnerships will largely depend on effective joint strategic commissioning plans (JSCP). It has already been acknowledged that housing plays a part in effective planning and Housing Contribution Statements (HCS) were introduced in 2012/13 as a way of highlighting the potential housing contribution to existing JSCPs. This first round of HCSs has been reviewed by the Joint Improvement Team and various issues have been highlighted. Whilst we acknowledge the challenge that local partnerships faced in developing and agreeing HCSs within a short timescale we nevertheless think it important to take the opportunity to learn lessons from the exercise.

4.2 The review found that although HCSs were submitted with partnerships’ JSCPs, only a minority actually integrated issues around improving housing and housing related services into the body of the JSCP. There was a tendency for the HCS to appear as a “bolt on”. HCS could be the key mechanism for linking Local Housing Strategies with JSCPs, and will be vital for the housing sector to play a strategic role in meeting the national outcomes associated with integration of health and social care. The housing dimension of integrated planning needs to be dealt with within the JSCP rather than sitting on the margins. In other words, we believe the best place for housing to demonstrate its actual and potential contribution to improving outcomes for people within the health and social care system is through proper integration of housing issues within JSCPs.

4.3 To further the integration of housing issues in JSCPs there needs to be a shared understanding of data relating to housing, health and social care, and a shared commitment to producing meaningful information from such datasets for planning purposes. We note that a review of the guidance relating to Housing Need and Demand Assessment (HNDA) is currently underway. This will consider explicitly improvements needed to aid our collective understanding of the housing needs of vulnerable groups such as older people and those with particular needs, and we propose that revised HNDAS be regarded as part of the toolkit required for JSCPs.

4.4 Together with ALACHO and SFHA, the JIT is currently surveying the sector to extend understanding of the housing sector’s experience of the first round of HCS. The review of HCSs submitted in March 2013 identified that these tended to consider housing with care and adaptations, but there was concern about a lack of focus on housing advice, lower level housing support services and other housing related services. The sector, working with the Scottish Government will use the information obtained to provide feedback and advice to practitioners across the housing health and social care sectors on how the housing contribution to JSCPs might be improved.

4.5 The Bill sets out integration across all adult age groups rather than simply older adults and this seems appropriate given the experience of housing providers in deprived areas where the onset of long term conditions tends to happen at a lower age. We note, however, that much of the Bill continues to

---

2 Housing Need and Demand Assessments are undertaken to assess local housing need and demand to inform the development of local housing strategies and development plans.
focus solely on the needs of older people and suggest this should be addressed if the principles set out in the Bill are to be pursued effectively.

4.7 Effective leadership at a local level will be crucial if the required change is to be implemented. The role of social landlords as a community anchor at a local level could be fundamental to helping to link leaders within public bodies with local people and leaders in the voluntary sector and in community based organisations. The Bill could be strengthened by requiring integration authorities to work with housing and the third sector as partners rather than simply adhering to principles to engage with ‘community and local professionals’. As a comparison, there is currently in place a requirement that Reshaping Care for Older People Change Fund plans are signed off by four signatories: the NHS Board, the local authority, the third sector and the private sector. We would urge that the housing sector be given formal recognition as a signatory for future integration plans in addition to the third sector.

4.8 There is a lack of clarity about the elements of funding which will go into integrated budgets and the extent to which local authority budgets currently directed at housing related services, such as housing support for homeless people, will be expected to be part of this. If each integration authority is left to decide this there is a risk that the financial context within which housing related services operate will become increasingly complex, to the detriment of the individuals who currently benefit from such services, with an increased risk that the policy objectives set out in the Bill will not be achieved.

4.9 Social landlords and many of the individuals they serve are already dealing with financial uncertainty resulting from welfare reform. It will be important that the financial arrangements introduced under the Bill do not destabilise housing related services further.

4.10 The HCG agrees with the planning and delivery principles as set out in the Bill (sections 4 and 25). These are in line with those originally set out in the consultation document and have gained the support of housing professionals across the sector. The ‘housing sector’ has much to contribute to the objectives of integration and the opportunity to put this on a more secure footing should not be missed.
Local Government and Regeneration Committee

Children and Young People (Scotland) Bill

Submission from Association on Directors of Education in Scotland

Part 3 Children's Services Planning

1. We support the requirement, the aims and the process indicated for the Children's Services Plan. However, in section 13, we believe that the prime aim should be to focus on the outcomes for children and young people rather than the mechanisms for planning.

2. In relation to guidance in Children’s Services Planning, it would be important to ensure that there are long term evaluations of the impact on children and families rather than reportable short term proxy measures which may divert attention from the long term aims of the legislation.

3. We have significant concerns around section 17 and the default powers of the Scottish Ministers. This appears to be focused almost entirely on the role of Scottish Ministers to change structures and to direct resources rather than a consultative and meditative role where they feel that Councils and Health Boards are not achieving best outcomes required for children. This has significant implications for local authorities which were not made explicit during the consultation period.

4. There is no suggestion anywhere else in the document that joint boards are a prerequisite for effective Children’s Service Planning. As an organisation with particular interest in education we would have concerns that decisions could be made to divert resources from this function to support underfunded pressures in other areas of children’s services. This would appear to be increased centralisation of decision making which does not sit comfortably with local democratic responsibility for services.

Association on Directors of Education in Scotland
August 2013
Local Government and Regeneration Committee
Public Bodies (Joint Working) Bill
Submission from Argyll and Bute Council

1. I refer to your letter of 26th June and would offer the following comments which have not been formally considered by the Council given the timescale for reply but nevertheless I trust that it will be helpful.

2. Argyll & Bute Council welcomes the introduction of the Bill, whilst recognising the challenges, going forward, that are inevitable during a period of transformational change.

3. The key objectives identified by the Christie Commission and the intent of the Bill provide us with the impetus to make the changes required to deliver our vision for the people of Argyll & Bute. The remote and rural nature of this area means that we have already, of necessity, developed a strong Health and Care Strategic Partnership that supports many excellent, and some award winning, integrated services. Through Reshaping Care for Older People (RCOP) and the move to Joint Commissioning we have further enhanced that partnership by fully involving the Third and Independent sectors as equal partners on the RCOP Project Board and in all of the associated workstreams.

4. Over the last 4 years we have developed a comprehensive joint reporting framework for adult care services, with monthly reporting that both informs strategic decision making and supports pro-active operational management.

5. We recognise that both service delivery and performance reporting need to continue to move towards an outcome-focused approach, going forward. We have recently hosted presenters from the Swedish Esther Network and we are considering how we can implement that model in Argyll & Bute.

6. Implementation of joint working will require a major culture change for both the Local Authority and our NHS colleagues, there will need to be changes in behaviours and attitudes and a willingness to overcome obstacles, driven by strong and enthusiastic leadership. We need to improve on staff and community involvement and overcome risk aversion to achieve truly customer-led service delivery. We also face financial and logistical challenges, particularly given the rurality of our environment; however, it is clear that unless we achieve both economies of scale and economies of skill, through this opportunity for joint working, we will not be able to meet the demographic-demand challenges of the future.

7. At present we are looking towards a Body Corporate model of implementation. We have appointed a project team to scope the Council's position and inform our
Elected Members and we look towards commencing joint planning for integration, with our NHS colleagues, in the early autumn.

8. The Argyll and Bute Council has supported the Children and Young People Bill through the COSLA consultations. In particular the Council welcomes the:

- Emphasise on Children and Young People’s Rights
- Promotion of GIRFEC principles (child’s plan and named professional)
- Extension of early years support (minimum 600 hours for 3 and 4 year olds)
- Improving permanence planning and LAC outcomes (right of care leavers to be assessed for support until their 25th year)
- Defining of corporate parenting and the duties of the corporate parent

9. The Council are, however, cautious as to the accuracy of the take up assumptions and the actual cost of implementation. The position taken by CoSLA in subsequent negotiations with the Scottish Government in respect of the financial arrangements reflects these concerns in detail and highlights discrepancies in funding for local government in comparison with recurring funding arrangements for the NHS. The Council are also concerned that there are proposals similar those in the recent Bill on Health and Social Care integration to give Ministers powers to establish Joint Boards, including the transfer of staff and functions from councils and Health Boards, if both sides fail to deliver integrated children’s services planning as set out in the Bill.

10. I would highlight the following link to further detail of the council’s position in relation to the Children and Young Persons Bill:


Roddy McCuish
Leader
Local Government and Regeneration Committee

Submission from Audit Scotland on Behalf of the Auditor General for Scotland and the Accounts Commission

Introduction

1. Audit Scotland is the public sector audit agency undertaking the external audit of the majority of public sector bodies in Scotland. We do this on behalf of the Auditor General for Scotland (for the NHS and central government) and the Accounts Commission (for local government). We provide this written evidence to assist the Local Government and Regeneration Committee with its interest in the Public Bodies (Joint Working) (Scotland) Bill and the Children and Young People (Scotland) Bill and their potential impact on local authority functions and partnership/joint working.

2. The Auditor General and the Accounts Commission welcome the opportunity to comment on the implications of the Bills and how the joint working arrangements established by them will link with the work of Community Planning Partnerships (CPPs).

Issues highlighted in audit work

3. This response draws on a wide range of audit work, in particular our report on Improving Community Planning in Scotland (March 2013). This report highlights that there is now a renewed focus on community planning which provides a clear opportunity to deliver a step change in performance. This will require strong and sustained shared leadership. There are many examples where joint working is making a difference for specific communities and groups across Scotland. However, our report concluded that overall, and ten years after community planning was given a statutory basis, CPPs are not able to show that they have had a significant impact in delivering improved outcomes across Scotland.

4. Over a number of years, Audit Scotland has highlighted the need to improve how public services work together to meet the needs of the people of Scotland and make the best use of available resources. We have highlighted in several reports the need for barriers to partnership working to be addressed. It is encouraging that both the Public Bodies (Joint Working) (Scotland) Bill and the Children and Young People (Scotland) Bill seek to address these problems. However, questions remain about the implications for CPPs and the responsibilities of local government from the introduction of these Bills.

5. There are a series of key issues not addressed within the Bills or the associated documents, and further information is needed to understand how these changes will work in practice. Significantly, the relationship between CPPs and the new integrated health and social care arrangements (through the Public Bodies (Joint Working) (Scotland) Bill) and changes to children’s services (through the Children and Young People (Scotland) Bill) are not clear.

6. There is a need for a clear articulation of how these new arrangements fit with CPPs. We noted in Improving Community Planning in Scotland that:

“There is a risk that wide-ranging reforms of public services in Scotland creates tensions between national and local priorities for change. Significant changes are under way aimed at integrating health and social care services, creating national police and fire services and regionalising colleges, all of which are important
community planning partners. It is essential that those who lead and manage local public services work together to ensure that they are providing public services in ways that make sense locally, while delivering the stated intention of the reforms. Equally, the Scottish Government has a key role to play by:

- ensuring ‘joined-up’ approaches to reform across government
- clearly and consistently setting out how it expects services to be provided in an integrated way
- streamlining policy guidance and arrangements for measuring performance across different parts of the public sector, and making sure they are consistent with each other.

At present, it is not clear how important aspects of the community planning review and health and social care integration developments are being integrated. For example, how policy guidance on governance and accountability arrangements is being coordinated and how performance reporting requirements will be aligned.”

7. It is still unclear, now the Public Bodies (Joint Working) (Scotland) Bill has been published, how some of these tensions will be resolved. There are similar issues with the Children and Young People (Scotland) Bill, for example, how the requirement to produce a children’s services plan will fit with the work of the CPP in each local area.

8. It essential that sound governance and accountability arrangements are in place, that organisations are able to respond flexibly to local needs and that there is some national monitoring of progress in improving services in line with policy intentions. Any new governance and accountability arrangements should be effectively aligned with existing arrangements.

9. The new integrated arrangements will be responsible for directing significant resources, representing a significant proportion of local government services. Under the Public Bodies (Joint Working) (Scotland) Bill, the new integrated partnerships may opt to include other services, such as services for children. Given the potential scale of these integrated arrangements, in terms of both the resources involved and the policy areas covered, it is even more important that the links to CPPs are clear and fully understood. There are also tensions between the introduction of a statutory partnership for health and social care services and the non-statutory CPPs. We have provided more detailed written evidence to the Health and Sport Committee to assist its scrutiny of the Public Bodies (Joint Working) (Scotland) Bill which you might find helpful. (Full submission set out in appendix 1). In relation to the Public Bodies (Joint Working) (Scotland) Bill, it is unclear how the external audit function will be funded and arranged and how it will work in practice. In taking forward the new arrangements, consideration will need to be given to audit committee and scrutiny arrangements, alongside the external audit issues we have raised.

10. The Public Bodies (Joint Working) (Scotland) Bill gives Ministers powers to make certain decisions about how services are planned and delivered locally, including powers to issue directions to local authorities, health boards or integration joint boards, about the functions related to the Bill, or in the integration plan. These powers are significant and need to be carefully considered given the unique position of local government as democratically accountable to their local communities.

11. The Children and Young People (Scotland) Bill covers a wide range of services for children. The Bill includes provisions for enforcement, which state that if a local authority or health board do not comply with the planning requirements or with
Ministerial guidance about these plans then Scottish Ministers can transfer their children’s services planning function to other health boards or local authorities or require joint boards to be established to plan services. This has significant implications for local authority services and needs to be considered further in taking forward the new arrangements. We note that the extent of the proposed ministerial powers set out in the Bills are different, with the powers in the Children and Young People (Scotland) Bill greater than those indicated in the Public Bodies (Joint Working) (Scotland) Bill.

12. There is significant overlap between the agencies involved in CPPs and those who will need to be involved in the arrangements set out in the Bills. This is another reason why there needs to be clarity about the role of various organisations in these joint working arrangements, their focus and how their performance will be measured, in order to make best use of resources in the local area. There is a risk that this may lead to duplication and a cluttered partnership landscape if this is not fully addressed.

13. Links between various performance management and reporting arrangements are unclear, for example, how the children’s services plan will link to the Single Outcome Agreement for each CPP. There are lessons to be learned from other partnership arrangements. When commenting on Community Justice Authorities in An Overview of Scotland’s Criminal Justice System, we noted:

“Although CJAs were established in 2007, there are no agreed measures to assess their performance or impact. As a result, CJAs use a range of different performance indicators developed locally with different systems for reporting and presenting data. CJAs have recently agreed to improve information sharing and to look at developing a common set of core measures and associated information requirements.

The lack of agreed performance indicators across the range of services designed to reduce reoffending means the cost-effectiveness of different local projects cannot be compared.”

14. Any outcome measures must be transparently reported and available to the public and this information should be used to drive improvement. National measures are useful but partners also need a mechanism for ensuring local needs and priorities are met and for measuring the difference that specific services are making to the individual.

15. Finally, the Committee is interested in views about the impact on local authority functions. It is difficult to be specific about the potential impact from the Public Bodies (Joint Working) (Scotland) Bill, given the needed for further details in key areas (see appendix 1). The Children and Young People (Scotland) Bill will potentially have a significant impact on local authority services. This includes specific changes, such as increasing early learning and childcare, but also the potential for a major change in how services are controlled, through the ministerial powers noted above.

Further information

16. We hope that you find our comments helpful and should you require any further information please contact Fraser McKinlay, Director of Performance Audit and Best Value, Audit Scotland, 18 George Street, Edinburgh, EH2 2QU, e-mail fmckinlay@audit-scotland.gov.uk.
Appendix 1

SCOTTISH PARLIAMENT HEALTH AND SPORT COMMITTEE

PUBLIC BODIES (JOINT WORKING) (SCOTLAND) BILL

WRITTEN SUBMISSION BY AUDIT SCOTLAND ON BEHALF OF THE AUDITOR GENERAL FOR SCOTLAND AND THE ACCOUNTS COMMISSION

Introduction

1. Audit Scotland is the public sector audit agency undertaking the external audit of the majority of public sector bodies in Scotland. We do this on behalf of the Auditor General for Scotland (for the NHS and central government) and the Accounts Commission (for local government). We provide this written evidence to assist the Health and Sport Committee’s scrutiny of the Public Bodies (Joint Working) (Scotland) Bill.

Background

2. The Auditor General and the Accounts Commission welcome the opportunity to comment on the Public Bodies (Joint Working) (Scotland) Bill and to contribute to the future integration of adult health and social care in Scotland. This submission refers to the experience and audit evidence gathered through the work Audit Scotland has carried out on our behalf. This response draws on a wide range of audit work, but in particular Audit Scotland’s reports on Review of Community Health Partnerships (June 2011) and Commissioning social care (March 2012).

3. The Committee invites comments on a number of questions and we have focused our response around them.

Question 1: Do you agree with the general principles of the Bill and its provisions?

4. We support the principle that public services should be designed around the needs of the service user, and that public bodies should seek to overcome the organisational barriers that get in the way of delivering seamless integrated health and social care. Over a number of years, Audit Scotland has highlighted the need to improve how health and social care services work together to meet the needs of the people of Scotland. It is essential that services are able to work well together to respond to needs whilst making the best use of existing resources and delivering high quality services. We have highlighted in several reports the need for barriers to partnership working to be addressed and the importance of having a joint vision and clear priorities for the use of shared resources. It is encouraging that the Bill seeks to address these problems.

5. In our previous report on Community Health Partnerships (CHPs), we highlighted that a more systematic and joined-up approach to planning and resourcing health and care services is needed to ensure that health and social care resources are used efficiently. We saw few examples of good joint planning underpinned by a comprehensive understanding of the shared resources available. This message was echoed strongly in our work on Commissioning social care where we found slow progress with strategic commissioning and limited joint working. One of our concerns about CHPs related to their lack of strategic influence over how resources were used.
in the local area. The principles in the Bill aim to improve these issues, however, the change needed is significant and this is a challenging agenda.
Question 2: To what extent do you believe that the approach being proposed in the Bill will achieve its stated policy objectives?

6. The Bill requires NHS boards and councils to work together to meet the needs of the people in the local area. There are specific aspects of the Bill that should address some of the concerns we have raised in previous audit work and help to achieve the stated policy objectives. In particular, the obligation to prepare, publish, monitor and report against a local integration plan, and involve and consult with service users and carers in developing the plan, should provide a focus for driving forward the policy intention of the legislation. The extent to which this will be effective will be dependent at least in part on the quality and effectiveness of local leadership and the commitment of local partners to the plan and to the delegation and sharing of resources. Similarly, the role of the Integration Joint Monitoring Committee will be important in providing oversight and challenge.

7. However, the change needed is significant and there are some areas of the Bill where more detail is needed.

- It is not clear from the Bill how local people will be engaged in the changes proposed, whether the new partnerships will be central or local government bodies and how audit arrangements will operate.

- To date, GPs, clinical professionals and social care staff have not been fully involved in service planning and resource allocation for health and social care services. The lack of influence that CHPs have had over overall resources has been a barrier to professional staff engaging with CHPs. This needs to be addressed because these professional staff influence a large proportion of the health and care budget as a result of their decisions. The role of professionals is unclear in the Bill.

- The Bill provides little detail about how locality arrangements might work in practice. There needs to be a real contribution from professional staff groups to informing how resources are used and services improved.

8. In our report on Community Health Partnerships, we highlighted that partnership working between one or more organisations is challenging due to the differences in accountability arrangements and differences in organisational cultures, planning and performance and financial management. The proposals set out in the consultation appear to address some of these challenges but greater clarity is needed in some areas, include how acute NHS resources will be affected and how funds will flow via the new arrangements. The real test will be how the partnerships work in practice.

9. There are lessons to be learned from other partnership arrangements. When commenting on Community Justice Authorities in An Overview of Scotland’s Criminal Justice System, we noted:

   “Although CJAs were established in 2007, there are no agreed measures to assess their performance or impact. As a result, CJAs use a range of different performance indicators developed locally with different systems for reporting and presenting data. CJAs have recently agreed to improve information sharing and to look at developing a common set of core measures and associated information requirements. The lack of agreed performance indicators across the range of services designed to reduce reoffending means the cost-effectiveness of different local projects cannot be compared.”
10. The proposals set out in the Bill seek to avoid some of the above limitations, for example, the expectation that the local strategic plan will have regard to national health and well-being outcomes should ensure a greater focus on performance expectations.
Question 3: Please indicate which, if any, aspects of the Bill’s policy objectives you would consider as key strengths

11. Our reports on CHPs and Community Planning Partnerships (CPPs) highlight the importance of applying certain key principles to underpin successful partnership working. It is encouraging that the Bill recognises the importance of these key issues, including the need for leadership, vision, clear roles and responsibilities and for risks to be identified and managed. Accountability arrangements and processes also need to be clear. Partners should have a shared understanding about what success looks like and that there are arrangements in place to monitor and publically report on progress. Although these issues are identified in the Bill, this needs to be an area of focus when the Bill is implemented.

12. We have commented in a number of our reports about the lack of joined-up, transparent and comparable performance measures for health and social care services. This makes it very difficult to build a clear picture of relative performance and does not help the public or the Scottish Parliament to be assured about the quality and efficiency of the service. Therefore, we welcome the proposal for a set of nationally agreed outcome measures. When taking the Bill forward, it is important to be clear how these new measures will fit with existing frameworks such as Single Outcome Agreements (SOAs) and HEAT.

Question 4: Please provide details of any areas in which you feel the Bill’s provisions could be strengthened

13. There are a number of key issues not addressed within the Bill or associated documents, and further information is needed to understand how these changes will work in practice. If these issues are not addressed in the Bill, they need to feature in subsequent implementation guidance. These issues fall into six main areas:

- **Resources.** In previous audit work we have highlighted that, for successful partnership working, it is essential that budgets and resources are clearly set out and agreed by all partners. The partners should be clear about the rationale for how money is allocated and spent, and efficiencies should be sought through sharing of resources and improved ways of working. There needs to be transparency about how devolved budgets have been determined and what resources are included in the devolved budget. Our work has shown that these key principles have not been applied fully in partnerships in Scotland to date.

From the information in the Bill, there are clear potential risks and tensions around how organisations will determine which budgets will be included in the integrated budget and the implications of this for their own governance and accountability arrangements. It is essential that there is clarity at a local level about governance and accountability arrangements and how risks will be identified and managed, and that there are effective dispute resolution arrangements in place. There is no minimum requirement for resources or services to be included in the new arrangements. This creates a risk of significant differences of approach across the country.

Linked to this point, it is unclear from the Bill the role that other policy areas will play, specifically housing. It is important that the new arrangements maximise the valuable contribution that housing can play in improving care and support for older people. More details on how self-directed support and personalisation of care will be addressed through the new partnerships would also be useful.
• **Links between health and social care integration and Community Planning.**
  The relationship between the new partnerships and the existing Community Planning Partnerships (CPPs) is not clear from the Bill. There is a need for a clear articulation of how these new arrangements fit with CPPs given the significant leadership and co-ordinating role for local public services that the Scottish Government/COSLA see for CPPs in their Statement of Ambition for Community Planning and Single Outcome Agreements. That document identifies community planning arrangements as being at the core of public service reform and ‘providing the foundation for effective partnership working within which wider reform initiatives, such as the integration of health and adult social care… will happen.’ Specifically it is not clear how accountability and outcomes/performance management will link between CPPs and the new health and social care partnerships. It essential that sound governance and accountability arrangements are in place. Any new governance and accountability arrangements should be effectively aligned with existing arrangements to avoid further complicating approaches to governance and accountability - we noted in our report on Community Health Partnerships that:

  “Approaches to partnership working have been incremental and there is a cluttered partnership landscape. CHPs were set up in addition to existing health and social care partnership arrangements in many areas. This has contributed to duplication and a lack of clarity of the role of the CHP and other partnerships in place in a local area. There is scope to achieve efficiencies by reducing the number of partnership working arrangements”

Given that the new integrated arrangements will be responsible for significant resources, and may opt to include other services, such as services for children, it is even more important that the links to CPPs are clear and fully understood.

• **Implications for audit and scrutiny arrangements.** The Bill does not set out whether the corporate body will be a local government or central government body. This has significant implications for financial arrangements and for the audit function. There are other potential issues for auditing and other scrutiny arrangements because of these changes. Specifically, if local partners opt to establish a body corporate there will be implications for internal and external audit arrangements. For example, the VAT status of the new body will need to be clarified. These issues have implications for audit and inspection arrangements as well as Parliamentary scrutiny. Furthermore, there are different budgeting cycles for NHS and Local Government bodies. It is also unclear from the Bill and associated documents, how the external audit function will be funded and arranged and how it will work in practice. In taking forward the new arrangements, consideration will need to be given to audit committee and scrutiny arrangements, alongside the external audit issues we have raised. There is a need for more detail on how these integrated services will be regulated and inspected through the work of Healthcare Improvement Scotland and the Care Inspectorate to ensure that there is appropriate independent public assurance about the performance of the new partnerships.

• **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 needs 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.

- **The role of health and care professionals.** The Bill recognises the importance of health and social care professionals being at the heart of making the partnerships a success. However, there is a lack of detail on how this will work in practice. We recognise the need for a degree of local flexibility to allow partnerships to respond to local needs, but we have noted in previous audits that historically these professional groups, such as GPs, have not played a key role in partnership working to date. Their involvement will be critical to the success of the new arrangements.

- **Ministerial powers.** The Bill gives Ministers wide-ranging powers to make certain decisions about how services are planned and delivered locally, including powers to issue directions to local authorities, health boards or integration joint boards, about the functions related to the Bill, or in the integration plan. These powers are potentially significant, in particular in relation to the role and responsibility of local government. For that reason, more information on the circumstances in which Ministers might seek to exercise these wide-ranging powers would be useful.

**Question 5: What are the efficiencies and benefits that you anticipate will arise for your organisation from the delivery of integration plans?**

14. The new arrangements will require NHS boards and councils to improve and share information on how resources are used locally for specific groups within the local community. Audit Scotland has highlighted a number of gaps in information which could be addressed through this approach. Specifically, we have highlighted previously a lack of information on community services to inform how best to use shared resources for the local area. The new arrangements may make it easier for health and social care providers to see their services as part of a single system of care, making it easier to reduce overlaps and to ensure that people receive the care they need, while best use is made of existing resources.

15. We recognise the major challenge in integrating health and social care services. We have previously commented that there has been no large-scale shift in the balance of care to community services and on the lack of joint resourcing in Scotland, and consider that many partnerships will find agreeing on the resources to devolve to the integrated budget difficult. Our recent report on Commissioning social care found that there was a way to go to develop how services are planned and commissioned within a single agency, not least between partners. This will be a major change for partners and require strong leadership, investment and support to make the change.

**Question 6: What effect do you anticipate integration plans will have on outcomes for those receiving services?**

16. The intention from the Bill is for a clear change to how services are planned and managed as a result of the proposals. The Scottish Government, and local agencies, will need to consider the potential cost implication of these changes and the impact on professional staff who deliver frontline services. The focus should be on improving outcomes for local people as well as on integrating systems and services. 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 are welcome. The Bill provides the opportunity for better coordination of services and making better use of available resources at a local level.

17. Any outcome measures must be transparently reported and available to the public and this information should be used to drive improvement. National measures are useful but partners also need a mechanism for ensuring local needs and priorities are met and for measuring the difference that specific services are making to the individual.

18. The Scottish Government, together with NHS boards and councils, will need to ensure there is minimum disruption to existing services and service users during the move to better integration. NHS boards and councils need to continue to deliver services to those who need them during this period of change and must ensure that people are not adversely affected. Whilst these changes are under way, it will be important to maintain the progress made by CHPs at a local level.

Further information

19. We hope that you find our comments helpful. Should you require any further information please contact Fraser McKinlay, Director of Performance Audit and Best Value, Audit Scotland, 18 George Street, Edinburgh, EH2 2QU, e-mail fmckinlay@audit-scotland.gov.uk.
Local Government and Regeneration Committee

Children and Young People (Scotland) Bill

Submission from Children in Scotland


1. Children in Scotland is the national umbrella agency for organisations and professionals working with and for children, young people and families, with around 400 members. We welcome the opportunity to respond to the Finance Committee’s call for evidence on the National Performance Framework, as part of the process of scrutinising the Scottish Government’s draft Budget for 2014-15.

2. Our comments in this submission reflect our remit to support and promote improved outcomes for children, young people and their parents/carers, so our contribution focuses on these aspects of the NPF.

General Observations.

3. The National Performance Framework project was always going to be a major challenge to deliver and the Scottish Government is to be commended for its ambition in drawing together a hierarchy of strategic objectives, supported by national outcomes and key indicators. The shift of focus towards measuring outcomes, rather than inputs and processes was also a positive development. However, while we welcomed the inclusion of some outcomes and indicators in the NPF directly related to children and young people, they only represent around 16% of the 50 indicators in the Framework and only two indicators relate directly to pre-school children.

4. Children in Scotland has also welcomed the major shift of policy towards the principles of prevention, early intervention and a strong focus on the early years. As we note below, however, we consider that it is too early to come to a reasoned view as to whether resources are following the shift of policy to any significant extent.

The NPF as a means of measuring improved outcomes for children, young people and families.

5. Life chances and outcomes for children and young people are directly affected by a whole range of environments and issues covered by the NPF eg deprivation, housing, play and recreational space, health and other inequalities, public safety etc. We suggest, therefore, that scrutiny of only the few indicators which refer to children and young people would present a seriously incomplete and potentially misleading picture of progress in dealing with the many aspects of Scottish life which affect children.
6. Rather than focus solely on the specific outcomes and indicators relating to children and young people, we recommend, therefore, that the Scottish Government must take a broader overview across all relevant elements of the NPF to ensure that it can present a full picture of progress in improving outcomes in a positive and sustainable way for the youngest members of Scottish society.

**Choice of outcomes and indicators.**

7. We are aware that the Scottish Government is not directly responsible for day to day delivery of the services which will, in reality, determine whether improved outcomes are generated for our children, young people and their families. Therefore, identifying available and consistent data and information from a wide range of service providers, notably local government and the NHS Boards, was always going to be a major challenge.

8. There was always unease, however, that the indicators directly affecting children and young people were dictated by what information was readily available, rather than what would be the optimum measures to show that the lives and opportunities for our children and young people are being improved. While the limited national outcomes aimed directly at children and young people are laudable, we have significant reservations as to whether the related national indicators are sufficient to show if they are being delivered.

9. For example, the indicator “improving children’s services” seems focused entirely on child protection inspection results. It is clearly important to know that child protection services are scrutinised and improved where needed, but we suggest that this indicator either needs to be retitled “improving child protection services” or the range of services covered by the indicator needs to be widened. The Care Inspectorate’s new methodology goes beyond child protection services, so there is perhaps an opportunity to realign this indicator to cover a wider range of services which, we believe, would be the more desirable and meaningful option.

10. Inspection reports are essentially retrospective audits on the performance of services, rather than measurement of sustained and improved outcomes for those who use them. This contention applies to the indicators around positive inspections of schools and pre-school settings. These are valuable in reassuring parents and funders that providers are offering high quality services, but we would argue that they say little about the experiences of children and young people and whether outcomes for them are actually improving and thus contributing to meeting the associated national outcomes.

11. The national indicators around healthy birth weight, dental health, weight and physical activity are certainly useful as quantifiable ways of looking at the health and development of children but they are effectively proxy measures. We are not convinced that what are statistical snapshots tell us nearly enough for anyone to take a reasoned view on whether outcomes for our children are improving, particularly in respect of the early years.
Proposals for improvement.

12. Children in Scotland accepts that, in the current financial environment, developing expensive and extensive new data collection systems may not be a viable option and we recognise the benefits of using existing and consistent data sources wherever possible. Our question remains, however, as to whether the national indicators which are directly aimed at children and young people really provide the right and right amount of information to show progress in meeting the associated national outcomes.

13. Children in Scotland also questions whether advances in Scottish Government policy priorities aimed at children, young people and parents/carers (and their associated measures) have resulted in the NPF being overtaken and sidelined as far as looking at progress in improving outcomes for children and young people. In suggesting this, we see considerable and positive scope to create a more meaningful and streamlined framework and better alignment between the Framework and other current and developing measures of improved outcomes for children and young people.

14. The current planning and policy environments relating to children and young people are very complex. In our view, they do not link up well, thus adding to bureaucracy and lack of clarity for practitioners, planners, policy makers and families. Children in Scotland has been concerned for some time that planning for children’s services, a legal requirement under the Children (Scotland) Act 1995, is largely peripheral to wider Community Planning and the associated Single Outcome Agreement (SOA) process. As we indicate earlier in this submission, outcomes for children and young people are affected by a wide range of environmental and societal factors and we firmly believe that plans for direct support to children and young people should not be seen as separate from wider community development.

15. The duty on local authorities to produce and publish children’s services plans is augmented in the Children and Young People Bill, currently at Stage 1 in Parliament. Children in Scotland’s evidence to the Education Committee suggests that there should be formal links between Community Plans, SOAs and Children’s Services Plans. In our view, the Bill provides an opportunity to make these much needed links and for the Scottish Government to look again at whether SOA targets/outcomes adequately cover the interests of children and young people.

16. The Bill also describes a “wellbeing framework” based on the Getting It Right for Every Child (GIRFEC) principles of Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included (SHANARRI). Our understanding is that there is to be a suite of indicators and measures to help demonstrate progress, based on SHANARRI principles and that these should be included in progress reports on delivery of children’s services plans.

17. Children in Scotland considers that it would both sensible and feasible to use measures and indicators, based on the SHANARRI framework, as a
foundation for reporting at locality level, aggregate such information to Community Planning Partnership level and then include it in national reporting eg through SOAs, which, ultimately, would feed into the National Performance Framework. This would provide “bottom up” performance information to aid direct service providers at locality level, local policy and planning partnerships, national government and Parliament in respect of assessing successful delivery of national outcomes, policy priorities and resource allocation.

18. If the SHANARRI indicators are well designed and measured consistently, this would ultimately provide the National Performance Framework with a wider range of more meaningful and relevant information on how children and young people are faring in Scotland.

19. Children in Scotland also believes that the Growing Up in Scotland research outcomes could serve as a useful input to the national outcomes set out in the NPF, again making better use of existing sources of information.

20. Growing Up in Scotland (GUS) is a large-scale and ongoing longitudinal research project aimed at tracking the lives of several cohorts of Scottish children from the early years, through childhood and beyond. The research covers key domains which are very relevant to the national outcomes in the NPF, including cognitive, social, emotional and behavioural development, physical and mental health and wellbeing, childcare, education and employment, home, family, community and social networks, involvement in offending and risky behaviour.

Opportunity to rationalise and streamline indicators.

21. We suspect that many current performance and reporting requirements are linked to earlier, specific policies and strategies and they may not reflect the shift of focus towards prevention, early intervention and the early years.

22. We suggest, therefore, that the Scottish Government should take the opportunity to review the plethora of performance and other reporting information it currently gathers (and plans to gather in future) in respect of improving outcomes for children and young people. As matters stand, Children in Scotland would contend that there is a need for greater cohesion and scope for significant rationalisation which could save scarce human and financial resources that could be better used to support front line services and improve outcomes.

23. For example, we understand that an ongoing project, the Early Years Collaborative, is developing a new suite of stretch aims and targets, based around a quality improvement model. While Children in Scotland has always welcomed greater emphasis on the early years, we suggest that the Scottish Government should be invited to set out in detail how these new measures fit with GIRFEC/SHANARRI indicators, the indicators which underpin the Early Years Framework and the reporting requirements in the Children and Young People Bill. Our hope is that these could be rationalised and streamlined, rather than creating additional burdens on hard-pressed service providers.
24. There is also a major issue around the availability of robust baseline data to form the foundations from which progress can be monitored and the Scottish Government should ensure that it has sufficient baseline information to support improved indicators and measures in respect of improving outcomes for children and young people.

**Links between NPF priorities and spending decisions.**

25. Children in Scotland welcomes the policy intentions and rationale behind shifting resources towards prevention, early intervention and the early years, including the prospects of generating savings to the public purse in the short, medium and long terms. However, it seems to us that there is no consistent understanding or definition of what prevention and early intervention mean in practice, so we question how effective any attempt to categorise and quantify the allocation of resources would be.

26. In addition, it is very difficult to obtain information on how much is spent in Scotland on supporting children’s services and to track trends. Local authority financial returns are one complex, source of information. Our understanding is that NHS spend on children and young people is almost impossible to identify, due to the way in which budgets are structured. Against this backdrop (coupled with the virtual removal of ring fenced budgets for local government), we suspect that it will be difficult for the Scottish Government and for Parliament to measure from a meaningful baseline whether there is a shift of resources towards the prevention and early intervention priorities.

27. Another factor which will conspire against shifting resources is that this initiative has come about at a time of severe pressures on public sector budgets and we know that local authorities and other providers are already struggling to meet their existing legal obligations to children and families. We consider that there is very little in the way of “slack” in the financial system which would allow a major shift of resources, while still ensuring that current statutory duties are met.

28. While the Scottish Government’s Change Fund is a useful incentive, our partners have pointed out to us the dilemma they face in transferring increasingly scarce resources to meet revised priorities, particularly identification of the budgets which might be reduced and the consequences of doing so. For example, existing children and families with multiple, complex and challenging needs will still require extensive and expensive support over time and reduction or withdrawal of support could have very serious consequences for all concerned.

29. Given the serious financial conditions facing the public sector in Scotland, we suggest that policy makers, planners and practitioners need to take careful stock of current activities to ensure that they are delivering improved outcomes for children and families and value for money. Where there is spending on provision that is clearly failing to deliver, shutting down such activities and transferring resources into services and actions that have been
proven to work, may be another option to free up human and financial capital. Diverting resources into prevention and early intervention priorities would certainly be welcome, but it is equally important to have common definitions, measures and indicators to ensure that such resources are delivering genuine and sustainable improvements to outcomes.

30. The desired transitions in resource terms will, in our view, take much longer to emerge and progress is likely to be slow and variable across Scotland. The consequence of this is likely to be that the improvement in outcomes for children and young people envisioned by the Scottish Government, and supported by Children in Scotland, will take longer to emerge. We are not advocating a shift away from the policy aims of prevention, early identification of problems and early intervention from the earliest years in a child’s life, but offering something of a “reality check” in managing expectations.

Conclusion.

31. In conclusion, Children in Scotland supports the rationale and aims which underpin the National Performance Framework, but we can see considerable scope to enhance the range and quality of information on children and young people that feeds into it. In this submission, we offer suggestions which, we hope, might provide more relevant and comprehensive information, while streamlining the means of reporting at local and national levels.

32. While we believe that it is too early to respond in detail to all the questions posed by the Finance Committee, we wish the Scottish Government, Scottish Parliament and the key national and local agencies who plan and deliver services for children and young people every success in making these ambitious and laudable changes to the ways in which services for children, young people and families are planned, provided and funded.

Jackie Brock
CHIEF EXECUTIVE.
Local Government and Regeneration Committee

Children and Young People (Scotland) Bill

Submission from Children’s Hearings Scotland

Introduction

1. Children’s Hearings Scotland (CHS) is a Non-Departmental Public Body established under the Children’s Hearings (Scotland) Act 2011, which entered into force on 24 June 2013. CHS assists the National Convener with the delivery of her functions in relation to the recruitment, selection, appointment and re-appointment, training, retention and support of volunteer panel members within the Children’s Hearings System. Further information about CHS and the National Convener can be found on our website www.chscotland.gov.uk.

Children and Young People (Scotland) Bill: Part 3

2. CHS welcomes the strengthening of the legal framework for children’s services planning. However, at this stage we have some reservations about the duty being imposed on the National Convener. There are two reasons for this. First, children’s hearings themselves are not providing a service to children and families and panel members have no direct role in children’s lives, other than the critical role of decision makers within the care and justice tribunal for children and young people and families. Secondly, there is an additional complexity in relation to compliance with the European Convention on Human Rights (ECHR) and the need to maintain the independence of the children’s hearing.

3. We would welcome clarity and additional guidance to ensure that specific duties and expectations of different agencies and public bodies are set out to promote a real understanding of roles and responsibilities within the children’s planning framework.

4. We also think it is disappointing that the involvement of children, young people and families is not addressed within these sections of the Bill.

Public Bodies (Joint Working) (Scotland) Bill: s44

5. CHS welcomes the proposal contained in s44 to allow the Common Services Agency to enter into arrangements to provide legal, technical and administrative services with, amongst others, public authorities. In relation to this, we strongly welcome the statement in para 138 of the Policy Memorandum that the delivery of shared services by the Common Services Agency will “not be mandatory and it will remain a matter for these bodies themselves to determine the benefits of engaging with the Common Services Agency.” We consider it essential that the use of the services provided by Common Services Agency be optional. For example, in relation to legal services we would welcome the opportunity to discuss the provision of assistance with employment, property or contractual issues but in relation to legal
advise and assistance on matters relating to the Children’s Hearings System, the specific expertise required could not be provided by the Common Services Agency. If it became mandatory to use the Common Services Agency to provide shared legal services CHS and the National Convener would be at a significant disadvantage to the current position in this respect.

6. CHS currently has agreements with the Scottish Children’s Reporter Administration (SCRA) for the provision of human resources, procurement, payroll and transactional finance services, with National Records of Scotland (NRS) for procurement services and with the Scottish Government Information Service and Information Systems (ISIS) department for IT services. Based on this experience we think it is essential that the basis on which the shared service operates is crucial. In particular it is essential that the service provided is flexible, responsive, and is capable of being tailored to individual public authorities. Public authorities are a diverse group and have different needs depending on their size and the area in which they operate. It is important, therefore, that the service provided by the Common Services Agency is capable of being customised to the needs of the particular public body.

Children’s Hearings Scotland

August 2013
Local Government and Regeneration Committee

Children and Young People (Scotland) Bill

Submission from Coalition of Care and Support Providers

1. CCPS welcomes the opportunity to contribute to the Committee’s consideration of the Public Bodies (Joint Working) (Scotland) Bill (the ‘Joint Working Bill’) and the Children and Young People (Scotland) Bill (the ‘Children’s Bill’), in relation to the proposals relating to children’s services planning and shared services that they respectively contain. We have provided some initial feedback to both the Health and Sport Committee and the Education and Culture Committee on these two bills. The following points are drawn from those submissions and focus on the benefits and concerns for care and support providers, in relation to service planning.

Re Joint Working Bill

2. We have three points to note in relation to the proposals for service planning: firstly, the need to strengthen the role of the third sector in strategic planning; secondly, to make specific provision for the independent scrutiny of planning processes; and thirdly, the need to clarify the links between planning processes elsewhere (e.g. existing community planning via the CPP, and proposals for service planning in the Children’s Bill).

3. We very much welcome the emphasis in the Joint Working Bill on ‘strategic planning’. Ss. 23-30 provide for a framework for joint strategic planning, based on a set of integration delivery principles and include the establishment of a ‘consultation group’ to develop and agree the strategic plan.

4. While we strongly support the requirement for joint strategic commissioning, the involvement of non-statutory partners needs to be significantly strengthened. We are concerned that the Bill does not adequately reflect the policy intentions set out in the policy memorandum, which says: ‘... the full involvement of the third and independent sectors, service users and carers, will be embedded as a mandatory feature of the commissioning and planning process. This will strengthen the cross-sector arrangements that have been established during the first two years of the Change Fund.’

5. The Joint Working 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

---

1 At page 24.
and delivery of care and support. Otherwise, the effect of the Bill will be to ‘downgrade’ the third sector (and indeed the private sector) from the status it has already been accorded in respect of similar processes for Reshaping Care for Older People and the Change Fund, where relevant plans must be signed off by four partners equally: the NHS Board, the local authority, the third and the private sectors. To underline this point, we note that the Financial Memorandum identifies the costs of clinical involvement in locality planning (estimated at £3 million, points 88 and 89) but no cost is identified for involvement of the third sector in either locality or strategic planning, which perhaps tells its own story.

6. We have also argued that there needs to be a level of independent scrutiny of the strategic planning process. However, the Joint Working Bill makes no reference to any requirement for independent scrutiny of integration authorities in respect of quality, performance or the achievement of national outcomes. The Health and Sport Committee has supported CCPS in promoting the view that poorly commissioned care poses as much of a risk as poorly delivered care: it is therefore a major disappointment that whilst the policy memorandum is specific on the need for independent scrutiny of strategic commissioning\(^2\), the Bill itself makes no reference to it.

7. Linked to the above point, the Bill’s requirements for integration and strategic planning do not appear to be sufficiently co-ordinated with related legislative instruments (both existing and proposed). We are aware, for example, that the Joint Improvement Team (JIT)’s recent survey of progress on integration indicated that a fair number of partnerships are considering including children’s services in their integration plans. This raises a question about how integration plans in these areas should interact with the requirements set out in the Children’s Bill with respect to children’s services planning, and/or to requirements regarding community planning more generally. There is a risk that these various pieces of legislation will lead to a multi-layered, yet unco-ordinated, set of planning requirements for public authorities.

Re Children’s Bill

8. There are two principal issues we have raised in connection with the proposals in Part 3 of the Children’s Bill, which reflect similar concerns raised in respect of the Joint Working Bill. The first is that we would like to see the engagement of the third sector more clearly embedded in the joint services planning; and second, related to this, we would like to see greater consistency between the joint planning proposals in the Children’s Bill and the Joint Working Bill, as well as greater clarity about how the different planning processes will relate to each other.

9. The proposals in the Children’s Bill for service planning build on the provisions in the Children (Scotland) Act 1995 but appear to fall short of the level of collaborative

---

\(^2\) At para 131 onwards.
strategic planning that is being developed in the context of the integration of adult health and social care noted above. The Joint Working Bill provisions on strategic planning, while not going as far as we would like, appear to be a significant step up from the more basic 'duty to consult' requirements in Part 3 of the Children’s Bill, not least because they require the involvement of a range of stakeholders (including voluntary sector service providers) from the beginning of the planning process, and include both a set of principles and a structure for the process.

10. Interestingly, while there is only a basic ‘duty to consult’ with voluntary sector service providers in the Children’s Bill, there appears to be a ‘duty’ placed on voluntary and independent sector providers, social landlords and others (in s.10(6)) to ‘meet any reasonable requests to participate or to contribute to the preparation of the plan’.

11. We welcome wide participation in the planning process, but we query the extent to which this legislation can place ‘duties’ on non-statutory bodies. Thus we would like to see clarification of the meaning of this provision in relation to both the policy aim and the legal impact. As set out above, we consider the approach taken in the context of the Joint Working Bill, (where duties are placed on statutory bodies to undertake a process of joint planning that includes voluntary sector providers and others) to be a better model.

12. In the context of involvement in strategic planning, it is notable that the financial memorandum for the Children’s Bill anticipates no extra costs as a result of these planning proposals based on the assumption that local authorities already have a duty to produce integrated children’s services plans. As with the Joint Working Bill, there is no consideration given to the costs that might come with wider participation in the planning process by voluntary sector providers and others. However, we think that there will be potential costs to voluntary sector providers, not just from engagement with the planning process but also in connection with the duties to provide information, advice and assistance (e.g. ss.14, 26, and elsewhere in the Bill) and that this should be reflected in the financial memorandum.

CCPS August 2013

About CCPS
CCPS is the coalition of care and support providers in Scotland. Its membership comprises more than 70 of the most substantial third sector providers of care and support, supporting approximately 270,000 people and their families, employing over 45,000 staff, and managing a combined total annual income in 2009-2010 of over £1.2 billion, of which an average of 73% per member organisation relates to publicly funded service provision.
Care and support in the third sector

The third sector is at the forefront of quality care and support in Scotland. More than a third of all care and support services registered with the Care Inspectorate are provided by third sector organisations. In many areas of care and support for adults and older people – including care home provision, care at home and housing support – third sector services receive a higher proportion of ‘very good’ and ‘excellent’ quality gradings from the Care Inspectorate than their counterparts in either the public or the private sector.
Introduction

1. COSLA welcomes the opportunity to provide written evidence to the Education and Culture committee on the Children and Young People Bill. We have been pleased by the inclusive way that Scottish Government has worked with COSLA in the development of the Bill and we hope to continue this positive approach in evidence to Parliament.

2. We acknowledge that this response is longer than we would typically submit on a Bill. However, the legislation is arguably the most significant change to children’s services since devolution so we believe all sections need to be considered carefully. The Bill is positive and ambitious, and it is worth emphasising that COSLA supports the policy intentions behind much of the Bill. As a result the majority of our work on the development of the Bill has focused on practical challenges of implementation and the resources required by local authorities.

3. The Children and Young People Bill is a complex piece of legislation with significant financial implications for local authorities. The accuracy of the Scottish Government’s analysis and therefore the funding that would be made available depends on a large number of assumptions that will not be fully tested until the Bill is implemented. Councils have concerns over the future financial impact of the policies and that for this reason the financial implications to local authorities require in-depth scrutiny during the parliamentary passage of the Bill. COSLA has gained a confirmation from the Scottish Government that it is the intention to fully fund the requirements of the Bill, but with the implementation stretching beyond both the current spending review period and the end of this current parliament in 2016 then future budgetary decisions would be dependent on the result of several spending reviews. The commitment made by this administration to fully fund the Bill must be honoured in future years by whatever Government is in power and kept under on-going review. We also believe that it will be necessary for both COSLA and Scottish Government to jointly scrutinise and monitor the spend on this legislation, to ensure that local government is and continues to be sufficiently resourced to carry out the new duties that will be enacted.

Summary of Bill

4. COSLA supports the policy intentions of the Bill’s proposals on:

- Children’s rights;
- Children’s services planning and Getting it Right for Every Child;
- Early learning and childcare, and
- Looked after children.

5. However, we have a number of important points to make on the implementation of Bill proposals, and the financial implications of the legislation. COSLA will be
responding to the Finance Committee call for evidence in relation to the Financial Memorandum for the Bill, but we also provide summaries of comments on the financial issues in this submission of evidence. We also have a small number of concerns with specific proposals in the Bill - chiefly relating to new powers being sought by Ministers and proposed changes to the Children’s Hearings Scotland Act. These and other issues are discussed in more detail in the sections below.

**Part 1 - Rights of Children**

6. Children’s rights are well embedded within the practice of local government. We believe that no public sector organisation is likely to object to the proposal for realisation of children’s rights as stated in the proposals. Issues around transparency of decision making and policy implementation and scrutiny are of equal importance to local government, as other public sector organisations. COSLA has maintained since the Bill proposals were consulted upon in 2012 that we remain of the view that the duty of due regard need not extend beyond ministers when councils are already addressing children’s rights. Local authorities have already made much progress especially in the school setting, in terms of the promotion of children’s rights.

7. A number of organisations such as the Children’s Parliament are working with children on this issue. In explaining rights issues to children, it often provides clarification for adults working and caring for children and young people that the focus of the rights in the UNCRC are not about giving children the right to say no, but rather the ability to feel safe, secure and healthy with their help, guidance and support. We believe that this understanding helps and empowers children and young people.

8. COSLA remains of the view that organisations and structures such as the courts and Children’s Hearings need to acquire a clear understanding of the UNCRC in terms of their dealings and undertakings to children and young people. In that context, we are prepared to accept the proposals as set out in part 1 of the Bill.

**Part 2 - Commissioner for Children and Young People**

9. COSLA would be concerned if the use of the proposed additional powers as set out in Part 2 of the Bill became a “naming & shaming” exercise. Equally we would be concerned if the additional powers were to be used in a way that would duplicate both the existing complaints procedures & external inspection by Education Scotland and the Care Inspectorate. While we acknowledge that the Explanatory Notes for the Bill make reference to the Commissioner not duplicating roles of other organisations, this still leaves an opening for the Commissioner to investigate something that would be better handled by another agency.

10. It is our view that any powers should be used only as a last resort after all other avenues are exhausted.

11. Equally, we are clear that there needs to be clear guidance available to councils on what the UNCRC means for them in the delivery of children’s services, in light of Part 1 of the Bill, as well as Guidance on how and in what circumstances the
Office of the Commissioner will have the scope to implement the additional powers.

**Part 3 - Children’s Services Planning**

12. For many years, COSLA has argued for better integration of public services locally. Whilst we therefore accept the intention behind the Bill to improve integration and planning for Children’s services, COSLA believes that to be effective in practice any Bill proposals must not exist in a vacuum and should add value to other existing arrangements.

13. In particular, we want to be sure that Children’s services planning contributes to and is driven by the wider Community Planning arrangements that all partners are engaged in locally. This should be the forum through which partners should come together to develop partnership approaches to improving outcomes. For example there is an existing duty for local authorities to produce integrated children’s services plans, linked to Community Planning. Although we would argue that more needs to be done to put CPPs at the centre of reform our view is that this Bill should be an opportunity to drive that work forward in the context of children’s services, and avoid any chance of competing agendas or duplication arising.

14. It is therefore important that Committee considers how the Bill sits within this existing landscape; the activity going on to strengthen community planning, and alongside the developing Community Empowerment Bill which will set out in statute the new framework for Community Planning.

15. There are also clear links to the current proposals on the integration of adult health and social care services and it is possible that some local partnerships may wish to consider the inclusion of children’s services in those arrangements. Ultimately, it will be for individual local authorities and their health board counterparts to make that determination. We would also add that other organisations/people with an interest in children’s services within the voluntary or private sector that are not always directly connected to CPPs will also have a key to play in these tasks and should be equally covered by the proposals.

16. There is one aspect to the proposals in children’s services planning with which COSLA does not support. Part 3 paragraph 17 proposes Ministerial powers to establish joint boards, should there be concern that insufficient progress is being made in terms of integration. This was a late addition to the Bill, and one which had not been previously discussed with COSLA. Whilst we can understand the desire on the part of any Government to ensure the successful implementation of its policies, the discretionary powers taken within this section of the Bill are extensive and allow for the transfer of staff, property and functions to the new boards.

17. The powers appear also to be linked to section 16 of the Bill which concerns powers to issue direction to public bodies, including local authorities. Section 16 is a concern in itself as it allows Ministers with the broad scope to issue directions to local authorities and health boards on the exercising of their functions. We firmly believe that decisions on the operation of services, including how best to
tackle outcomes, are best taken at the local level in close collaborations with partners. Taken together one interpretation of sections 16 and 17 is that local authorities and health boards could be restructured if directions of Ministers were not followed to the liking of the Government of the day.

18. This is a concern for anyone who champions local democracy, but given our good relationship with Government it is strange that Ministers feels the need to seek such strong powers. Local government has demonstrated a strong commitment to both the Bill and children’s services improvement generally and we have a strong track record of arguing for better, outcomes focused integrated services. This is consistent with our representation to the Christie Commission and our recent work to agree a vision for local government. We are also uncomfortable with notion that Parliament is being asked to grant powers to Ministers to restructure the public sector in a way that normally would require the full scrutiny afforded to primary legislation. It is possible to argue that these powers not only undermine local democracy, but national democracy too.

19. COSLA is completely opposed to the powers described in paragraph 17 and have made this point already to Government. Our principled position as agreed by our Convention is that there is no need for such powers, and that they should be removed from the Bill.

Part 4 - Provision of Named Persons
20. Scottish local government has been delivering the Getting It Right for Every Child approach for some years and recognises the value of GIRFEC in the improvement of children’s services. The proposal that the Named Person role should sit with local government, with the inference, though not expressly set out, that the role should sit with with schools in terms of their contact with children and young people from 5 to 18 years is welcome. It is clear that outside the family or care structure, children and young people have the most contact with school teaching and support staff. The Financial Memorandum provides for resources to be made available to provide GIRFEC training for senior teaching and support staff in schools and provide resources for backfill, while training is undergone. COSLA has worked with Scottish Government in testing these figures based on the current situation. As noted in the introduction this is a necessary area that will need to be monitored and scrutinised in future years to ensure funding is available for the provision to be sustainable.

Part 5 - Child’s Plan
21. The value of a Child’s Plan is already recognised since the GIRFEC approach was launched. COSLA has worked with Scottish government to promote the approach across local authorities. It is reasonable therefore that COSLA continues to support in principle, the proposals regarding a Single Child’s Plan. The idea of a child’s plan is one that we completely support, but there is a need to consider how the plan relates to other plans. The best example is the coordinated support plan which is set out in ASL legislation. We understand that Government is looking at how coordinated support plans sit with respect to the child’s plan – with the option that a CSP could form part of the child’s plan where this is appropriate being perhaps the best solution. In an ideal world we would not require two pieces of legislation – this Bill and ASL legislation – to describe
different aspect of children’s services planning, but it is the practical reality on the ground that is most important. It is therefore important that legislation and guidance makes clear how both the child’s plan and coordinate support plans will operate in practice.

22. In principle COSLA would accept that children, young people and families should be involved in the development of a Child’s Plan, where possible. However, in practical terms, while local authorities will seek to improve life chances for children and young people, managing expectations against practicality and the needs of other vulnerable members of the community will continue to be addressed by councils.

**Part 6 - Early Learning and Childcare**

23. COSLA supports the expansion of early learning and childcare as proposed in the Bill. The proposals in the Bill came about as a result of considerable joint discussion between COSLA, ADES and Scottish Government. This is also the most costly section of the Bill, and from the start COSLA recognised the very significant implications of the proposals on local authority resources.

24. The figures within the financial memorandum were developed through the work of COSLA with local authorities. They are the best figures we have for the implementation of this section of the Bill, and it is worth noting that local authorities have indicated that they are broadly happy that they are an accurate assessment of implementation costs in line with the agreed approach to delivering this aspect of the Bill, that is, to deliver the 600 hours in as practical a way as possible and without the additional requirement of more flexibility for parents. However, as we have already outlined the implementation of the Bill will stretch beyond the end of this spending review, which means it needs to be recognised that it is future budgets that will determine how effectively this policy can be implemented. Parliament needs to be aware that any shortfall in future funding will be felt by local government and ultimately parents and children.

25. Following discussions with Scottish Government we agreed that the Bill would require local authorities to deliver the increased hours in as practical way as possible by August 2014 with no immediate requirement for more flexibility for parents. This recognised practical challenges facing local authorities, and the short lead time to implement the additional hours in time for the start of the academic year 2014/15. In subsequent years additional flexibility will be introduced gradually, in consultation with parents, and within the overall resources made available by Scottish Government. Delivering increased flexibility is more complex and costs more money as a result, so it is important to understand that local authorities will only be able to implement what they are funded to deliver. Local authorities have the flexibility to tailor future delivery of 600 hours of early learning and childcare to meet local needs, incorporating the views of parents.

26. On the basis that these issues have been agreed with Scottish Government, we support the proposals outlined in the Bill.

**Part 7 - Corporate Parenting**
27. COSLA has long been an advocate of corporate parenting and has been an enthusiastic supporter of publications such as ‘These are our Bairns’. This section of the Bill is important as for the first time it will set out a legal definition of what it means to be a corporate parent, and extend this to other public bodies – the corporate family, to extend the analogy.

28. We agree that a definition of Corporate Parenting should refer to the collective responsibility of all public bodies and those acting on their behalf to provide the best possible care and protection for looked after children. In addition, it would be helpful if other public bodies or community planning partners have their roles clarified to achieve better outcomes through joint working. This will require the updating of guidance on corporate parenting.

29. We have to be clear though that the corporate parent cannot act in the same way as a birth parent. As such, any definition requires to define the parameters of the responsibility lucidly and to manage expectations in terms of the financial and human resources it would involve. However, local authorities and other public bodies can and do use their influence and weight in innovative ways to support both children in care, and those who have recently left it.

30. It is also important to note that any formalised definition of corporate parenting will have practical resource challenges in terms of on-going training/briefing sessions to ensure organisational wide commitment for councils and other community planning partners. At the same time though it should be acknowledged that there are some real examples of good practice around the country in relation to corporate parenting from councils that should be promoted.

31. One concern that we have on part 7 of the Bill again relates to powers of Scottish Ministers to issue direction to public bodies – including democratically elected local authorities. As with part 3 of the Bill we are not certain why Ministers feel they need to seek the ability to direct public bodies as set out in section 58. Local government has shown a strong commitment to the concept of corporate parenting in recent years and developed a good partnership with Government. Local and Scottish Government have a shared goal for improving lives of looked after children, so it seems disproportionate for Ministers to require the ability to issue directions. On a practical note we would also argue that the powers presuppose that Ministers somehow know better than local agencies about how to meet the needs of children in their care. We do not doubt Government’s commitment on this subject, but the experience of elected members and local professionals across all agencies and services must be respected.

Part 8 - Aftercare
32. COSLA is supportive of the policy intent of the extension of aftercare provision to young people that have previously been looked after. We understand that Government are looking for authorities to provide a level of support broadly consistent with what is provided currently on a discretionary basis for 19-21 year olds. However, paragraph 60, sub-section 8 states that Ministers will determine such types of support, the detail of eligibility will not be determined until secondary legislation. It is therefore important to emphasise that the full
implications of this policy on local authorities will not be known until the secondary legislation is passed.

33. Currently, there is no equivalent legislation or statutory guidance for such type of support for 19-21 year olds. The decision on eligibility is made by the local authority, as they have the skills and expertise to assess the individual case. Potentially paragraph 60, sub-section 8 could restrict the provision local authorities can offer and could lead to a difference in the provision that is currently provided and the provision that could be provided after the legislation is implemented. It also restricts the flexibility a local authority has to amend the elements of support available to eligible kinship carers to reflect changing circumstances or the future identification of further support needs.

34. The assumptions that Government make on the number of young people leaving care and percentage of young people expected to be successful in applying for support seem reasonable and are based on national statistics and the experience of local authorities.

35. Our concern on this issue is one that we have no way of knowing what the impact of welfare reform will be on this group of young people, so there is every possibility that the numbers seeking assistance may not fall as much as expected. Early indications of the impact of welfare reform show significant increases of presentations in many authorities for this service.

36. Further, COSLA has less certainty over the accuracy of the costings of this aspect of the Bill due to the difficulties for local authorities in estimating the financial impact. In particular, we are not convinced that the Scottish Government have accurately estimated the average annual cost of support (£3142 per young person). This figure includes an estimate that the average cost for travel would be £400 per year; that emergency payments up to £200 per year could be payable and that payments to outside agencies (such as for third sector support) would be around £1500. It also includes an estimate of staffing costs required to support the young person. From discussions with local authorities we believe that these costs underestimate the actual cost of supporting a young person who has left care. In particular we are aware that some local authorities have indicated a concern that travel costs are not realistic and do not factor in cost of travel particularly in rural areas.

37. Finally, if the subsection detailed above remains in the Bill the actual cost will not be clear until secondary regulations have been passed potentially leading to a gap in funding which could undermine the intention of this section of the Bill.

Part 9 - Counselling Services

38. We believe the intention of this section of the Bill is to ensure that families in the early stages of distress are provided with support. The move towards early intervention is welcomed by COSLA however the provisions set out within Part 4 19 (5) already provide for this to happen under the functions of the “named person”. This section of the legislation may therefore duplicate the earlier section.
39. Further, if the section remains the term “counselling” used is unhelpful and should be replaced with support. Counselling is a specific form of formal support that will not be appropriate for all families. All forms of support (e.g. family group decision making, drug and alcohol support groups etc) should be considered after an assessment of need is carried out. Also, as there is no definition of ‘eligible child’ within the Bill it is difficult for local authorities to be able to assess the impact of this. As things currently stand local authorities are to provide undefined counselling services to parents or those with parental rights and responsibilities of an undefined group of children.

40. Further, it should be noted that as consequence of this provision children and families may also be brought into the care system at a far earlier stage than is currently the case.

Part 10 - Support for Kinship Care

41. The policy intention of kinship care orders is to help families become more able to deal with the issues which they face, without the need for formal care. The number of children looked after in formal kinship care arrangements has grown significantly in recent years and is projected to increase further. A mechanism that provides families with a better alternative to formal care is therefore welcome. It has also been well discussed over the last few years that the growth in kinship care and the corresponding increasing in kinship care allowances have put pressure on local government finance. By transferring parental rights to carers, the orders should allow families to better access other financial benefits from the DWP. The Government believes that this should go some way to reduce the financial pressure on local authorities, but it also, just as importantly, minimises the distinction between kinship care and the lives of other families.

42. In the end how successful orders prove to be at reducing payment of kinship care allowances will depend on how attractive the orders are to families. At this point of time it is difficult to project accurately how many families will take out a kinship care order. Uptake will depend on a number of factors such as impact of welfare reform, the support provided by authorities and the detail of how orders will operate - including eligibility and length of support – which will be set in secondary legislation. The interplay of these variables makes it difficult to know for certain whether the financial assumptions made by Government are accurate. Again, we would reiterate that local authorities will only be able to implement what they are funded to deliver.

43. The accuracy of the financial assumptions is the biggest issue that we have discussed with Scottish Government. When COSLA discussed with local authorities the financial implications of this aspect of the Bill no national picture emerged, and it is clear that local authorities have found it difficult to evaluate the future impact of the policies. With accuracy depending on the financial assumptions made, without actually implementing the legislation and testing the assumptions for real, there will always be a degree of risk for local authorities. For example, the Scottish Government predicts a 6.5% continual annual increase until 2019-20 of those applying for a kinship care order. Over the past 3 years Falkirk Council have seen around a 30% increase whilst Inverclyde has seen a 37% increase since 2011. Both Councils, in different ways, have proactively
supported families to move to kinship care orders. Whilst not all local authorities have experienced such significant increases this clearly demonstrates the potential increases local authorities are likely to face if the order is popular with kinship carers (which is the intention). Further, we are aware that the recent experience of some authorities of the introduction of Adoption Orders shows that the financial costs to councils were underestimated. Additionally, the assumptions relating to estimating the take-up and level of costs per Order made by Scottish Government that underpin the figures for this complex area are numerous, increasing considerably the potential for the actual costs to differ from the estimated costs.

44. The figures which have been developed by Scottish Government are a genuine attempt to assess the cost/benefits of kinship care orders. It is our hope that kinship care orders are a success and provide an alternative to formal care for some families. However, with considerable uncertainty over how many families will take up an order, the financial risk facing local government is potentially significant. The exact size of this risk depends on how accurately Scottish Government has modelled the take up of kinship care orders. We therefore believe it is necessary that both COSLA and Scottish Government jointly scrutinise and monitor the spend on this legislation to ensure that local government is, and continues to be, sufficiently resourced to carry out the new duties that will be enacted.

Part 11 - Adoption Register
45. Local authorities always put children first and will have good reasons for currently not using the register. We are aware, for example, that some local authorities already recruit enough people who are willing to adopt to meet the needs of children in their area. Councils in this position may therefore not feel an urgent requirement to join the register. Presently, consortia arrangements work very well between local authorities in various parts of the country.

46. COSLA accepts that the development of the national register is a positive one and we are aware that its usage is rising. It provides local authorities with another option when trying to place vulnerable children with adoptive families across Scotland. However, the proposal to move to a national adoption register through compulsion for local authorities should only be considered where there is complete confidence that it is in the interests of children to do this.

Part 12 - Other Reforms - Children’s Hearings
47. As mentioned in the summary to this submission, the sections of the Bill which relate to amendments to Children’s Hearings (Scotland) Act 2011 give us concern. During the passage of the 2011 Act through Parliament COSLA raised some real concerns about centralisation of services and the establishment of a new national body – Children’s Hearings Scotland (CHS) – to run what had been local services. In particular we were worried that the newly established office of National Convener would only have to consult local authorities when drawing up area support teams. There was no requirement to reach a mutual agreement. For COSLA it seemed inappropriate that an unelected official should have this power, and that it was actually more appropriate for the Convener to have to
reach agreement with local authorities concerned. In the end Parliament agreed with our position.

48. The proposed amendment in section 69 reverses the decision taken by Parliament and reinstates the original intention of Government. This is not something that COSLA can support. Whilst we have been told by both CHS and Government officials that the Convener would listen closely to views of local authorities concerned, there is still an issue of principle about the head of national body potentially acting against a decision of a democratically elected authority.

49. We are also very concerned about the proposal in section 70 to allow the National Convener to effectively compel a local authority to deliver specific support services to area support teams. At the moment CHS has to reach agreement with councils on support services. We expect that the dialogue between CHS and individual authorities is not always easy given the financial constraints faced by the whole public sector. Nonetheless, we would argue that this dialogue is necessary and allows for mutual agreement to be reached. This has to be preferable to the potential forcible allocation of staff, property and services against the will of the local authority, and potentially to the detriment of other services.

50. We would ask that Parliament considers carefully whether it is appropriate for the National Conveners of CHS to have these powers. It is COSLA strongly held view that the 2011 Act should not be amended as proposed in the Bill.

**Part 12 - Other Reforms – School Consultations**

51. COSLA currently does not have any comment to make on this section. However, we have a long standing interest in this area and will be responding to the Government’s consultation on possible changes to the Schools (Consultation) (Scotland) Act 2010. We would be happy to provide the Committee with additional evidence on any changes to the Bill that might be proposed at stage 2.

**Conclusion**

52. We acknowledge this is a long and complex response, but this matches the length and complexity of the Bill. COSLA has been working on the Bill for many months and would be happy to use our experience to help the Committee’s scrutiny of the legislation. We would therefore be happy to attend oral evidence sessions and to work with the Committee and individual members on all aspect of the Bill.

24 July 2013
1. Getting it Right for Every Midlothian Child (GIRFEMC) is a partnership within the Community Planning Partnership in Midlothian. The GIRFEMC Board includes representation from elected members, the Council, NHS, Police Scotland, Midlothian Youth Platform, voluntary sector, SCRA and the Child Protection Committee.

2. The GIRFEMC Board welcomes the Scottish Government’s request for our views as to how the proposed joint working arrangements established in the Children and Young People (Scotland) Bill will link with the work of the Midlothian Community Planning Partnership.

3. The Children and Young People (Scotland) Bill is founded on the key principles of early intervention and prevention that are designed to deliver better outcomes, more efficient use of public funds and sustainable economic growth.

4. For 2013/14 Midlothian took the opportunity to review its Community Planning process and have amalgamated the Single Outcome Agreement and Midlothian Community Plan which is known as the Single Midlothian Plan. Midlothian Council made clear its commitment to and civic leadership role for community planning by ceasing to have a separate corporate strategy, instead agreeing to adopt the Single Midlothian Plan as the Council’s strategic document. This places community planning at the centre of the ‘way forward’ for council services and requires each service plan within the Council to demonstrate how it will support the delivery of shared outcomes. Public sector partners have also agreed to use the Single Midlothian Plan as the strategic context for their service planning in the area and a Chief Finance Officers’ Group has been established, reporting to the board, to align budgets with priorities and support the planning cycle. This is work in progress and the current year’s plan does not yet reflect a shared budgeting approach.

5. The Community Planning Partnership structure includes service users in a variety of ways, from formal user groups in community care, to seeking the views of young people on specific topics through the Midlothian Youth Platform, including supporting these young people to undertake their own consultations with their peers. We recognise that the views of services users and the public is a vital part of the process and acknowledge that further work needs to be carried out in this area.
6. Each year we carry out a strategic assessment of the priorities in the Single Midlothian Plan and invite members of the public to have input. The responses received are incorporated into our strategic planning event where we discuss and agree our priorities for the forthcoming year. The GIRFEMC thematic group carries out consultation with service users and their families throughout the year and the introduction of the Children and Young People (Scotland) Bill will require additional consultation.

7. Midlothian is working closely with Colin Mair of the Improvement Services in relation to the Single Midlothian Plan and in his feedback he has said that he is pleased with our plan but we need to concentrate on fewer priorities to enable us to do them better.

8. There is an expectation that each Community Planning Partnership will demonstrate how it is giving priority to six of the 16 national outcomes. Midlothian has decided that it will focus on: -

- Economic recovery and growth
- Employment
- Early Years
- Safer and stronger communities and reducing reoffending
- Health inequalities and physical activity
- Outcomes for older people.

Midlothian has set Economic recovery and growth, Early Years and Positive destinations for young people leaving school as its key priorities.

9. In December 2012 the Council agreed to adopt the following principles across all Council services: -

- Communities are partners in service design and delivery
- Services are targeted and focused
- Best value outcomes are delivered through partnership working

For the Midlothian to achieve its aspirations significant and transformational change is required. The public have confirmed that they wish to be actively involved as partners in decision making and local service development and that resources should be redirected towards preventative approaches and to reduce inequality, even if this means the reduction of other services.

10. Throughout all priority setting exercises we ensure that our partner organisations are included with joint working at the heart of our successes in delivery of the Single Midlothian Plan’s priorities and we propose to continue to develop this when the Children and Young People (Scotland) Bill is introduced.
Local Government and Regeneration Committee
Children and Young People (Scotland) Bill
Submission from Police Scotland

I refer to the above and provide the following comment on behalf of Police Scotland.

I note at the outset that the Children and Young People (Scotland) Bill has provided guidance on wellbeing within section 74 whilst there would appear to be no such clarity in the Public Bodies (Joint Working) (Scotland) Bill. I would ask for clarity as to whether this is a deliberate position, to leave the matter silent in the latter, or if the terms set out in section 74 are intended to be a precedent applicable to both Bills.

I have hereafter provided comments related to both Bills.

The Children and Young People (Scotland) Bill

Police Scotland welcome this legislation and the clarity related to children’s rights, children's services planning, the provision of a named person service and the guidance on information sharing; all of which will promote, support or safeguard the wellbeing of the child or young person. The Bill seems entirely consistent with a drive to improve outcomes for our communities through improved joint working.

As discussed above, the provision set out in sections 74(1) and 74(2) assist greatly when advising Officers and Staff as to how we may best assess when a child is in need of support and provides a framework on which we can relay this information to partner agencies.

In particular, the role of the named person will substantially benefit and support cases where we engage with children and young people and have concerns related to their wellbeing. This opportunity for early and effective intervention, through appropriate and measured steps, will assist to prevent any escalation of concerns and minimise the opportunities for harm.

The proposals arising from this Bill affect Police Scotland as follows;

1. As a single service we have opportunities to consistently apply the principles of the Bill across the country, whilst allowing for local arrangements and engagement with partner agencies.
2. Application of the Indicators as set out in sections 74(1) and (2) supports our national training strategy and how we instruct our Officers and Staff to recognise, record, assess and share concerns appropriately.
3. The provision of a named person provides clarity on notification processes for low level concerns; and will support existing arrangements in place for child protection cases where an immediate investigation is required.
4. The duty to help the named person also provides clarity and an avenue for appropriate support to be sought when required.
5. The provision of a child’s plan will assist the Police to work more effectively with partners.

The Public Bodies (Joint Working) (Scotland) Bill

Whilst the Police Service of Scotland is not specifically mentioned in the Bill, we acknowledge that through our functions we have a clear role to play in supporting the health and wellbeing of our communities. It is a fact of Policing that we are called to attend at many varied scenarios, and our Officers and Staff are frequently the first point of contact where concerns are identified and provide opportunity for early intervention.

As indicated in the opening paragraphs above, we note the strong reference to wellbeing and would welcome consideration of the clarity provided by the above Children and Young People (Scotland) Bill being provided in this respect also.

Clearly, the Police Service of Scotland work across and with all Local Authorities and Health Board areas hence we would appreciate being involved in any consultations locally related to the development of integration plans.

Observations

The main focus of expenditure within the Public Bodies (Joint Working) (Scotland) Bill is clearly aimed at adult services. There may be value in some provision and comment being provided on impact, if any, against universal provision.

There may also be value in considering how this Bill links with the Adult Support and Protection (Scotland) Act 2007, which sets out a threshold for notifications of concerns to Local Authorities with a duty to investigate. There are many situations where the Police come across concerns, which do not meet that threshold, however uncover circumstances of concern related to a multiple of factors. As discussed above, clear definitions and understanding of ‘wellbeing’ would greatly assist in this regard.

Malcolm Graham
Assistant Chief Constable
Local Government and Regeneration Committee

Children and Young People (Scotland) Bill

Submission from the Royal College of General Practitioners

The Royal College of General Practitioners (RCGP) is the academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the ‘voice’ of general practitioners on education, training and issues around standards of care for patients.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College’s interests within the Scottish Health Service. We currently represent over 4750 GP members and Associates in Training throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

Comments

Advocating children’s rights and the ability to hold organisations and services to account is important. It will be interesting to see how it works out and what legal challenges are made. We very much hope that it improves outcomes for all children and young people and especially the most vulnerable.

1. We welcome the Children and Young People (Scotland) Bill and support its general aspirations. Specific areas that are valuable include clarification of the ‘named person’ role, improvements in permanency planning for looked after children and the provision of better early learning and childcare. We do, nevertheless, have some concerns about the lack of specificity in the draft bill in relation to provision of services to children under three years of age.

2. The only universal services used by almost all parents of children under three years are midwifery, health visiting and general practice. Each of these professions has a specific role in supporting parents, and in recent years a range of well-intentioned but ultimately misguided policies has led to a fragmentation both of the services that each is able to offer and to inter-professional communication. Examples include: recent failures of communication between midwives and GPs since the Refreshed Maternity Services Framework; the abolition of universal preventive child health contacts between six weeks and school entry in 2005 (partially reversed this year); the ending of the training of health visitors in child developmental assessment since 2001; the introduction of corporate caseloads and skill mix teams in health visiting, leading to loss of continuity of care; the disengagement of health visitors from general practices; and a progressive disengagement of GPs from the delivery of preventive
child health services. Effective preventive spending could substantially reverse these trends.

3. Our specific recommendations are as follows:
   - That the named person for preschool children should always be a qualified health visitor
   - That the professional title ‘health visitor’ be restored to its former statutory status, with specific reference to training and expertise in child development and parenting support
   - That all those working with preschool children should have a duty to report concerns about those children’s health, wellbeing and development to the named health visitor
   - That health visitors should have a statutory duty to communicate concerns about child wellbeing and development to general practitioners and to others as required
   - That general practices should have a named, attached health visitor.
   - That health visitors should have a maximum caseload of 200 children under five years, with smaller caseloads being allocated to those working in areas of deprivation or those working with high risk groups.
   - That each child should have the right to an annual assessment of developmental progress before the age of five years by a qualified health visitor or in exceptional cases by a general practitioner. These assessments should include investigation of language development, motor function, social behaviours, capacity for attention and of the parent’s relationship with the child. We know that developmental vulnerability cannot be adequately predicted on the basis of pre-existing risk factors. Furthermore there is now substantial evidence that many children with remediable problems have failed to have these problems addressed since the introduction of Scotland’s bold policy of abolishing its universal child health surveillance programme. This policy, at variance with practice in all other developed nations, should be reversed.
   - These assessments should be considered as a child’s right: parents and carers should not be considered to have an automatic right to refuse on behalf of their child. There is some evidence that children who are not seen at preventive care contacts are more likely to have problems. Failure to find ways to include all children in a universal child health programme (there are, for example, good systems for ensuring universal coverage in the Netherlands), thus risks increasing social inequity.

Specific Details within the proposals

4. SPICe document

P13 5th para re the NHS: The proposals are likely to involve at least 1 extra hour/year per child of GP work in assessing and report writing (at present often done as a goodwill gesture, but with increased level of accountability needed and increased interagency co-operation, more GP work is envisaged. To make it sustainable, costs and GP capacity needs to be factored in).
P14 “Well-being” is defined by the child being safe, healthy, achieving, nurtured, active, respected, responsible and included. “Well-being” examples would help compare one case with another so we know where the threshold is. Many children in “normal” families go through times of life when their well-being is compromised so help in knowing when to signal this would be of value. We agree we should include “Welfare” as well as well-being.

P16 Information Sharing – It would be helpful for GPs to include something from the GMC’s “Protecting Children and Young People” 2011 document. Once information has been shared without the permission of the parents or child or young person, it is difficult to keep track of what they don’t know has been shared so we would recommend that in most cases the child or young person or parent is informed when information is shared (except where it poses more risk). We attach a useful Information Sharing summary by Jonathon Leach, an RCGP member.

Early Years provision
We support good quality Early Years’ provision, but it has to be more than a crèche facility. Early identification of learning and developmental issues through proper play and learning facilities, supervision, teaching and reporting from the Early Years to the parents and GPs should be encouraged.

Looked After Children and Care Leavers
We support the proposals aimed at supporting the transition from care to independent adult life which has been sadly lacking. We support stability of placements, registration with a GP and communication with GPs on a regular basis.

P23 Counselling
Although it is clarified in the text that this means Family Mediation therapy or group therapy for those families listed. We would question the evidence of effectiveness of this expensive and potentially time-wasting exercise unless clear targets, time frames and penalties are used. Too often children and young people are returned to abusive families because of feigned compliance with “counselling”. The ones who are shown to respond are generally the milder, more straightforward cases (such as Domestic Abuse where the abused partner separates and institutes effective exclusion).

P25 Kinship care
Kinship care is challenging and the carers are often silent about their difficulties except to the GP. Those taking on kinship care need ongoing support. The children or young people have extra needs and their well-being has already been compromised.

Adoption
The proposals appear to shorten delays and unnecessary bureaucracy which very often occur in the adoption process so we hope these lead to better outcomes for those children and young people.
Reports on Corporate Parenting and Children’s Rights
Having to make regular reports on children’s and young people’s rights should keep the issue at the forefront of the corporate mind which is welcome but will involve ongoing costs.

5. Policy Memorandum

The aims of the policy are admirable. We note that those being home-schooled are not mentioned. Concerns over this group of children should prompt their inclusion in these excellent plans to improve the welfare and well-being of children and young people.

Section 1.43 Respecting, recognising, children’s rights. RCGP has many contacts in the third sector and regularly comments and supports publications connected with improving care pathways for children and young people and responding to feedback and complaints. Examples include the Contact a Family leaflet on accessing GPs, the Meningitis Trust “Yellow Book”, the Foetal Alcohol Disorders charity educational materials for GPs. RCGP is working with the National Children’s Bureau after their report (2013) “Opening the door to accessing GPs”.

Conclusion

Providing a lot of support in early years is most likely to have long lasting benefit, the evidence supports this and this is emphasised in the document. What is missing for us is supporting young adults who are out of work. GPs routinely spend a great deal of time writing letters of support for people who, due to ongoing health conditions, would have great difficulty in obtaining and maintaining work. There appears to be no organisation or person that we can refer these individuals to for support and training. We need to invest in these young people who should have a personal responsibility to contribute to society but in return society should have a responsibility to offer opportunity and training for all young people so that they have a future. The cost of this would be offset by later savings in social, medical and societal costs.

Dr John Gillies
Chair
August 2013


(10) RCGP 2022 Vision
Requests for access to Medical Records for Safeguarding Reasons
PCCSF documents © Jonathan Leach 29/05/2013

1. General Practice is increasingly being requested to supply clinical information for safeguarding reasons. On most occasions the decision to divulge information is straightforward, however it can become problematic and especially when third party information is requested (for example when it relates to the medical care of parents or carers).

2. Requests for information are usually made by social care colleagues who are governed by very similar professional guidances to health professionals. Both nationally and locally, reviews of cases reveal that frequently it is failing to pass on information that leads to harm. Whilst health professionals correctly are sometimes concerned about divulging sensitive clinical information, guidance from the General Medical Council (and others) is that a doctor is more likely to be criticised for not passing on relevant information.

3. Guidance on when and how information is to be divulged is available from a range of Organisations these include:

1. The General Medical Council

Confidentiality is important and information sharing should be proportionate to the risk of harm. You may share some limited information, with consent if possible, to decide if there is a risk that would justify further disclosures. A risk might only become apparent when a number of people with niggling concerns share them. If in any doubt about whether to share information, you should seek advice from an experienced colleague, a named or designated doctor for child protection, or a Caldicott Guardian. You can also seek advice from a professional body, defence organisation or the GMC. You will be able to justify raising a concern, even if it turns out to be groundless, if you have done so honestly, promptly, on the basis of reasonable belief, and through the appropriate channels.

Your first concern must be the safety of children and young people. You must inform an appropriate person or authority promptly of any reasonable concern that children or young people are at risk of abuse or neglect, when that is in a child’s best interests or necessary to protect other children or young people.

You must be able to justify a decision not to share such a concern, having taken advice from a named or designated doctor for child protection or an experienced colleague, or a defence or professional body. You should record your concerns, discussions and reasons for not sharing information in these circumstances.

Additionally, the GMC provides the following guidance\(^3\):

Ask for consent to share information unless there is a compelling reason for not doing so. Information can be shared without consent if it is justified in the public interest or required by law. Do not delay disclosing information to obtain consent if that might put children or young people at risk of significant harm.

Tell your patient what information has been shared, with whom and why, unless doing this would put the child, young person or anyone else at increased risk.

Get advice if you are not sure what information to share, who to share it with or how best to manage any risk associated with sharing information.

2. Working Together to Safeguard Children 2013\(^4\) provides the following guidance:

Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision.

Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Serious Case Reviews (SCRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children.

Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children.

**What to do if a request for information is received**

4. Given the very clear advice on the requirement to share information the following process is recommended with the clear understanding that there would need to be good reasons not to share relevant information.

Upon receipt for a request for information:

1. Confirm the identity of the requestor and *bona fide* nature of the information requested. This should usually be in writing and should include some information on why request is being made.
2. Confirm whether you hold any information on the patient
3. Consider whether consent to release information can be sought and if possible, gain consent. In some cases this is possible, whereas in others (for example when

---


\(^4\) Working Together to Safeguard Children - Department for Education 2013
a Police investigation is taking place), it maybe inappropriate and/or potentially unsafe.
4. If releasing information without consent, document your reasoning.
5. If not releasing information, document any advice sought and your reasoning.
6. Reply in a timely manner to the requestor providing relevant information.
7. If in doubt seek advice - this is available from local child protection specialists (such as the Named GP for Safeguarding or Named Nurse) or from Defense Organisations.
Local Government and Regeneration Committee
Children and Young People (Scotland) Bill
Submission from Scottish Fire and Rescue Service (SFRS)

How the proposals will affect the Service

The proposals will have a number of implications for the SFRS; the Service seems to fit the definition of an “other service provider” of “children’s services”.

In terms of the proposals, the SFRS may be consulted and have an opportunity to participate in or contribute to the preparation of the children’s services plan and agree the plan. These requirements would apply to any subsequent review of the plan. The SFRS would then be responsible for providing any services or related services in accordance with the plan.

If the SFRS participated it would require to have regard to any guidance issued by the Scottish Ministers after having responded to any related consultation about the guidance and additionally would be required to comply with any direction issued by Scottish Ministers.

The SFRS facilitates children’s participation in projects such as young firefighter programmes, fire reach, etc., albeit subject to the availability of funding which was previously sourced externally. Such children’s projects could potentially fall within the definition of children’s service or related service (i.e. service or support) in that it would be capable of having a significant effect on the wellbeing of children. Certainly, if not available to children generally then on occasion such projects are introduced with the stated aims and objectives of addressing children with needs of a particular type e.g. awareness of fire risks and home fire safety; deterring fire setting; deterring fire hydrant vandalism etc., although such projects are not in themselves an SFRS function at this time. The Scottish Government’s 2009 report entitled “Scotland Together”, acknowledged the importance of Fire and Rescue Service safety programmes for children and young people.

The perceived benefits that can accrue

The proposals should promote a standardised, multi-agency approach to the delivery of children’s services and it is anticipated that such action would deliver better outcomes for children and young people across Scotland.

Concerns that the Service has around the proposed legislation

Participation in inter-agency (emergency services and charity) sports projects, such as street football to deter anti-social behaviour does not appear to be caught by the definitions.
Does the Bill fit with the reform process

It is anticipated that the proposals will support a standard, formalised approach to planning and service delivery. As such it is expected that the Bill will assist the SFRS to achieve the aims of fire reform; in particular the proposals will assist to improve local services and strengthen the connection between fire services, communities and local authorities.

The Public Bodies (Joint Working) (Scotland) Bill

The role of the SFRS in the joint boards and any role the SFRS expects to have in future

It is anticipated that effective partnership working between the SFRS, local authorities and health services will continue to take place through Community Planning Partnerships.

It would be beneficial for the SFRS to be appropriately involved in planning and decision making in line with its role as a Community Planning partner agency.

With respect to Part 2 Shared Services, would the SFRS as a non-departmental body of Scottish Government fall within the definition of “persons” as currently provided for at Section 44(2)? If not, it should be included as it may wish to partake of the services narrated at Section 44(3) if these were to prove best value for public monies. The SFRS appears to fall within the definition of “Scottish public authority” provided for at Section 126 of the Scotland Act 1988 but this position is not confirmed.

Anticipated efficiencies and benefits that will arise for the SFRS from the delivery of integration plans

It is intended that integration plans will support the effective delivery of the National Performance Framework and Single Outcome Agreements. The SFRS corporate planning framework and associated key performance indicators reflect these aims and objectives. As such there are perceived benefits for the SFRS, for example more effective management of individuals who are in receipt of services and are at specific risk from fire for some reason; perhaps people suffering poor health including mental health, or addiction for example. The Scottish Government’s 2009 report entitled “Scotland Together”, acknowledged the link between house fires and casualties, and a range of health and other factors.

Anticipated effect that integration plans will have on outcomes for those receiving services

Integration should achieve a standard, formalised approach to planning and service delivery and such action should deliver better outcomes for service users.

Does the Bill fit with the reform process
It is expected that the Bill will assist the SFRS to achieve the aims of fire reform, specifically in relation to improving local services and integration with community planning partnerships.
Local Government and Regeneration Committee
Children and Young People (Scotland) Bill
Submission from UNICEF UK

Overview
1. UNICEF UK advocates for the protection and promotion of children’s rights, and UNICEF has a specific role under the United Nations Convention on the Rights of the Child (UNCRC) to give advice and assistance to States Parties in implementing children’s rights. This brief submission is intended to support the Local Government and Regeneration Committee to consider Part 3 of the Children and Young People (Scotland) Bill in light of related legislation. It focuses primarily on how obligations under the UNCRC can be effectively mainstreamed through children’s services planning and delivery.

2. UNICEF UK welcomes the leadership shown by successive Scottish governments in implementing the UNCRC, and commends the intention of the Bill to make rights a reality for children. We recognise that the rights measures in the Bill – when taken together – give new focus to children’s rights in Scotland, but are disappointed they do not amount to a stronger imperative for Ministers and public authorities to respect and protect children’s rights.

3. It is fundamentally important that the Children and Young People provide a clear and robust child rights framework for the delivery of children’s services across Scotland. This is not only to reflect the evolution of a child rights focus at a national level but also to ensure all children, regardless of their circumstances or geographical location, have the opportunity to develop to their full potential. With this in mind, we urge the Committee to actively consider the following issues in its scrutiny of Part 3 of the Bill:

   i. The Bill fails to create a systematic children’s rights framework for Scotland, within which both government decision-making and local service delivery will sit. This cultural and legal disconnect can be addressed through better integrating the rights and well-being provisions in Parts 1 and 3 of the Bill.

   ii. Complementary duties on those whose decisions and actions affect children and young people – namely public authorities – to act to give better effect to the UNCRC, rather than simply to report on what they have done to implement it.

   iii. Bringing together duties on children’s rights and children’s services reporting in order to put children’s rights at the heart of children’s services planning and delivery, improve the effectiveness of local reporting mechanisms, and to reduce the burden on public authorities.

Incorporating the UNCRC into Scots law
4. As the Committee will be aware, the UNCRC was adopted by the United Nations in 1989 and ratified by the UK Government in 1991. It was the first internationally binding human rights treaty to comprise the full range of civil, political, economic, social and cultural rights. It is a unique instrument in that it focuses on these rights in the context of the particular needs of children. The
UNCRC contains 42 substantive rights for every child under the age of 18, and places corresponding duties on governments to support children to realise those rights and develop to their full potential.

5. UNICEF UK’s experience and recent research shows that legislative steps are essential for embedding the UNCRC within legislation, policy, practice and attitudes towards children. The step-by-step approach taken by successive governments to child rights implementation has led to significant inconsistency and gaps in the extent to which children are able to enjoy the full extent of their rights. The direct incorporation of the UNCRC into Scots law would make its principles and provisions a reality for children, placing duties on Ministers and public authorities to respect and protect children’s rights, and allowing children to challenge violations of their rights. This approach would provide not only the foundation for a sustainable culture of children’s rights in Scotland but also the most effective and immediate way of putting “children and young people at the heart of planning and delivery of services and [ensuring] their rights are respected across the public sector.”

6. For more detail on the case for incorporation and UNICEF UK’s analysis of the child rights duties on Ministers in Part 1 of the Bill, see our submission to the Education and Culture Committee dated July 2013.

Building a child rights framework for local government

7. Part 3 of the Children and Young People Bill sets out a series of duties related to children’s services planning to achieve the full implementation of GIRFEC across Scotland and improve the well-being of children. These duties inter alia require local authorities and health boards (hereafter referred to as public authorities) to prepare children’s services plans every three years and report annually on their implementation. The aim of a children’s services plan is to safeguard, support and promote the well-being of children in a local area.

8. Clearly, one of the notable challenges in drafting the Children and Young People Bill has been in joining up a well-being approach to children’s services with the broader children’s rights framework Scottish Government aspires to. This disconnect risks undermining attempts to “make rights real” for children and young people in Scotland. The Bill could successfully embed children’s rights across the design and delivery of law, policy and services impacting on children and young people, but to achieve this a child rights framework needs to be introduced within children’s services planning, through which public authorities can safeguard, support and promote the rights and well-being of children in their area.

2 See consecutive reports from Together (the Scottish Alliance for Children’s Rights) on the State of Children’s Rights in Scotland
3 UN Committee on the Rights of the Child (2003), General Comment 5, paragraphs 19-20
4 Transposing the UNCRC into Scots law in the same way that the European Convention on Human Rights was transposed into UK law through the Human Rights Act 1998. This is within the power of Scottish Government and Scottish Parliament, see Aidan O’Neill QC (2012), Legal opinion for UNICEF UK.
5 Children and Young People (Scotland) Bill: Policy Memorandum, paragraph 2
9. There are many opportunities to do this within the existing clauses in the Bill, not least of which is looking creatively at how comparable duties on well-being, planning and reporting can be broadened in scope to embed a child rights based approach and include explicit duties on child rights implementation\(^7\), and also at how these reporting duties can be streamlined to enable a more efficient, effective and coherent picture of local service provision for children across local authority areas. It is also important that these duties, in and of themselves, reflect the principles of the UNCRC. For example, the planning duty in Clause 10 should explicitly reference children as a group that should participate in the development of the children’s services plan.

10. Although we welcome the greater focus that the duty on public authorities in Clause 1 (2) to \textit{report} steps they have taken to implement children’s rights will put on the UNCRC at local level, it is important to recognise that the duty is not yet accompanied by any obligation on public authorities to \textit{act} to better implement the UNCRC. This is important because it is often at the local level that children experience rights violations. This omission will have a serious impact on the extent to which a rights culture can truly be developed in Scotland – without a children’s rights duty on public authorities to reflect a duty on Ministers, the legal machinery for promoting and securing children’s rights is weaker than it otherwise could be.

11. We would like to see public authorities placed under a positive duty to implement the UNCRC to ensure that children’s rights genuinely become the framework for services and decisions that affect children and young people in Scotland. Such duties would also provide consistency across public functions both geographically but also no matter by whom those functions are delivered – local authorities, health boards, the private sector or the voluntary sector\(^8\).

12. The systematic consideration of children’s rights, and the use of a child rights based approach to delivering services for children, is essential to ensuring children’s rights are respected, protected and realised, no matter who the child is or what their personal circumstances are. UNICEF UK’s experience in developing rights-respecting programmes at a local level\(^9\), evidence from the national implementation of the Rights of Children and Young Persons (Wales) Measure 2011, and learning from the roll-out of GIRFEC to date all underline the importance of training and capacity-building on the application of children’s rights in order to improve outcomes for children. With this in mind, we strongly support the new duty on Ministers to promote awareness and – importantly – understanding of the UNCRC in Part 1 of the Bill. However, from a local implementation perspective, we would like further clarification from Ministers on

\(^7\) For example, within clauses 9 (aims of children’s services plan), 10 (process for children’s services plan), and 13 (reporting on children’s services plan)
\(^8\) UN Committee on the Rights of the Child (2005), \textit{General Comment 5}, paragraphs 40-44 – State Parties have a responsibility for ensuring the compliance of non-State actors with the UNCRC; the reporting duty on public authorities in clause 2 as it currently stands does not cover those delivering public functions such as private or voluntary sector providers.
\(^9\) UNICEF UK’s programmes in Scotland comprise the Baby Friendly Initiative, Rights Respecting Schools, and Child Rights Partners (the latter currently in development)
how this duty will be delivered (and resourced) in relation to those delivering services for children and young people.\textsuperscript{10}

\textbf{Contact details}

Sam Whyte
Policy and Parliamentary Manager
UNICEF UK
T: 020 7375 6193
samanthaw@unicef.org.uk

\textsuperscript{10} UN Committee on the Rights of the Child (2008), \textit{Concluding observations: United Kingdom of Great Britain and Northern Ireland}, paragraph 21
Thank you very much for the opportunity to contribute to the Local Government and Regeneration Committee’s examination of both the Children and Young People (Scotland) Bill, and the Public Bodies (Joint Working) (Scotland) Bill1 in terms of their implications for local authority functions and partnership/joint working.

West Lothian Community Planning Partnership has considered these pieces of legislation, and how the proposed joint working arrangements established by them will link with the development work of our partnership and are pleased to offer the following comment, -

“West Lothian Community Planning Partnership is a mature, strategic alliance with well established arrangements for joint working and achieving partnership outcomes. We have recently completed the draft version of our new Single Outcome Agreement – to be titled Achieving Positive Outcomes – which focuses on ‘tackling inequality’. The development of the new SOA has been guided and informed by forthcoming legislations and concurrent and independent reform processes and builds on an already well advanced governance structure and partnership understanding of key emerging issues such as prevention, early intervention and outcomes approaches.

The emerging agendas and proposed new legislation likely to relate to the development of the new Bills mentioned are unlikely to be against the direction of travel already agreed by the CPP Board and underpinning structures. The processes already underway to review the CPP governance structure and performance management arrangements are being developed with these potential changes in mind. The visions within these proposed legislation fit with our own ambitions for the wider community of West Lothian.”

I hope this response is useful,

Lorraine Gillies
Finance Committee

7th Report, 2013 (Session 4)

Report on The Financial Memorandum of the Public Bodies (Joint Working) (Scotland) Bill

Published by the Scottish Parliament on 26 September 2013
Finance Committee

7th Report, 2013 (Session 4)

Report on The Financial Memorandum of the Public Bodies (Joint Working) (Scotland) Bill

The Committee reports to the lead committee as follows—

INTRODUCTION

1. The Public Bodies (Joint Working) (Scotland) Bill was introduced in the Parliament on 28 May 2013.

2. The Policy Memorandum states that “the Bill is designed to establish a framework to support the integration of local authority and health board functions. The Bill will permit Scottish ministers to require the integration of, as a minimum, adult health and social care, based on the principles of a person-centred approach to service planning.”

3. The Bill provides for two distinct models of integration: delegation between partners (also referred to as lead agency arrangements and implemented by NHS Highland and Highland Council) and delegation to a body corporate model, under which a joint board is established hold an integrated budget and to allocate it between the constituent health board and local authority or authorities.

4. Under Standing Orders Rule 9.6, the lead committee is required, among other things, to consider and report on the Bill’s Financial Memorandum (FM). In doing so, the lead committee is also required to consider any views submitted to it by the Finance Committee (“the Committee”).

5. In June 2013, the Committee agreed to seek written evidence on the Financial Memorandum from a range of organisations potentially affected by the Bill. A total of twenty submissions were received.\(^1\)

6. At its meeting on 11 September 2013, the Committee took oral evidence from stakeholders and the Scottish Government bill team.

\(^1\) The written submissions are available at: http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/65999.aspx
7. Following the evidence session, further information was provided by the Bill team in relation to current targets for delayed discharge in terms of the national performance framework and the calculations used to reach some of the estimated efficiency costs set out in the FM.

8. The Bill provides for a framework to support the integration of local authority and health board functions and, permits Scottish Ministers to require the integration of, as a minimum, adult health and social care. The focus of the written and oral evidence considered by the Committee can be captured under the following headings—

- estimates of the financial implications of the Bill
- costs of transition
- realising efficiencies.

**ESTIMATES OF FINANCIAL IMPLICATIONS OF THE BILL**

9. The FM provides estimates based on the two models of integration provided for by the Bill; delegation between partners and delegation to a body corporate.

10. The FM estimates potential efficiencies of between £138 million and £157 million for health boards and local authorities from the combined effect of anticipatory care plans, reducing delayed discharge and reducing variation. However, the FM also notes—

    “That there is considerable uncertainty around these estimates and the eventual outcome and phasing will be dependent on local decisions taken by partners on resource allocation through their strategic plans.”

11. A number of the costs arising from the Bill will depend on the overall shape of the integration models that are chosen across Scotland. The Committee noted that, in discussing the potential costs arising under Part 1, the FM states—

    “...the likely case is based on the assumption that all partners, with the exception of Highland, will opt for delegation to a body corporate; this reflects feedback on the preference of partnerships between the two mains models.”

12. The uncertainties acknowledged by the Scottish Government in the FM were also commented on in written submissions. For example, Scottish Borders Partnership noted—

    “...the figures in the paper are very much estimates at this time and agree that much more research and a robust evidence base will be needed to ensure the financial assumptions accurately reflect the costs and,
importantly, the potential opportunities to both local authorities and the NHS arising from integration. Given the limited information, it is not possible to comment on the completeness of the financial implications at this stage.\footnote{Scottish Borders Partnership. Written submission, paragraph 7.}

13. Dumfries and Galloway Council also commented on this matter—

“At paragraph 35, the FM recognises that there is considerable uncertainty around the estimates in relation to projected efficiencies. It is important to recognise that this qualification applies not only to the projected efficiencies but also to a range of other estimates and timescales reflected in the document. This uncertainty is not unreasonable at this stage.”\footnote{Dumfries and Galloway Council. Written submission, paragraph 12.}

14. Other responses noted that there is ongoing work being undertaken in order to fully inform the development of integration models. For example, East Dunbartonshire Council commented—

“The five workstreams being taken forward by the Integrated Resources Advisory Group will fully inform the development. For reference these are:-

- Accounting Treatment and VAT
- The Financial Reporting
- Controls and Assurance
- Financial Management, Planning and Finance Function
- Capital and Assets.”\footnote{East Dunbartonshire Council. Written submission, paragraph 2.}

15. The Convener asked the Bill team to explain how much uncertainty they estimated that there is. In response, the Bill team stated—

“On uncertainty, part of the challenge for us is that, as in all health and social care systems in developed countries, the issues at work are highly complex. There is a wealth of evidence but that is, in itself, complex. Drawing down what potential improvements are available requires a multifaceted calculation.”\footnote{More information about the Integrated Resources Advisory Group is available at: http://www.scotland.gov.uk/Resource/0041/00416904.pdf}

16. The Committee notes that the move towards integration that the Bill provides for is complex to deliver and that at this stage it is not unreasonable for there to be uncertainty as to the costs of establishing the framework for, and the delivery of, integrated services.

17. Nonetheless, the Committee is concerned about the level of uncertainty surrounding the estimated costs set out in the FM. It will be important for

review and monitoring of the costs to be undertaken throughout the implementation of the Bill and the Committee intends to include this as part of its wider and ongoing commitment to monitor the delivery of the shift to preventative spending.

18. The Committee suggests that the lead 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.

COSTS OF TRANSITION

19. Parts 1, 2 and 3 of the Bill set out the provision which will result in costs of transition, recurring and non-recurring, falling on the Scottish Government, local authorities, health boards and other public bodies.

20. A description of the “transitional non-recurrent costs to the Scottish Government associated with Bill implementation” states that the SG “will provide approximately £16.7m” to health boards and local authorities “as partners in integration joint boards or lead agency arrangements, on a proportional basis for transitional costs, to implement the organisational development and other change management functions necessary.” It further states, however, that “in moving to these arrangements, it is reasonable to assume that health boards and local authorities will realise opportunity costs, which will be expected to support transitional arrangements.”

21. The Committee sought clarification from the Bill team as to what the opportunity costs are likely to be. The Bill team explained—

“The method that we used to calculate the transition costs was to take the Highland example…and remove from its costs any costs that do not apply under the bill, such as children’s services costs and costs that are specific to the lead agency model, to give us a transition cost estimate for the integrated joint board or body corporate model.”

In carrying out that calculation, we understood from Highland that it incurred some costs on which it did not have to expend expenditure; it covered them by reallocating resource from other budgets in its programme. We noted that as a potential opportunity for other partnerships to follow in due course, but we did not apply it to our calculations, so the estimate for transition costs in the financial memorandum makes no assumptions for opportunity costs.”

Identification of transition costs on local authorities

22. A number of responses commented that the costs on health bodies are more clearly identified and addressed than costs on local authorities, including in relation to the transitional costs identified in relation to Part 1 of the Bill.

---

9 Public Bodies (Joint Working) (Scotland) Bill. Explanatory Notes (and other accompanying documents) (SP Bill 32-EN, Session 4 (2013)), paragraph 38.
23. For example, ADSW commented—

“The...non-recurring Scottish Government investment is either targeted to Health Boards or retained to fund central government support or third sector initiatives. While we understand that CHP leadership posts will be deleted by the Bill, other management posts, including those in some local authorities, are also at risk of deletion as partnerships develop integrated management structures... Therefore we think that potential redundancy and redeployment costs will be significantly larger than those contained in the FM.”

24. This was echoed by Glasgow City Council—

“Focus of the Financial Memorandum is on the additional recurring and non-recurring costs likely to be incurred by health, with an incorrect underlying assumption that all additional local authority costs can be met from within existing resources.”

25. Dumfries and Galloway Council identified both the displacement of local authority staff and the costs of non-clinical care professionals in locality planning as areas where costs are not addressed in the FM—

“One particular point is that the FM focuses mainly on those costs likely to be incurred by the Health sector and does not sufficiently recognise those costs likely to be incurred by local authorities. For example:

- Paragraph 50 indicates that while there will be displacement costs associated with displaced Community Health Partnership posts, it is assumed that no such costs should be incurred by local authorities; and
- Paragraph 89 provides an estimate of costs associated with clinical involvement in locality planning but does not recognise potential costs associated with the involvement of other care professionals.”

26. In oral evidence to the Committee, East Dunbartonshire Council commented, in relation to organisational redevelopment, that—

“Some costs are reflected in the financial memorandum, such as those for the appointment of joint accountable officers and for the displacement of community health partnership managers – under the bill, those posts will go. However, there seems to be no reciprocal provision for the local authority side, which has management or leadership posts that will go under the new arrangements as well as management structures that are underneath them.”

27. The Bill team explained that the specific focus of the FM is on changes that arise directly as a result of provisions in the Bill—

---

11 ADSW. Written submission, paragraph 32.
12 Glasgow City Council. Written submission, paragraph 2.
“...we included a provision for the potential displacement cost of CHP general managers. We have not included any other posts, as the CHP general manager posts are the posts that will be directly removed as a result of the bill.”

28. The Bill team also commented on the information that they are able to use on the basis of the pilot in the Highland area—

“We recognise that the various partnerships are at different stages, but some of them are already implementing what they call shadow arrangements and some have already appointed people to posts, so there are different partnerships that we can use to give us a bit more assurance — or not — about costs... We would hope that the fact that the partnerships have more time to put their arrangements in place will allow them to resolve potential issues and to work through any potential for redeployment.”

29. It is clear from the evidence provided to the Committee that local authority stakeholders have significant concerns that the transition costs they will face have not been fully considered and are not reflected in the FM.

30. The Committee is not convinced that the explanation provided by the Bill team gives sufficient reassurance about the capacity for partner organisations to absorb any costs that arise for staff displacements that occur as a consequence of the provisions in the Bill.

31. The Committee recommends that the lead committee asks the Scottish Government why funding has not been provided for local authority staff displacements that may occur directly as a result of the requirements of the Bill.

Recurrent Cost Implications to Health Boards and Local Authorities from Provisions in Part 1 of the Bill

32. The estimated total recurrent cost to health boards and local authorities would be £4.55 million per annum for delegation between partners and £5.6 million per annum for delegation to a body corporate.

33. The FM does not specify whether these respective total costs would be incurred in the event that all health boards and local authorities adopted the same model exclusive of the other, but the Bill team has confirmed this to be the case. It would therefore seem reasonable to assume that the total recurring annual costs arising from the provisions in Part 1 of the Bill could be expected to be somewhere between the two figures.

Achieving a VAT neutral solution for both partnership models

34. The costs under Part 1 of the Bill identify £35,000 for the development of VAT guidance with HMRC. This guidance would be a necessary part of ensuring a VAT neutral solution could be delivered for the delegation to a body corporate.

model. (Existing HMRC guidance allows for a VAT neutral solution to the delegation between partners model.)

35. However, the potential cost exposure should a VAT neutral solution not be achieved is identified in the FM as a recurrent cost of £32 million per annum. The FM does not comment on any funding being provided to meet any cost exposure in the event that a VAT neutral position cannot be agreed with HMRC.

36. The current understanding of the issue in relation to the VAT status of the delegation to a body corporate model was set out by the Bill team in oral evidence to the Committee—

“HMRC has advised us that, in its opinion, the integration joint board – the body corporate model – is not a taxable person because it does not provide services. However, the bill includes provision that, at some point in the future, a body corporate might be empowered to do so. In that case, in HMRC’s view, the body corporate would become a taxable person and the questions of section 33 or section 41 status – in terms of the Value Added Tax Act 1994 – would need to be decided on.”\(^\text{17}\)

37. A number of responses comment on this issue, with South Lanarkshire Council stating that—

“The position in respect of reclaiming VAT is critical and requires to be confirmed in order to inform the formation of the optimum partnership model.”\(^\text{18}\)

38. ADSW commented, in relation to both VAT and staff harmonisation costs, that—

“The Financial Memorandum correctly identifies the risks to VAT recovery and staff pay and conditions harmonisation, and estimates their potential annual costs at up to £32m and up to £27m respectively. It is a matter of concern that the FM does not commit the Scottish Government to fund these pressures should they occur in the future.”\(^\text{19}\)

39. Falkirk Council also raises the question of an undertaking to review costs in the light of experience—

“This is particularly true in the case of VAT where there is a presumption that a VAT cost neutral solution will be found but a potential additional cost of £32m per annum if such a solution is not found.”\(^\text{20}\)

40. When questioned on this issue by the Committee, the Bill team set out the most current position—

\(^\text{18}\) South Lanarkshire Council. Written submission, paragraph 17.
\(^\text{19}\) ADSW. Written submission, paragraph 3.
\(^\text{20}\) Falkirk Council. Written submission, paragraph 7.
“We are close to a resolution on VAT. We have been working effectively with Her Majesty’s Revenue and Customs on the issue and have had good engagement with it. We are not yet at the point of a formal decision, but the advice that we are getting on the model that we have proposed is that, on the face of it, HMRC is in agreement with our working assumptions, which would mean that there would not be an additional VAT burden.”

41. The Committee notes that the potential exposure to VAT could represent a significant recurrent cost to local authorities. The Committee invites the lead committee to request an update from the Scottish Government on discussions with HMRC and confirmation of whether any additional funding would be made available should a VAT neutral solution not be found for the body corporate model.

Information technology costs

42. The FM provides £0.75 million up to 2014/15 for the purposes of developing IT in relation to management information to support strategic planning. In evidence to the Committee, the Bill team outlined that—

“The information we have used to support the figures in the financial memorandum is based on a project that we have had underway for a number of years, which is called the integrated resources framework.”

“The experience in health over the past five years or so has certainly been very much about the convergence of systems as opposed to creating new systems, and focusing on the standardisation of clinical information as well as the data itself. The approach very much fits the wider e-health strategy of using existing systems and accepting that sometimes the answer is not a one-size-fits-all system for every part of the country.”

43. ADSW commented on the costs going beyond those identified as falling to the central Information Service Division—

“The FM rightly notes the need to improve management information and to develop IRF jointly linked patient/client activity and cost datasets. However, all costs are seen as ISD’s, with partnerships accessing data remotely. This under-states the need for greater analytical and intelligence capacity within partnerships, and also the need to invest in IT improvements locally.”

44. North Ayrshire Council also commented on this issue from the perspective of multiple local authorities working with a single health board—

“Insufficient ICT developments and recurring costs e.g. within Ayrshire the three local authorities operate different social work management information systems.”

23 ADSW. Written submission, paragraph 33.
24 North Ayrshire Council. Written submission, paragraph 3.
45. Glasgow City Council shared this view and commented that—

“There is insufficient ICT development and recurring costs to allow for improved data sharing of information held on Health and local authority information systems. We need to integrate our IT systems so that information is only recorded once to improve the experience for the service user.”

46. The lead committee is invited 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. In particular the lead committee may wish to ask whether additional funding has been requested and, if so, why there is no discussion of this in the FM.

Harmonisation of terms and conditions for staff transferring between partner organisations

47. The FM states that, in the event that partners choose to “transfer some staff between them in order to better integrate delivery teams,” they will do so under TUPE arrangements. It goes on to note that in such cases, “there is a risk of a potential cost to partners in terms of harmonisation of terms and conditions, including equality of pay; the risk is different depending on which model of financial integration is chosen.”

48. The FM notes that staff moving from local authorities to health boards would be likely to migrate to more advantageous NHS terms and conditions but where the reverse was the case, there would “be a risk of an equal pay claim from the existing local authority staff.” It further notes the potential for such transfers to result in surpluses or deficits in pension funds but states only that “the SG is considering options for a solution to this issue and no estimate has been included in the scenarios at paragraph 121.”

49. Paragraph 121 of the FM provides “three estimates for costs associated with staff transfer under the two main models of integration” ranging from the lowest cost scenario of £nil per annum “where all partnerships opt for delegation to a body corporate model (except Highland)” to a mid-cost scenario costing £13.5 million “where half of partnerships opt for delegation to a body corporate model and half opt for delegation between partners model,” and finally to the highest cost case of £27 million per annum “where all partnerships opt for delegation between partners model with functions delegated to health boards and adult social care staff transferring to Boards.”

50. The FM predicts that “most partners will use the body corporate model” and states that “it is not intended that staff will transfer to the body corporate, but partners may nonetheless choose in time to transfer some staff between each other in the same way as under delegation between partners.”

51. In such circumstances, the FM states that “the situation would be similar to those under delegation between partners outlined above,” before noting “an additional theoretical risk” that staff may bring future claims “on the grounds that

25 Glasgow City Council. Written submission, paragraph 9.
they undertake similar duties but work for separate employers on different pay, terms and conditions, within an integrated system.”

52. However, the FM then states that “given the contingent nature of staff transfers under delegation to a body corporate, in the scenarios for potential costs described below, we have assumed that no staff will transfer under this model and have therefore assumed no harmonisation costs.”

53. On this point, Dumfries and Galloway Council noted—

“…it is important to recognise that there are significant risks associated with a number of areas, including those where the FM has assumed that the impact will be nil or cost neutral... the estimated costs associated with potential staff transfers and the harmonisation of terms and conditions indicate that these issues/costs are expected to be relatively small. Again, given the potential amounts involved and the uncertainty associated with issues such as potential pay claims, it should be recognised that there are significant risks associated with this assumption.”

54. North Ayrshire Council also commented on—

“Wider concerns around the emergence of additional staffing costs pressures and integrated teams develop. Specific examples include; harmonisation of terms and conditions – a particular issue where similar services are being provided e.g. support services; jobs being evaluated on different bases; concern re the NHS no redundancy policy and current and future pension risk around potential transfer of employees between funded and unfunded schemes and rising employer contributions.”

55. The Committee recommends that the lead committee asks the Scottish Government to provide further information about—

- the number of partnerships that have confirmed they will use the model of delegation to a body corporate
- what options are being considered in relation to the pension funding issue set out in paragraph 116 of the FM, including estimated costs and the provision of funding
- whether any additional funding would be provided to partnership bodies in the event of equal pay claims being successful.

Cost Implications to other Public Bodies from Provisions in the Bill

56. The FM states that “the performance of partnerships in achieving the nationally agreed outcomes and other relevant outcomes in relation to the delegated functions will be assessed jointly by Healthcare Improvement Scotland

---

26 Dumfries and Galloway Council. Written submission, paragraph 13-14.
and the Care Inspectorate” and estimates that “these bodies will undertake six inspections per year” at a cost of £173,362 per joint inspection.”

57. North Ayrshire Council stated—

“In the section which deals with impact on other agencies additional inspections costs have been identified, it is not clear why this would be additional to rather than different from the current inspection arrangements. Any additional costs for external inspectorates require to be matched with partnership funding to prepare for additional inspection. There is a view that rationalisation of the current inspectorates is possible as the HSCPs develop.”

58. Scottish Borders Partnership also commented—

“Additional inspection costs are identified for inspection agencies but the association costs of preparing for inspection both in the NHS and Local Authorities are not factored in.”

59. The FM further notes that “additional resource, longer term, will also be required to fund the Care Inspectorate and Healthcare Improvement Scotland for scrutiny of strategic commissioning,” estimating that this will result in a recurrent cost of £670,000 per annum.

60. However, in its submission to the Committee, Healthcare Improvement Scotland noted—

“The costings included in Part Three are estimates that were based on particular assumptions at the time of the consultation. In practice those assumptions may change and this may impact on Healthcare Improvement Scotland’s financial requirements… For Healthcare Improvement Scotland to comply with the Bill, it will be necessary to review the appropriate skills and resources to conduct the required inspections. We will consider the associated financial implications in the context of our broader financial strategy. Additional costs may require some uplift to our baseline funding which is currently reducing on an annual basis and any uplift will have to be agreed with Scottish Government finance colleagues.”

61. The Committee suggests that the lead committee requests details from the Scottish Government of any further discussions it has had with Healthcare Improvement Scotland about the estimated costs, and provision of additional funding, for delivering inspections under an integrated model.

62. The FM states that, at present, “whilst the Common Services Agency (CSA), commonly known as NHS National Services Scotland, may provide goods and services to NHS bodies in Scotland generally, it may only provide a limited range

28 Public Bodies (Joint Working) (Scotland) Bill. Explanatory Notes (and other accompanying documents) (SP Bill 32-EN, Session 4 (2013)), paragraph 122.
30 Scottish Borders Partnership. Written submission, paragraph 9.
31 Healthcare Improvement Scotland. Written submission, paragraphs 4 and 6.
of goods and services to other public bodies.”\textsuperscript{32} The Bill seeks to change this so the CSA can “offer services such as legal, procurement, counter fraud and IT support to the wider public sector, which have the potential to produce operating and cost efficiencies.”\textsuperscript{33} The FM then states that “costs to the public sector will be cost neutral. There will be no increase in the level of the Common Services Agency budget as a result of it delivering services to the wider public sector.”\textsuperscript{34}

63. NHS National Services Scotland has provided a submission which identifies a number of risks but also highlights that there is ongoing national work to manage those risks. The risks identified include—

- That revenue may fall if the procuring entity changes given that Health Boards are currently required to buy some services from the CSA
- How compliance with procurement procedures would operate and be ensured given the existing provisions that enable the sourcing of optional goods and services from the CSA by Health Boards (and vice versa) without the need for a formal procurement process.

64. \textbf{With reference to the ongoing national work cited in the submission from the CSA, the Committee suggests that the Scottish Government is asked what action has been taken to address the risks identified and on what basis the Parliament can be certain that this change will be cost neutral to the public sector.}

\section*{REALISING EFFICIENCIES}

\subsection*{Challenges to realising efficiencies}

65. Beyond the costs identified in the FM as arising directly from the Bill, a number of comments were received on the difficulties that will be presented in terms of the statutory partners being able to realise the efficiencies that will support the intention of the Bill, specifically the transfer of resource from acute service provision and the impact of demographic change.

66. East Dunbartonshire Council commented—

“\textit{There is no focus on the issues arising from the delegation of budgets and resources under each of the 2 options available which is a key area of concern and will have far reaching implications in the medium/longer term and the realism attached to releasing resources from budgets tied into acute budget without de-stabilising hospital provision.”}\textsuperscript{35}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{32} Public Bodies (Joint Working) (Scotland) Bill. Explanatory Notes (and other accompanying documents) (SP Bill 32-EN, Session 4 (2013)), paragraph 96.
\item \textsuperscript{33} Public Bodies (Joint Working) (Scotland) Bill. Explanatory Notes (and other accompanying documents) (SP Bill 32-EN, Session 4 (2013)), paragraph 97.
\item \textsuperscript{34} Public Bodies (Joint Working) (Scotland) Bill. Explanatory Notes (and other accompanying documents) (SP Bill 32-EN, Session 4 (2013)), paragraph 99.
\item \textsuperscript{35} East Dunbartonshire Council. Written submission, paragraph 5.
\end{itemize}
\end{footnotesize}
67. BMA Scotland addressed the reduction of acute hospitalisation but also comment on the demographic pressures in relation to service demands—

“Growing numbers of frail elderly patients with multiple physical co-morbidities, and often with dementia, will produce significant pressure on hospital-based services, undermining the perception that the funding necessary for quality community-based healthcare can be found solely through the transfer of resources from secondary care. There is often an assumption that the only way to develop community services is to move funding from secondary to primary care, or health to social care, rather than considering the overall resource envelope and whether that needs to change.”\(^\text{36}\)

68. The Association of Directors of Social Work (ADSW) stated—

“For the integration vision to be achieved, health and social care partnerships need to unlock the budgets currently funding emergency inpatient admissions. ADSW is extremely concerned that the Scottish Government may set the minimum inpatient budgets to be transferred to Partnerships at too low a level to deliver the step change required.”\(^\text{37}\)

69. NHS Highland noted that from experience—

“It is not clear yet, but just to hold the line in acute spend might be a good result, given the demographic increases and pressures in the acute sector. We are not yet confident that we can take large amounts of fixed costs out of the acute sector. That is untested. We are confident, however, that having all the resources in one place can only help with that.”\(^\text{38}\)

70. East Dunbartonshire Council stated that—

“There needs to be more consideration of how we meet the pressures that will be caused by demographic growth. Although integration will go some way towards addressing that, it would have been helpful had the financial memorandum set out the extent of the issue that we are going to be dealing with over the next 20 years, if we are indeed going to be predating efficiency savings on that basis.”\(^\text{39}\)

71. Responding to questions on this, the Bill team stated—

“The bill focuses on enabling parts of the NHS to use resources better across the entire spectrum of care. At present, there are artificial disconnects between boards and local authorities, all of which affect expenditure in each of those sectors. The bill’s premise is that, by bringing those things together and focusing on them all, we can better allocate the resource…

\(^{36}\) BMA Scotland. Written submission, paragraph 9.

\(^{37}\) ADSW. Written submission, paragraph 3.


There are efficiencies to be made through reallocating resources, but that will not be sufficient to offset demographic change, and we indicate that in the financial memorandum.”

72. Further expanding on this, the Bill team also reiterated the approach to integration—

“It is not really about handing money over; it is about bringing money together to reflect the care journey of the growing population of need, which largely consists of people who are frail and in their older years, but also includes other adults who have multiple and complex needs.

We are focusing in particular on the importance of strategic planning effort across primary care, social care and the particular aspects of acute hospital care that we believe lend themselves to being redesigned in favour of prevention. The key is the bringing together rather than the handing over.”

73. The Committee invites the lead committee to ask the Scottish Government what level of resource transfer from acute services provision has been identified as being required to deliver the change to delivery of integrated services. The lead committee may also wish to ask what impact this is anticipated to have in ensuring that sufficient resource remains to deliver acute services.

Efficiencies identified in the FM

74. The FM sets out three areas in which efficiencies can be realised that would release money to support the provision of integrated health and social care. These areas are—

- Anticipatory care plans
- Delayed discharge
- Reducing variation.

Anticipatory care plans

75. The FM identifies potential savings of £12 million from putting in place anticipatory care plans, explaining that this estimate is based on extrapolated figures from a study carried out in Nairn. The Committee questioned how robust the Nairn study is and the likelihood of the findings from there being deliverable elsewhere.

76. In response, the Bill team stated—

“The study is robust. It was published in the British Journal of General Practice, is second-tier and has been peer-reviewed. However, although its evidence is transferable to other partnerships in Scotland, it is contingent on

---

having an integrated approach. Nairn fostered an integrated approach between health and social care, with locality and integrated teams working closely together and a reactive response to admissions. There is no question but that it is transferable. Indeed, a subsequent study across other settings supports our initial assessment and indicates a £16 million saving.”

77. **The FM does not provide any detail of the how the estimate of £12 million has been reached.**

78. **The lead committee may therefore wish to ask the Scottish Government to provide the calculations and assumptions that led to the estimate included in the FM.**

*Delayed discharge*

79. The FM outlines anticipated efficiencies of £22 million per annum for a maximum 14 day delay in individuals being discharged from hospital. This would tie in with the NHS Scotland performance target of no-one being inappropriately delayed for more than 2 weeks by April 2015.

80. In considering the challenges of meeting that target, the Committee notes the comments made to it in oral evidence. East Dunbartonshire Council stated—

“From my perspective, to go from 28 to 14 days is asking a lot of the social work teams that will need to provide assessments in that timescale... To reflect realistic expectations about that, it might be worth considering the extent to which other partnerships are achieving the current 28-day target. As that moves to 14 days, it will become more and more difficult for teams physically to get people out in those timescales.”

81. NHS Highland also commented on this issue and what experience from other integration projects might demonstrate—

“...I think that we have set ourselves a target of beating that target. However, we currently have issues with delayed discharges, so we are looking at care-home capacity and at-home capacity. Now that such matters are under our direct control, it is in our gift to address the problem, whereas in the past we had to negotiate with the council on a joint response... I do not have the figures to hand, but I think that evidence from Torbay, where there is a similar model to the Highland model, suggested that fairly good results on delayed discharges have been achieved from the integration approach.”

82. The July 2013 statistics from the Scottish Government’s Information Services Division, set out in the table below, provide information about the achievement of delayed discharge targets.

---

### Table

<table>
<thead>
<tr>
<th></th>
<th>July 2012</th>
<th>April 2013</th>
<th>July 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed over 28 days</td>
<td>164</td>
<td>44</td>
<td>118</td>
</tr>
<tr>
<td>Delayed over 14 days</td>
<td>390</td>
<td>208</td>
<td>312</td>
</tr>
</tbody>
</table>

#### 83.
Given that the existing 28 day target was not delivered by April 2013, the lead committee is invited to pursue with the Scottish Government whether there can be any degree of certainty that 14 day target, upon which the savings set out in the FM are predicated, will actually be met in the anticipated timescale.

**Reducing variation**

#### 84.
The largest area of efficiency identified in the FM is £104 million per annum from reducing variation in per capita expenditure. To ascertain the certainty with which the figures in the FM can be regarded, the Committee sought clarification from the Bill team of the methodology used to calculate the potential efficiencies from reducing variation. The clarification provided is set out at Annexe B of this report.

#### 85.
The FM notes that this efficiency relates only to healthcare expenditure and does not include social care expenditure “due to the confounders for variation in per capita social care expenditure”. The confounders are identified as; differences in local democratic decisions, input costs, prevalence of unpaid care, the relative size of the voluntary sector or inefficiencies.

#### 86.
Referring to the estimation of costs around reducing variation, the Bill team explained—

“*We are indicating that, through the integration proposals, the difference in expenditure per head will be evident to the partnership and there will be a basis for scrutinising that. However, we are unsure about the processes that the partnerships will follow and the decisions that they will make in reviewing that information and informing their allocations subsequently. That is the uncertainty in that area. It is more uncertainty about the decisions that partnerships will take than uncertainty about the figures.*”

#### 87.
Asked how the provisions of the bill would make a difference in terms of the existing knowledge of differences in health board expenditure across partnership areas, the Bill team stated—

“We think that the bill’s provisions will give it [variation] more prominence and that there will be at least the potential for partners to scrutinise why expenditure per head in, say, Edinburgh is different from that in Midlothian. It will allow comparison of the outcomes to be achieved for the additional

---

expenditure per head and conclusions to be drawn from that. We hope that in
due course that would then inform partners’ strategic spending decisions.”

88. The Committee notes the projected savings are substantial and invites
the lead committee to ask the Scottish Government how confident it can be
that this efficiency will be realised in practice and, if not, what implications
that has for other aspects of the delivery of integrated health and social
care, such as the shift of resources from acute provision.

CONCLUSION

89. The lead committee is invited to consider this report as part of its
scrutiny of the FM for the Public Bodies (Joint Working) Scotland Bill.

---

ANNEXE A: EXTRACT FROM THE MINUTES

21st Meeting, 2013 (Session 4) Wednesday 11 September 2013

Public Bodies (Joint Working) (Scotland) Bill: The Committee will take evidence on the Financial Memorandum from—

Jean Campbell, Planning and Development Manager, East Dunbartonshire Council; Nick Kenton, Director of Finance, NHS Highland; Frances Conlan, Bill Team Leader, Christine McLaughlin, Deputy Director Finance Health and Wellbeing, Paul Leak, Integrated Resources Framework Lead, and Alison Taylor, Policy Lead, Scottish Government.
The bill’s premise behind integration is around effecting a shift in resources from emergency admissions to community-based alternatives. Obviously, there must be sufficient budget under the control of the single accountable officer to enable that and to effect that kind of change. There might be some risks if there is not enough in the pot, if you like, and the financial memorandum does not delve into risks that might arise in trying to deliver the agenda.

The Convener: The next paragraph says:

“A significant omission appears to be an estimate of the cost of the rising demographic of older people requiring a service ... given there are savings predicated on the way this will be delivered into the future.”

Can you comment further on that and talk a wee bit more about risks, which you touched on?

Jean Campbell: The financial memorandum does not go into any great detail on estimations of costs that will come from demographic growth. Studies suggest that, by 2031, we will be looking at an increase of £2.5 billion being needed in the budget. The efficiency measures that are highlighted in the financial memorandum will go some way—although not a lot of the way—towards trying to address some of that pressure.

Obviously, a lot of the efficiencies that are built into the financial memorandum are about assumptions about delivery in terms of delayed discharge and the effectiveness of anticipatory care planning. I suppose that there are risks around how successful that will be in delivering the efficiencies that are outlined in the bill, and the extent to which that will deliver in relation to the demographic pressure that we know is out there, but which is not as evident in the financial memorandum as it could be. However, certainly, work has been done elsewhere on the issue.

The Convener: Mr Kenton, would you like to comment on what we have heard so far?

Nick Kenton (NHS Highland): It is true that the bill does not delve into the impact of demographic changes. Of course, those changes are happening irrespective of the bill or integration so, in a sense, those costs are not directly relevant to the bill, so I suggest going down the route of integration as a way of trying to mitigate the impact of demographic change rather than building such mitigation into the cost of the bill. I agree with Jean Campbell that the sort of offsets that are quoted in the financial memorandum are fairly high-level costs that try to give an overview of the bill. They also rely on releasing fixed costs from the acute sector, and there are risks around that.

The key point is that the demographic changes will happen whether the bill is passed or not, and we need to address those rather than get hung up on them as part of the scrutiny of the bill.
The Convener: In NHS Highland’s submission, you say that it is reasonable to assume that the financial implications will be in line with the estimates that are made in the financial memorandum, and that the assumptions seem to be reasonable.

You also touch on an issue that the committee and the Scottish Government has wrestled with when you say:

“It is worth noting that the integration of budgets between partner bodies requires a high degree of trust and openness—and this is as much about leadership and culture as legislation.”

I think that we would all agree with that. How confident are you that that will be delivered? I know that NHS Highland has some experience of the issue.

Nick Kenton: The issue of the financial implications works on two levels. The first level concerns the costs of making the transition; I think that the bill makes a reasonable attempt to quantify them. They are quantifiable, but they pale into insignificance when compared with the wider implications of sharing budgets for real. My view is that it is hard to legislate for that—it has to be done with a degree of openness and transparency that is hard to set down in legislation. We had to place trust in our counterparts in Highland Council. It is no secret that, during our first transitional year, we had some challenging negotiations in relation to the money, but we came through that and were always open and above board.

Our move to integration began in December 2010. About a dozen key people in various parts of the organisation took that forward, working with a high degree of openness and trust. Our partnership agreement is 400 pages long. That might sound like a large document, but it does not cover every eventuality. Even in the first year, we found that issues arose that were not covered by the partnership agreement. What we always said was that, if we have to have recourse to the agreement, we have failed, to some degree, because we should be able to agree things as partners without having to go to the book.

Jean Campbell: The success of the bill will lie in its effecting a culture change in how organisations work together. In terms of money, there needs to be openness and an open dialogue between partners to effect the shifts that need to happen and to ensure that there is a realism about how that can be done. Obviously, getting the key people involved will be pivotal to ensuring that.

Nick Kenton: One thing that we found in the first year was that even with that level of openness and trust, there were times when we were almost not talking the same language from an accounting point of view, because the regimes were so different. Sometimes, there were misunderstandings rather than disagreements, and we had to work through those as we went along. It was a real learning experience; we would be happy to share that experience with colleagues who are interested in learning from our model.

The Convener: I want to talk about some of the wider issues that have been discussed. NHS Highland’s submission says:

“The wider financial consequences of integration are difficult to quantify but our belief is that these will be beneficial rather than a cost burden.”

However, you also say that

“the bill does not seem to make provision for the potential costs of transferring ownership of assets (or long term leasing of assets).”

You also point out

“the potential efficiencies from reducing delayed discharges”—

which we have touched on already—

“reducing variation and anticipatory care plans are presumably based on ‘full cost’ estimates which are therefore not fully realisable unless fixed costs are reduced as a result of the changes.”

Is there an opportunity to reduce those fixed costs? Could you comment more widely on those matters?

Nick Kenton: There is an opportunity to reduce fixed costs. It is very challenging, and it is a medium to long-term goal. As we always said when we went down our integration route, the first two years would be about bedding in and almost “business as usual”—that is the phrase that we used. In transferring £89 million and 1,500 staff one way and £8 million and 200 staff the other way, all the pensions, payroll and accounting treatments were transferred, too, so there was real potential for things to go wrong. Our hope is that all the resources for adult services being in one place in the health service will bring opportunities.

We touched on the demographic pressures earlier. It is not clear yet, but just to hold the line in acute spend might be a good result, given the demographic increases and pressures in the acute sector. We are not yet confident that we can take large amounts of fixed costs out of the acute sector. That is untested. We are confident, however, that having all the resources in one place can only help with that.

Property demonstrates a feature of the differences in accounting regimes. At the moment, we are delivering services from care homes that remain owned by Highland Council, but the services that we deliver from there are delivered by staff whom we now employ; they moved over from Highland Council. We would like to lease the buildings or own them, but even if Highland
Council wishes to sell them to us for £1—which it might be prepared to do—the accounting regime in the national health service will not allow that to happen easily. We are working with colleagues in the Scottish Government to find a way round that.

The transfer itself would be a cost. When an asset is owned in our NHS system, a cost or depreciation is paid on it; it is a real cost. In the local government system, it is a notional cost. There are significant differences in the accounting regimes. At the moment that is, in accounting terms, probably the biggest barrier to moving forward, although we are working closely with colleagues in the Scottish Government to resolve that.

Jean Campbell: We do not have the same experience that Nick Kenton has had in Highland, but natural efficiencies will come from integration in relation to management posts when there is co-location, for example. That makes delivery of services much more real for people, and efficiencies come from that. A lot can be done around information and communication technology systems by integrating them a lot more and by streamlining processes. It would be a lot more efficient to input information only once, for example.

The bigger costs and the shift of resource from the acute sector result in questions about whether that might eventually result in ward closures or the closure of buildings and so on, but those are probably quite a long way away—that is probably quite aspirational, given the demographic pressures and the fact that, even if we are able to free up beds, there are other areas of pressure in the health service that would quite easily suck up that resource for other purposes. Natural efficiencies could be made by way of assets, perhaps involving co-location and ICT systems, but the bigger aim around wards, hospitals and beds is probably longer term.

The Convener: I will ask one more question before I let the rest of the committee in. This question is to you, Ms Campbell, although Mr Kenton can of course comment, too. What concerns do you have in relation to potential equal-pay claims for staff who will be working more closely together?

Jean Campbell: There are provisions in the bill such that if we were to use the lead commissioning model, with rafts of staff—under the Transfer of Undertakings (Protection of Employment) Regulations—TUPEing over, there might be natural harmonisation of pay claims as teams come together. There are differences in the pay and conditions of occupational therapists, for example, so in an integrated occupational therapy team, people could see that their counterparts from either the health service or the local authority might be on more advantageous terms and conditions. As a result, there would, naturally, be pay claims around that. That issue might not arise as instantly as it would under a lead-commissioning model, but under a body-corporate model, it might well emerge as teams come together.

10:15

The Convener: Do you have any idea of the cost implications for a health board area of, say, the size of NHS Greater Glasgow and Clyde?

Jean Campbell: I could not comment on that.

The Convener: That would certainly be difficult to estimate.

NHS Highland is much further down the road with all this, so Mr Kenton obviously has more experience in this area. What is your view on the matter?

Nick Kenton: It is certainly worth pointing out that pay claims are a risk. I summarise our approach as proceeding with caution. We do not have a harmonisation policy, but if posts become vacant or if there is a redesign, we are—where we can—moving posts over to the relevant pay scale for the new employer. As I have said, however, we are proceeding with caution.

The Convener: I open the session to colleagues around the table; Malcolm Chisholm will be the first to ask questions.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I agree with Nick Kenton that integration can mitigate the effects of demographic change, but I suppose that that will happen only if it works properly and shifts the balance of care in a way that structural change on its own will not.

However, even assuming that it does shift the balance of care, I have to say that I do not really agree with you that demography is irrelevant, because the whole implication of the financial memorandum is that quite large savings can be delivered by reducing delayed discharge, by putting in place anticipatory care plans and by “reducing variation”. You might want to comment on what is involved in reducing variation, but we would all agree that reducing delayed discharge and anticipatory care plans are good things. However, because of demography, there is no way that they will produce those savings, which means that in that sense the financial memorandum is highly misleading.

Nick Kenton: Perhaps I did not previously express myself as I meant to. My point in response to Jean Campbell’s comment—that demographics need to be included as a cost of the bill—was that those costs will happen whether or not the bill is passed and that the issue is
therefore not directly relevant to the costs of the bill. However, it is—as I think you have suggested—a relevant part of the context and we need to be aware of it. Indeed, for me, it is one of the issues in support of the bill.

Malcolm Chisholm: Do you agree with that, Ms Campbell?

Jean Campbell: The context of that comment is our view that in seeking to predicate efficiency savings on the basis of the bill, it is relevant to consider the extent of demographic growth in order to see the extent to which integration would deal with certain issues. There needs to be more consideration of how we meet the pressures that will be caused by demographic growth. Although integration will go some way towards addressing that, it would have been helpful had the financial memorandum set out the extent of the issue that we are going to be dealing with over the next 20 years, if we are indeed going to be predicated efficiency savings on that basis.

Malcolm Chisholm: Obviously you fully understand that, but the problem is that many local authority submissions about the bill assume that significant resources can be released from acute budgets to pay for the development of services in the community. If people think that that is going to be possible, they are being misled because of the demography issue. It might be more possible in some parts of Scotland than in others; it certainly will not be possible in NHS Lothian, given our demography.

I suppose that this question is more for Nick Kenton, given his health experience. To what extent would NHS Highland be able to release money from acute budgets to shift the balance of care?

Nick Kenton: That is our aim, but at the moment we do not have a timescale. As I said, the change is a medium to long-term issue. We are looking to keep the ship steady for two years before we try to do anything clever, as it were. I do not have a glib answer to your question, but we certainly want to do what you suggest and we think that it is more likely to happen if all the resources are in one place than if there are organisational divisions between the resources.

Malcolm Chisholm: I was also puzzled by the comment in the financial memorandum that quite a lot of the savings are going to come from “reducing variation”. After all, variation can be a good or a bad thing. It might be a bad thing because it shows that the service is inefficient, or it might be a good thing because it shows that the service is better. I am interested to hear your comments about making savings by reducing variation.

Nick Kenton: We should be looking at variation across the whole NHS and local government, and not just in the context of integration. We in Highland certainly need to focus on that issue. You are absolutely right to suggest that sometimes variation can be completely appropriate, but we need to understand the issue, bring it to light and challenge it.

Malcolm Chisholm: Thank you. Those are all the questions I have, for now.

John Mason (Glasgow Shettleston) (SNP): One of the things that strikes me in all of this is that we are starting with two organisations—local government and health boards—and ending up with three. On the surface, it seems that that might make things even more expensive because there will be more bureaucracy: before a pound is spent, it will have to be approved three times rather than just twice. Is that assumption wrong?

Nick Kenton: I am not sure who you are directing the question to.

John Mason: The question is for both of you.

Nick Kenton: There are only two statutory bodies in the lead-agency model, and even under the terms of the bill the situation in Highland would not need to change much. We would need a joint committee, but we already have a strategic commissioning group that involves both organisations and which actually looks fairly similar to the proposed joint committee. As I have said, the Highland model still has only two statutory bodies.

John Mason: So, you have just been transferring between yourselves without the need for a third organisation to do all that.

Nick Kenton: That is correct.

John Mason: It has been suggested that a third organisation could be set up to do all that.

Nick Kenton: I think that that is correct with regard to the other model, but that is probably a question for the Scottish Government.

John Mason: Why did you not go down that route?

Nick Kenton: When we considered which model to introduce, there was no bill; instead, our model was put together under the terms of the Community Care and Health (Scotland) Act 2002. When in 2010 we first looked at the various models, a third-party model was considered. I am not sure whether that would have required legislation, but the view was that putting in place another body would simply put more boundaries into the system instead of eliminating them.

John Mason: That is very much my point. Do you share that concern, Ms Campbell?
Jean Campbell: The key will be in what the guidance says and the level of autonomy that the body corporate will have. It seems from the bill that the body will have quite a lot of autonomy over decisions about the pots of money that are allocated to it, and that it will be able to set clear direction on allocation of resources across the landscape to meet key outcomes. However, the bodies that sit at the back—the local authority and the health board—will need to agree those outcomes and the strategic or joint strategic commissioning plan for allocating the resources.

We should also remember that each year efficiencies will be applied to our separate annual budgets. The body corporate will be a separate entity that might have quite a lot of autonomy, but people will be concerned about two separate bodies in the background having a say over the amount of money going in and where that money should go, and about the fact that the body corporate cannot be completely autonomous and cannot make decisions without having regard to those two bodies. I think that such a move will create additional bureaucracy.

John Mason: I am quite concerned by those comments. At the moment, if £10 million goes into, say, social work, social work decides how that money is spent. In the future, however, that £10 million might be transferred to the new organisation. How hands-on will social work be with that £10 million? Will it simply hand the money over and let the new body get on with it, or will it be quite involved in decisions on how that money is spent?

Jean Campbell: The guidance will be key in setting out how that money is dealt with once it is transferred. That said, the council might transfer £10 million one year, but the next year it might have to make 3 per cent efficiencies and so might deduct 3 per cent from that £10 million, put in place a process for allocating efficiency savings or ask the body corporate to make those savings. There will need to be a dialogue between the council and the body corporate about the level of funding and the extent to which it will have a say over what happens to that funding. The guidance will make clear the level of autonomy the body will have in such decisions.

The bill suggests that the body corporate will be quite autonomous but, as the years pass, it will have to meet the efficiency pressures—or whatever else might be going on in the background—that are faced by its parent bodies. It will have to comply with those efficiencies just as happens with money that is allocated to education or sports and leisure. Everybody must contribute to the bigger agenda and the overall council and health strategies. As I said, the body corporate will be autonomous and be able to do what it likes with that £10 million, but it will have to make the efficiencies that the parent bodies must deliver on, too.

John Mason: Your council, which is relatively small, deals with Greater Glasgow and Clyde NHS Board. Will there be one joint body for Greater Glasgow and Clyde?

Jean Campbell: That has still to be determined.

John Mason: That is not determined.

Jean Campbell: It is not. Under the bill, each local authority area will have a partnership agreement, so we would expect East Dunbartonshire Council to have its own partnership agreement. However, we share hospital provision with six other local authorities.

John Mason: I presume that your council will want to ensure that the £10 million that it puts into the pot benefits its residents rather than, for example, Renfrewshire residents.

Jean Campbell: Or Glasgow residents—yes.

Nick Kenton: When Highland Council transferred the £89 million, NHS Highland had a debate with it about how much influence and control or otherwise the council would have over that funding. We debated whether we should focus on the inputs—the staff and all the transferred budgets—or the outcomes. We are in a state of flux, but we prefer to look at the outcomes and how we deliver with the £89 million rather than how many social workers have been appointed or whatever. That debate has yet to be resolved but, as we mature, I hope that we will move towards looking at the outcomes that each of the other agencies has delivered, rather than focusing on the exact amount transferred.

John Mason: I realise that neither of you is directly answerable for my next topic but I will ask the question anyway. I understand that Healthcare Improvement Scotland and the Care Inspectorate would come in and do the inspections and so on. That has the potential for duplication. Is it your understanding that both bodies would do the same thing or would they do different things?

Jean Campbell: They currently do different things—Healthcare Improvement Scotland looks at the quality of healthcare and the Care Inspectorate looks at the quality of social care delivery. However, I understand that the bodies are moving towards joint inspections.

Our child protection services have just had a joint inspection, which looked at how organisations work together to deliver jointly on outcomes. The Care Inspectorate is certainly moving towards delivering such an approach. Were that approach to continue, it would perhaps eradicate the
duplication that is out there, but that has cost implications.

**John Mason**: To be sceptical, that sounds as if two people are turning up to inspect something together, although that is probably better than two people turning up and inspecting it separately. Would it ultimately be better if just one person turned up and did the inspection? That would save 50 per cent.

**Jean Campbell**: Yes. I hope that that is the way that things will go. When the Care Inspectorate came along, it looked at the whole joint landscape of child protection delivery and how we work jointly to deliver on related outcomes. When the healthcare inspectorate comes along, I hope that it will take cognisance of that care inspection and that that will inform the level of inspection that it does. As things develop, I hope that that will come together a lot more.

**John Mason**: Mr Kenton, do you share the view that it will be in the longer term that inspections join up?

**Nick Kenton**: I am not sure that we have a formal organisational view on that, so I will speak in a personal capacity. On the one hand, joining up and integrating the inspectorate regime and the care at the same time seems to make sense; on the other, we must ensure that we do not lose expertise. For example, if the national health service is running care homes, we need to ensure that the standards applied are not the ones that apply to hospitals, as otherwise we will end up with inappropriate responses. In principle, it makes sense to join up the regimes, but we must keep an appropriate inspectorate regime for each part of the organisation.

**John Mason**: In your experience of bringing together two organisations—or at least of joint working—was there a big financial input from outside or did you cover that with your own resources?

10:30

**Nick Kenton**: We had support from the Scottish Government to the tune of about £1.5 million, of which about £900,000 was for the direct costs of transition. Because we were first in the queue, some costs have not applied to other organisations. The model that we used also had some costs for human resources support that would not necessarily apply under other models.

The rest of the support concerned differences in accounting regimes. For example, if health service staff carry their leave forward beyond the end of the financial year, the health service is required to provide for that as if the time was paid for, whereas that accounting requirement does not exist for the council. We needed help to cover some transitional changes, but that was the scale of the support.

**John Mason**: So you just needed to get the accountants to behave themselves.

**Michael McMahon (Uddingston and Bellshill) (Lab)**: Like the deputy convener, I am interested in the costs of organisational development. Paragraph 53 of the financial memorandum states:

“Support will be necessary at all levels in the new partnerships, including the establishment of new integration joint boards, or integration joint monitoring committees, through to education and training for frontline practitioners, working in new ways to support service users.”

That is perhaps a statement of fact. Does the financial memorandum take into account the costs of that organisational redevelopment? What cost implications will there be for the establishment of the new bodies?

**Jean Campbell**: Some costs are reflected in the financial memorandum, such as those for the appointment of joint accountable officers and for the displacement of community health partnership managers—under the bill, those posts will go. However, there seems to be no reciprocal provision for the local authority side, which has management or leadership posts that will go under the new arrangements as well as management structures that are underneath them. Health and social work management teams will need to be joined up to deliver on the new agenda, but the fact that those arrangements could have redundancy and displacement costs in local authorities is not reflected.

**Nick Kenton**: In the Highland model, there was no new body to staff up. We have had to restructure on the back of integration, but that has been broadly cost neutral for us.

I am not aware of any new costs for training front-line staff. As I said in an earlier answer, the initial two years are business as usual for front-line staff. Although the staff involved are now paid from a different payroll and are part of a different organisation, the delivery of front-line care is pretty much the same, so I do not see that additional training is a particular issue for them in the short term.

**Michael McMahon**: Given that the new arrangements will apply across the whole of Scotland, have you considered how the provision in the financial memorandum will apply overall rather than just from your own perspective? The changes will apply to all health boards and local authorities, so there will be cost implications. We need to consider whether the Scottish Government has taken those cost implications into account in its planning for the financial arrangements.
Nick Kenton: I can answer only from an NHS Highland point of view, so that is probably a question for the Scottish Government officials who will appear on the next panel.

The Convener: Committee members have no further questions, so I will finish with a question to each of you, although both of you might want to respond to each question. Ms Campbell, your submission says:

“Delayed Discharges—predicated on a maximum 14 day delay in hospital—is this realistic and achievable?”

Do you believe that the target is realistic and achievable?

Jean Campbell: To establish whether the target is achievable, it would be helpful to see how successful partnerships across Scotland are in achieving the current 28-day target. Certainly, I know that our authority had no delayed discharges when there was a six-week target but, in the months leading up to the current 28-day target as well as in the initial months of having it, we had some delays against it, although we are now achieving it.

The bill identifies efficiencies from using care homes and home care rather than hospital admissions, but it does not recognise that, for example, assessment teams will need to run twice as fast to undertake assessments and get people out of hospital. From my perspective, to go from 28 to 14 days is asking a lot of the social work teams that will need to provide assessments in that timescale.

Although we in East Dunbartonshire are relatively successful in attaining the targets for delayed discharge, I am aware that performance is not consistent across Scotland. To reflect realistic expectations about that, it might be worth considering the extent to which other partnerships are achieving the current 28-day target. As that moves to 14 days, it will become more and more difficult for teams physically to get people out in those timescales.

The Convener: Mr Kenton, is the new target realistic and achievable?

Nick Kenton: This is not my direct area of expertise, but I think that we have set ourselves a target of beating that target. However, we currently have issues with delayed discharges, so we are looking at care-home and care-at-home capacity.

Now that such matters are under our direct control, it is in our gift to move resources to address the problem, whereas in the past we had to negotiate with the council on a joint response. Our system should make the target more doable, but that is not to say that it is not a challenge. I do not have the figures to hand, but I think that evidence from Torbay, where there is a similar model to the Highland model, suggests that fairly good results on delayed discharges have been achieved from the integration approach.

The Convener: My final question is to Mr Kenton, although Ms Campbell might also want to comment. Your submission states that it is important to have

“sufficient local discretion to achieve the objectives the government has set out ... However, we felt that there must be a level of flexibility ... The emphasis should be on functions and not services per se to ensure that the total resource required to deliver that function is included in the integrated pot.”

Can you expand on that a wee bit?

Nick Kenton: That relates to my earlier point that we cannot legislate for everything and write everything down. Although we have a 400-page partnership agreement, it does not cover all eventualities. We need to encourage flexibility to allow partnerships to find their own local solutions.

The wording in our submission is perhaps a bit clunky, as it should have referred to “outcomes” rather than “functions”—instead of talking about “functions and not services”, it should have said “outcomes and not services”. Rather than get hung up on the minutiae of the budget transfer, we should talk about what outcomes a partnership wishes to see.

Jean Campbell: I agree that we need to focus on the outcomes that we want to deliver, although it is hard to get away from the practicalities of transfers, partnership agreements and all the minutiae required to make those happen. At the front line, we need to do the best for older people, who do not want to be in hospital and want good-quality care at home. To deliver those outcomes for older people, we need to look at what we need in the pot.

The Convener: Before I call this evidence session to a halt, do you want to make any further points to the committee?

Nick Kenton: No, thank you.

Jean Campbell: No.

The Convener: Thank you both very much. We really appreciate the responses that you have given to our questions.

I call a short recess until 10.45.

Meeting suspended
The financial memorandum estimates potential efficiency savings of between £138 million and £157 million for health boards and local authorities from the combined effect of anticipatory care plans, reduced delayed discharge and reduced variation. However, the memorandum also notes that “there is considerable uncertainty around these estimates”.

Those uncertainties have been acknowledged by a number of people who have submitted evidence to the committee. For example, Scottish Borders partnership stated that “much more research and a robust evidence base will be needed”.

Dumfries and Galloway Council said that “there is considerable uncertainty around the estimates in relation to projected efficiencies.”

How much uncertainty do you estimate there is, and how did you arrive at the relatively narrow range of between £138 million and £157 million?

Alison Taylor (Scottish Government): I will begin with a general statement on the policy and then hand over to my colleagues, who did the calculations. Would that be best?

The Convener: Sure—I am happy with that.

Alison Taylor: On uncertainty, part of the challenge for us is that, as in all health and social care systems in developed countries, the issues at work are highly complex. There is a wealth of evidence, but that is, in itself, complex. Drawing down what potential improvements are available requires a multifaceted calculation.

Paul Leak (Scottish Government): The efficiency savings are estimated across three areas: anticipatory care plans, the reduction in delayed discharges and the reduction in variation. The range relates to the calculation for delayed discharges, for which there were two assumptions—14 days and 72 hours. That explains the difference in the range.

The basis of the calculation for variation is that we can track the expenditure for health boards by population down to partnership areas. For instance, we can track how much expenditure by Lothian NHS Board is spent across the four partnerships in Lothian. That shows that there is variation. Even though there is an average spend per head across Lothian, Tayside or wherever, there is variation in the spend per weighted head for the populations of the partnership areas.

We are indicating that, through the integration proposals, the difference in expenditure per head will be evident to the partnership and there will be a basis for scrutinising that. However, we are unsure about the processes that the partnerships will follow and the decisions that they will make in reviewing that information and in forming their allocations subsequently. That is the uncertainty in that area. It is more uncertainty about the decisions that partnerships will take than uncertainty about the figures.

The Convener: Colleagues will drill down into that, so I will resist the temptation to ask further questions on the issue.

On transitional, non-recurrent costs, the financial memorandum tells us that “it is reasonable to assume that Health Boards and local authorities will realise opportunity costs, which will be expected to be used to support transitional arrangements.”

What are those opportunity costs likely to be? I know that a table is provided but, for the Official Report, will you tell us a bit more about that?

Paul Leak: The method that we used to calculate the transition costs was to take the Highland example, as Mr Kenton indicated, and remove from its costs any costs that do not apply under the bill, such as children’s services costs, and costs that are specific to the lead agency model, to give us a transition cost estimate for the integrated joint board or body corporate model.

In carrying out that calculation, we understood from Highland that it incurred some costs on which it did not have to expend expenditure; it covered them by reallocating resource from other budgets in its programme. We noted that as a potential opportunity for other partnerships to follow in due course, but we did not apply it to our calculations, so the estimate for transition costs in the financial memorandum makes no assumptions for opportunity costs.

The Convener: We have received written evidence from some local authorities, and a representative of East Dunbartonshire Council has given oral evidence today. In its submission, East Dunbartonshire Council says:

“There is no focus on the issues arising from the delegation of budgets and resources under each of the 2 options available which is a key area of concern and will have far reaching implications in the medium/longer term and the realism attached to releasing resources from
bargains tied into acute budgets without de-stabilising hospital provision.”

Will you respond to that?

Paul Leak: From my understanding of the response that was given earlier, I think that that refers to the fact that we did not include in the bill the potential benefits of the redesign of secondary care by referring specifically to that. It could be argued that some of the potential efficiencies from reducing delayed discharges reflect that.

Alison Taylor: There has previously been helpful discussion about the difficulties associated with releasing any resource from acute spend and the need to incorporate acute spending and activity in what I would describe as the strategic planning process that we are laying out for the integrated systems. The main focus in policy terms is that we do not believe that we can deliver better outcomes for people unless we ensure a strategic planning process that reflects the entire journey of care. The assumptions that are worked in about redesign of all types of provision—primary care, community care and hospital care—depend largely on the local opportunity for improvement.

Christine McLaughlin can add more from a health perspective.

Christine McLaughlin (Scottish Government): The bill covers an overall approach in relation to scope. A number of submissions have referred to the extent to which scope is included in the financial memorandum, and the memorandum sets out the total spend on adults, although it does not specify in great detail the components of resources that will come within the scope of a plan. That work has been taken forward through the integrated resources advisory group, which I chair and which includes directors of finance from local government and health, the Association of Directors of Social Work, Audit Scotland, the Chartered Institute of Public Finance and Accountancy and other bodies. The issue is how to get the best use of the total resources; we have tried to outline that up front in the financial memorandum. This is not just about what things cost and what can be identified as tangible savings but about the wider question of making best use of the total resources available.

If members are interested, I can provide the committee with details of further work in which we have asked partners to give us information about the scope of resources that each partnership is looking to put into the overall scope of the plan, but that is not identified in the financial memorandum. I had the sense that that was where some of the responses were coming from; they were about quantifying the scope. I do not know whether that answers your question.

The Convener: To a degree, it does. I will continue on costs, which are fundamental to the financial memorandum. A number of people who have submitted evidence have said that the costs on health bodies are more clearly identified and addressed than the costs on local authorities are. Why is that?

Alison Taylor: That partly reflects the fact that the financial memorandum reflects the costs incurred under the bill. As the bill—if and when it is enacted—will take community health partnerships off the statute book, it will have a direct impact on management arrangements that health boards have had in place to support CHPs.

Paul Leak: We did not have the time to consult on the financial memorandum, so we took the opportunity to work informally with the ADSW and the Convention of Scottish Local Authorities to identify costs that local government might incur. We reflected all those costs in the financial memorandum.

In addition, we used the resources advisory group that we have established to advise us on the bill’s resource implications. We did not share the detailed figures with the group, but we shared with it all the headings and areas of cost that we had identified, to get a broader assessment of the costs that might apply. We used Highland as the model for the transition costs, but we captured all the costs that both partners in Highland incurred, which we incorporated, with adjustments, into the financial memorandum.

The Convener: You mentioned the ADSW, which believes that management posts are more likely to be deleted than is being suggested. It therefore says:

“we think that potential redundancy and redeployment costs will be significantly larger than those contained in the FM.”

Alison Taylor: As you will be aware, in the discussion with previous witnesses and in other discussions on the issue, there has been some reflection on the need to ensure that local systems have the flexibility to put in place arrangements that best suit local needs and which provide a smooth, sustainable and robust transition from current patterns of provision to a more integrated model. We have worked closely with representatives of the ADSW and other pertinent bodies in formulating the figures, as Paul Leak indicated. We have not been able to fathom in detail what such changes might amount to in a general sense, because they tend to be particular to local systems.

Paul Leak: Most of the CHP general manager posts are funded by boards, but some are part funded by boards and local authorities, so the estimate of the displacement costs in relation to
those posts addresses the costs that boards and local authorities will incur. That calculation relates just to the displacement of CHP general managers, as those posts are directly affected by the bill.

The Convener: An issue that North Ayrshire Council, which is the council for my constituency, commented on was “Insufficient ICT developments and recurring costs”.

The three local authorities in my area are coterminous with a single health board. According to North Ayrshire Council, "within Ayrshire the three local authorities operate different social work management information systems."

That will be an even greater issue in the Greater Glasgow and Clyde area, although perhaps less so in Lanarkshire.

What has been taken into account in that regard? There is clearly a concern that the financial implications have not been given as much consideration as those local authorities think that they should have been given.

Paul Leak: We have included in the financial memorandum costs specifically for a project to improve management information to support strategic planning. Strategic planning is a key proposal in the bill. The information that we have used to support the figures in the financial memorandum is based on a project that we have had under way for a number of years, which is called the integrated resource framework. It links health and social care data at an individual client/patient level and aggregates that up to larger geographies—general practitioner practice areas, CHP boundaries or local authority districts.

Having based the figures in the financial memorandum on work that is under way, we propose to roll out that work to all partnerships in Scotland so that, by the time the bill is implemented, we will have linked health and social care management data that can be used by partnerships to inform their strategic planning. The figures that we have included in the financial memorandum are based on actual costs that are incurred at the moment, which have been scaled up.

The process does not involve a standardisation of systems. Essentially, it uses existing systems, draws the data in and presents it back to partners in a way that they can access.

11:00

The Convener: Thanks for that. That is very helpful.

Christine McLaughlin: I know that a number of responses suggested that a new IT system is needed. The experience in health over the past five years or so has certainly been very much about the convergence of systems as opposed to creating new systems, and focusing on the standardisation of clinical information as well as the data itself. The approach very much fits the wider e-health strategy of using existing systems and accepting that sometimes the answer is not a one-size-fits-all system for every part of the country.

That is the straightforward answer to why we have not included a very large, multimillion pound figure for IT systems at this point.

The Convener: Okay. Thank you.

I have a further point before I open up the discussion to the committee. On the clinical negligence and other risks indemnity scheme—CNORIS, which is an acronym that I do not think many of us were familiar with before we came to the bill—Falkirk Council notes in its submission:

“In respect of Clinical Negligence and Other Risks Insurance, the FM notes that the costs of obtaining indemnity from the market might be prohibitive but makes no mention of additional costs that might arise from extension of the scheme.”

Can you talk us through your thinking in that area? What might the additional costs be?

Christine McLaughlin: CNORIS is not an insurance scheme as such; rather, it is a risk-sharing scheme that is mandatory across all NHS boards. Basically, it allows the total costs of claims in any one year to be shared on an agreed basis across all the members. Currently, it does not provide for social care functions. The reason for the scheme being in the bill is to extend its provision so that, if local authorities wished to join it for the functions that are defined in the bill, they can do so. In respect of additional costs, a premium would not be put in place; it is simply about sharing costs.

This is how I envisage the scheme working if social care functions were included. We would need to have a way of identifying the risks associated with those services to be able to attribute across all members the total costs incurred in any one year. We think that it is unlikely that there would be additional costs. In fact, the scheme was put into the NHS to try to make the best use of resources and avoid anyone having to hold reserves for any potential high-value claims. The aim was to have a smoothing effect across all the service.

Going out to market for services in health does not make a great deal of financial sense because of the potential for high-value claims in areas such as obstetrics. The proposal potentially allows social care functions to benefit from the same risk-sharing agreement. The strength in the NHS
scheme is that all boards work to very similar clinical risk management standards and procedures, and one would want to maintain that integrity for anyone who joins the scheme.

I have had discussions with people who have asked about the scheme more generally. There is nothing to prohibit anyone else from looking to set up a similar scheme for other functions, but we have focused on the functions that are within the scope of the bill.

The Convener: Thank you for that comprehensive response. I now open up the discussion to colleagues.

Malcolm Chisholm: I will start with the issue of reducing variations, in relation to which Paul Leak gave the helpful Lothian example. However, I am still struggling to see how that works. That is the largest potential efficiency, but I genuinely do not really understand it.

Paul Leak said that there would be uncertainties about the decisions taken by the partnership. To stick with his Lothian example, it is not clear to me how things would be different. There are variations among the four local authorities, but there are four different partnership boards, so I am not quite sure how the bill will change anything fundamentally in that regard.

Paul Leak: We considered very carefully the figures for the financial memorandum. We started by looking at the variation in health and social care expenditure across partnership populations. However, we were aware that some of the variation in local authority expenditure per head might be due to political decisions, so we took that out of the equation. That left us with the variation across partnership areas in health board expenditure. To stick with the Lothian example, that gave us expenditure figures per head of population for the four partnerships in Lothian, which, when they were averaged out, gave Lothian’s spend per head across the whole of the Lothian population.

The premise is that, through the bill’s provisions and the establishment of the partnerships, that variation will be apparent. I think that it is apparent in some boards at the moment, but it is perhaps a marginal issue. We think that the bill’s provisions will give it more prominence and that there will be at least the potential for partners to scrutinise why expenditure per head in, say, Edinburgh is different from that in Midlothian. It will allow comparison of the outcomes achieved for the additional expenditure per head and conclusions to be drawn from that. We hope that in due course that would then inform partners’ strategic planning decisions. What I tried to explain earlier about the uncertainty in the figures is that we are unsure about the decisions that partnerships will take when they are presented with the information. We are therefore saying that there is variation and that there are potential efficiencies but that it is up to the partners to act on that information.

Malcolm Chisholm: I will not pursue that, but I am sceptical about it. We already have separate partnership boards in Lothian, so I am not quite sure why they would not be able to act now if they wanted to.

Paul Leak: The question is whether that information—the total health and social care expenditure on adults in Midlothian, West Lothian and so on—is being reported at the moment. I am not sure that it is. At the moment, I think that all that is reported is information about the direct budgets that the CHPs manage. However, the fuller information will include figures on the use of all the services by the population, which will show quite material variation.

Malcolm Chisholm: Okay. That leads me on to my next question. You referred to the uncertainty about decisions taken by partnerships, but that also goes to the financial heart of the bill. Is that just about decisions taken by partnerships? Surely the totality of the resource that they have will be determined not by the partnership but by the council and the health board. I agree with the bill’s objectives and everything that you have said about the best use of total resources and so on, but it is still not clear to me how it will work in practice.

My question is perhaps a policy one. Is the Government comfortable with allowing 32 decisions in Scotland by health boards and local authorities on how much money goes in? That will be fundamental to all that is being proposed. The particularly important decision will be about how much money goes into acute services. I do not quite see how all that is going to work in practice in an equitable way. Is there a case for having more central direction of how much goes into the integrated budget?

Paul Leak: I will answer that unless Alison Taylor wants to.

Alison Taylor: There are several points in there that we might respond to. Paul Leak will start.

Paul Leak: Alison can address policy issues afterwards.

The resource advisory group that we have established is producing professional guidance for boards and local authority finance leaders on the process for setting the initial budget and subsequent budgets. The guidance will set out all the factors that should be considered by the partners in deciding what should be in the budget. One of the factors will be any movement by the parent bodies to remove some of the variation. For example, in discussions between a partnership...
and a parent body about the subsequent allocation to the partnership, the latter might argue that the parent body was allocating £50 per head less to it than to the next-door partnership while expecting it to achieve the same outcomes as that partnership. The discussion will then be around what can be amended. Therefore, the process will involve discussion between the parent body and the chief officer in the partnership about the resource that is being allocated.

Malcolm Chisholm: That will drive up costs, because no one will say to the parent body, “You’re allocating us £50 more than you’re allocating to the next partnership.”

Paul Leak: The challenge is for the parent body to say, “We’re allocating you £50 more than before. We’re setting you a differential efficiency target to achieve the same outcomes.”

Alison Taylor: Christine McLaughlin might want to speak about how local integrated budgets are arrived at and agreed, and about the interaction and support that we are putting in place around that with local partnerships. I go back to the discussion on variation and a point that Paul Leak made a few minutes ago about the investment that we are making in improving the provision of linked data at the local level. As he said, that will go below the partnership level as we work through the process and build on the experience of the integrated resource framework.

One of the things that we have learned from that experience, which is on-going, is that the data that comes out of that work gives local clinicians a great opportunity to look at variation between their own practices. That is absolutely not an area in which bureaucrats would wish to be involved, with one saying that one kind of variation was good and another suggesting that something was not right. Colleagues who are senior clinicians and senior medical officers have been involved in leading conversations at the local level that reflect on variation in spend activity and outcomes and what that means for local practice. Obviously, it is through primary care that we see a lot of unplanned admissions, so that transparency around activity and what is going on ought to be helpful in improving quality and outcomes, particularly for a frail elderly population.

I will hand over to Christine McLaughlin to talk about acute budgets.

Christine McLaughlin: Throughout the discussions that we have had on acute budgets, it has become evident that there are two different approaches: effort can be focused either on how much is in the pot or on the outcomes that will be delivered. We have got to the point of thinking that it is more productive to focus on the outcomes. As the committee will know, there are well-defined performance management arrangements in place for local authorities and health, so delivery of outcomes will be integral to those arrangements. We are not saying that we are leaving arrangements entirely to the discretion of local partnerships. If we do not see the outcomes that we expect to see, that would just fall within the normal management arrangements that already exist.

The point that Alison Taylor made was about transparency of information and the ability to compare and benchmark. In the Scottish Government, we anticipate a lot more investment of time and energy and a lot more focus across the NHS and local government more generally than just on this part of the spend, but there is a real benefit in having much more management information that will allow better decision making.

To put all that together, it is important to make sure that there is enough scope in here to make sure that the partnerships really work, but we would prefer to focus our efforts in that regard on the extent to which the required outcomes are delivered.

Malcolm Chisholm: My final question—

The Convener: Paul Leak wants to come back in.

Paul Leak: I just want to emphasise Christine McLaughlin’s point. The main focus for hospital provision in the bill is on unplanned admissions. A significant proportion of our hospital capacity is taken up with unplanned admissions, particularly of elderly people. I do not know whether this will be done through regulations, but we will target particular specialties for partners to include within the scope of the strategic plan. A relatively small number of specialties are responsible for most of the unplanned admissions bed days for elderly people so, through the bill’s provisions, we will direct partners to include those within the minimum scope of the strategy.

Malcolm Chisholm: That leads on to my final question, because the most difficult question is about the acute budgets. We had a representative of East Dunbartonshire Council here earlier, and I was struck by how many different local authorities Greater Glasgow and Clyde NHS Board has to negotiate with. It is difficult to see how that will work in practice. Your answer implies that you will give guidance or direction on which aspects of hospital budgets will have to be included.

I suppose that this goes back to the point about demographics. We all accept the objectives around late discharge and anticipatory care, but the hospital specialties that you are thinking of will still have all their beds filled because of the demographics.
The bill’s approach is based on the idea of a stable elderly population, which would allow us genuinely to reduce the need for hospital beds and build up community services. However, everybody in Lothian tells me that, while they have to increase community provision, they also have to keep hospital beds—in fact, they are increasing the number of acute beds at present.

11:15

It is not clear to me whether the thinking behind the savings is right, or how, in practice, you can include acute services budgets. Are you basically saying that each health board will include a budget for acute services? In some cases, I do not see how that can be done. Are you saying that boards will put in a small amount of money to increase the amount of community provision? What will that do? As you must know, that is one of the NHS’s concerns about the bill.

Glasgow is a good example. If there are a number of local authorities all trying to chip away at the health budget, and yet the board still has to run all the same hospitals—one of which is currently being rebuilt—with the same number of beds, I do not see how that will work in practice.

Paul Leak: I will address the technical points. The bill focuses on enabling parts of the NHS to use resources better across the entire spectrum of care. At present, there are artificial disconnects between community provision and acute provision within boards, and between boards and local authorities, all of which affect expenditure in each of those sectors. The bill’s premise is that, by bringing those things together and focusing on them all, we can better allocate the resource.

We think that there are efficiencies to be made through that process, as we indicate in the financial memorandum. If we compare the performance of our systems with that of integrated systems in other parts of the UK—for example, the care trust in Torbay and the system in North East Lincolnshire—we can see clearly that they have much lower bed day rates than we do.

There are efficiencies to be made through reallocating resources, but that will not be sufficient to offset demographic change, and we indicate that in the financial memorandum. The bill is about using the resources that we have now more efficiently and planning strategically across all the sectors to enable better use of resource in the future.

Alison Taylor: I reiterate what Paul Leak says, which goes back to the point that I made earlier. It is not really about handing money over; it is about bringing money together to reflect the care journey of the growing population of need, which largely consists of people who are frail and in their older years but also includes other adults who have multiple and complex needs.

We are focusing in particular on the importance of a strategic planning effort across primary care, social care and the particular aspects of acute hospital care that we believe lend themselves to being redesigned in favour of prevention. The key is the bringing together rather than the handing over.

As Paul Leak says, there is of course a large unknown quantity—as has been discussed a great deal this morning—with regard to the opportunity for redirection and reprovision. However, we believe that there is evidence to suggest that such an opportunity exists.

The primary aim of the job that we were given of bringing together policy and legislation was to seek a mechanism that makes much better use of the current resource envelope. If we do not make better and more efficient use of what we have now, we will certainly not be equipped to deal with demographic change. As Paul Leak said, the financial memorandum—specifically at paragraphs 34 and 35—states that we note and are reflecting on the impact of demographic change more broadly.

Malcolm Chisholm: Surely we are bringing such aspects together now. The bill sets up a body corporate, to which resources will be handed over, but you are proposing that we move a step on from that, and have a body that is, in a certain sense, separate from health boards and local authorities.

Alison Taylor: As we reflected on how we could integrate in the broadest and most straightforward sense, it struck us that—to return to what Mr Kenton said earlier—we could follow the type of model that Highland has used. It has also been used, to good effect, in some places down south, where—to put it in the simplest terms—one body hands something to the other, which takes the lead, and the money and the functions go together in that way.

Alternatively, we reasoned that we could take a different path and bring functions and resources together by creating something in the middle of a health board and a local authority that might resemble the overlap in a Venn diagram. That is what we have sought to do, but I challenge the idea that it is separate from the health board and the local authority.

The governance arrangements that we have in mind, which we have described in the accompanying material and which we have started to outline in appropriate terms for legislation, have a clear, strong role for the health board and the local authority. The objective of the exercise is to maximise their mutual support for each other as
regards delivering services for a common population of need. We do not see that as a separate exercise.

Also, as the bill stands, the duties that are placed on that joint board relate to strategic planning. It is conceived as a central point where the health board and local authority interests must come together to plan together for the population of need, to maximum effect for the population and to maximise the potential efficiency and effectiveness of the organisations themselves.

My colleague Frances Conlan will add to that.

**Frances Conlan (Scottish Government):** In terms of the technical aspects of the bill, there is a strong role for the health board and the local authority in relation to strategic planning. The duties are on the body corporate, as described in the bill. However, there is a clear duty on that body corporate to fully consult the health board and the local authority to ensure that they are full partners in that strategic planning process.

**Malcolm Chisholm:** It is probably beyond the remit of this committee, but I merely add that both NHS Lothian and the City of Edinburgh Council think that there is a big gap between the policy memorandum and what the bill actually says. That issue needs to be ironed out in the committee process.

**Michael McMahon:** The witnesses have already had a heads-up on the area that I am concerned about, and it is not dissimilar to Malcolm Chisholm’s point. There is an element of dancing on the head of a pin when considering whether a new integration joint board or an integration joint monitoring committee is a different institution from what already exists. However, the fact is that they are referred to in the financial memorandum as separate entities.

We have to take into account education and training when it comes to the organisational redevlopment. When the financial memorandum says that

“Support will be necessary”.

I assume that that is not flags, banners and cheerleaders and that we are talking about financial support. There is a cost involved in that. We heard from Mr Kenton that Highland did not have a take on that, because it is not going to work under that system, but concerns have been raised that the cost implications of the transformation are not adequately addressed in the financial memorandum. Will you comment on that?

**Paul Leak:** The estimates for organisational development that are included in the financial memorandum were based on estimates by—goodness, I have forgotten the name.

**Alison Taylor:** It was the Scottish Social Services Council and NHS Education for Scotland.

**Paul Leak:** They were estimates for providing organisational development for the members of the integration joint boards. In addition, we are looking to develop the strategic planning capabilities within partnerships, and that is included in the estimate from the SSSC.

**Michael McMahon:** In the response that I had earlier, there was a comment on management positions being lost and redundancy costs being incurred. Have those costs been included in the financial memorandum?

**Paul Leak:** Yes. I do not have the reference point, but we included a provision for the potential displacement cost of CHP general managers. We have not included any other posts, as the CHP general manager posts are the posts that will be directly removed as a result of the bill.

**Michael McMahon:** Have numbers been discussed in relation to that and can those numbers be achieved through voluntary redundancies?

**Paul Leak:** We have set out three scenarios for the CHP general managers. One is that all the general managers are successful in applying for the chief officer posts in the joint boards; another is that none is successful in securing a chief officer post; and the third is a midway point, where half the general managers are successful. For each scenario, we then calculated the potential displacement costs, depending on the number of general managers who are not successful. In each case, we assumed that half of the people who were not successful would be made redundant and half would go on to a redeployment register and then subsequently be re-employed. I am just trying to find my notes on that.

**Christine McLaughlin:** While Paul is doing that, I will mention that we are in a fortunate position in having had a pilot of which we can take cognisance in developing the costs. However, we are aware that there was a slightly different position in Highland, partly because of the speed of implementation there.

We recognise that the various partnerships are at different stages, but some of them are already implementing what they call shadow arrangements and some have already appointed people to posts, so there are different partnerships that we can use to give us a bit more assurance—or not—about costs. Some of the partnerships have set up their shadow arrangements without additional costs being incurred, but the situation will be different in each partnership. Some might have costs because of their particular circumstances and structures, whereas others might incur insignificant costs—there is a bit of a spectrum. We would hope that
the fact that the partnerships have more time to put their arrangements in place will allow them to resolve potential issues and to work through any potential for redeployment.

Paul Leak: Paragraph 51 of the financial memorandum, on page 31 of the explanatory notes, says:

“If none of the 28 displaced Community Health Partnership general managers “are successful ... the ... cost would be £3.5m incurred in 2014/15 and £1.3m”

in the two subsequent years. If half of them are successful, it would be proportionately lower—it would be

“£1.8m incurred in 2014/15 and £0.7m”

for the two years after that.

John Mason: Continuing on the same theme, I refer to a point in the NHS Highland submission that the convener quoted earlier. It states:

“It is worth noting that the integration of budgets between partner bodies requires a high degree of trust and openness - and this is as much about leadership and culture as legislation.”

We had the example of Glasgow where, basically, that did not work. Do you feel that the bill will be sufficient, even if people do not get on with each other? Does it actually depend on attitudes?

Alison Taylor: None of us would make the leap to saying that legislation alone is sufficient, but our position and ministers’ position is that, given the shape of population need, it is reasonable, in the light of the experience of the last several years of partnership working, to place particular emphasis at this stage on the importance of effective integrated working.

In this instance, legislation can place the importance of working effectively together on a different footing. In relation to public sector leadership, it can become something that is defined in statute as necessary, which places it in a different context. Alone, however, legislation is not enough. The financial memorandum reflects on issues such as organisational and leadership development, which are key to tackling the challenges ahead. We are not starting with a clean sheet in that regard, but there is a renewed emphasis on those issues as we reflect on developing need. It is a mixed picture.

John Mason: From what I can see at a distance, Highland seems to be a good example of where things have worked well. However, my concern is that, if we repeat the process 32 times, there might be one or two cost implications. The committee’s job is to be a bit sceptical about that. If the new joint board, or whatever it is called, develops a life of its own and we effectively have three legal entities all trying to relate to one another, there are cost implications in that.

Alison Taylor: The joint board has to have some life of its own. It is meant to lead strategic planning in an integrated way, which has been set out in a fairly novel manner. However, it needs to be carefully and closely bound into a relationship with the health board and local authority. Those are the points that Frances Conlan reflected on.

You are right to say that we have seen success in Highland. There are other examples of areas that are well down the path of developing an integrated approach although, for the reasons that Mr Kenton raised, nobody at this stage is actually doing the joint board arrangement as it is described in the bill. We can learn from examples such as Edinburgh, West Lothian, West Dunbartonshire and other places that have an integrated approach in place.

Where there are challenges—we all know that there will be areas where there are specific challenges in any programme of change, particularly for something so significant—we will need to provide support and improvement support. We have established arrangements in place to help with local development as necessary and as the programme rolls out.

I am not sure whether my colleagues who have worked directly on the detail of the financial memorandum want to add any comments.

Paul Leak: No.

11:30

John Mason: I asked the representative from East Dunbartonshire Council whether, if it hands over £10 million to the joint body, that money will have to be double accounted for, because the joint body will have to scrutinise exactly what the £10 million is used for and East Dunbartonshire will also scrutinise exactly where it goes. If they do not do that, will the auditors criticise them? I fear that there might be duplication.

Alison Taylor: I recognise your concern. It is of key importance to us that, in the pursuit of improved outcomes, we do not create a whole new bureaucracy and a whole new science. I will hand over to Christine McLaughlin to reflect on how we are handling the issue.

Christine McLaughlin: The resources group is focused on the accounting impact of the arrangements, with the focus being on doing it once and being able to take an approach that we use. Hosted arrangements are in place in many services. Glasgow is a good example of such an approach being taken, because often one part of the system or one council takes the lead on a
service and provides it to others. There are some pretty tried and tested ways of ensuring that a service can be provided somewhere and that that does not result in duplication of effort, whether in accounting, bureaucracy or the administration of the people who are involved.

Our approach in the bill is to achieve transparency through the accounting process and to avoid going down the multiple accounting route or having additional bureaucracy. At this point, we do not anticipate increases in the number of staff, because staff already work in the area in CHPs and local authorities. There is nothing to suggest that there is a need to overlay anything on top of that structure. We are looking at how we can use the existing resources and infrastructure as far as possible.

**John Mason:** Do you anticipate that the specific problem that Highland Council identified with properties moving between the two sides will arise? How would that be dealt with?

**Christine McLaughlin:** We are aware of that issue, which relates to the lead agency model. There is a way of dealing with that whereby assets would be retained under local authority provision.

I am fairly confident in saying that, until now, with every issue that we have identified as an issue to be resolved, we have either resolved it or there are a couple of different options for ways in which partnerships can resolve it. Those are all probably in the category of technical issues that arise because we are working within the existing structures in local authorities and health boards. There is pretty much a way through all those issues, and we will obviously try to ensure that any solutions do not have additional financial implications.

**John Mason:** Is the VAT issue one that has been resolved, or is it one for which there are a few options?

**Christine McLaughlin:** We are close to a resolution on VAT. We have been working effectively with Her Majesty’s Revenue and Customs on the issue and have had good engagement with it. We are not yet at the point of a formal decision, but the advice that we are getting on the model that we have proposed is that, on the face of it, HMRC is in agreement with our working assumptions, which would mean that there would not be an additional VAT burden.

We are clear that we are not looking to do something that creates additional opportunity on VAT, but are looking to create a VAT neutral position. All our risk mitigation is about ensuring that we deal with the issue early and have good engagement, because from the outset we have been relatively confident that there is an approach that would not increase the VAT costs to local authorities.

**Gavin Brown (Lothian) (Con):** I want to go through a few parts of the full financial memorandum, if I may. However, before I do so, I want to clarify something. Did Paul Leak say that there was no time to consult on the financial memorandum?

**Paul Leak:** I may have used the wrong terminology. Frances Conlan will expand on that.

**Frances Conlan:** We consulted with ADSW and COSLA and with our third sector and independent sector colleagues on some of the assumptions and estimates that we have identified and are in the financial memorandum. I suppose that Paul Leak was referring to a formal consultation that might involve a wider distribution and a wider stakeholder group.

**Gavin Brown:** To be clear, you spoke to some stakeholders, but there was no formal consultation. Why was there no time for a formal consultation?

**Frances Conlan:** It was felt that the best approach was to use existing examples around the country, as my colleagues have said. Using Highland as an example, we decided that speaking to colleagues who have already made good progress on the integration of services, such as West Lothian Council and East Dunbartonshire Council, and then speaking to specific professional groups and stakeholder groups that were involved in key areas, such as the third sector, which is a big provider of care services, would be the most efficient use of our time in identifying the estimates that are in the financial memorandum.

**Gavin Brown:** Forgive me for labouring the point, but did you do that because you thought that it was a better way of working or because of the pressure of time?

**Frances Conlan:** We felt that it was the most appropriate engagement method. In fact, we have received feedback from colleagues and stakeholders to the effect that they were receptive to that approach.

**Gavin Brown:** Thank you for clearing that up.

The convener raised the issue of efficiencies, and Malcolm Chisholm raised the specific point about reducing variation. I want to go through the three categories of efficiencies in a bit more detail. I feel that the financial memorandum is a bit light. It has a bit of blurb and then it produces a figure. As a member of the Finance Committee, I find it difficult to know where the figures come from and whether they are right. We are given a figure of £104 million for reducing variation, but it could have said £204 million and I would not have
known whether that was right, based on the information in the financial memorandum.

On delayed discharges, the savings are estimated to be between £22 million and £41 million per annum. What would need to happen in order to save £22 million a year? I have to say that my background in health issues is poor, but my understanding is that that would be the saving if nobody stayed in hospital for more than 14 days. Is that correct?

**Paul Leak:** Yes. To arrive at that figure, we took the total days that are spent in hospital following the point at which people are clinically ready to go home—we counted 14 days from that point, and basically took the subsequent days that were spent in hospital. The total delayed discharge equates to something like 80 wards across Scotland, so it represents a material level of resource. The assumption was that, if there was sufficient community capacity in community health district nursing and social care to prevent those delays, those patients could go home. However, the resource that would be released from that would need to be recycled into the provision of that community capacity.

We calculated the total resource that is used for those post-14-day delays and took away from that any fixed and semi-fixed costs, so that we were left with the direct costs that should be able to be released. We then offset from that the cost of the estimated social and health care that would need to be provided in the community. The net figure was £22 million.

**Gavin Brown:** How likely is it that we will get to a stage at which nobody is delayed for more than 14 days? Is that a realistic goal or is it a best-case scenario?

**Paul Leak:** We need to recognise that we are in a dynamic situation, as we have discussed. We have increasing demand due to demographic change, so any efficiencies that we make might just create capacity to cope with increased demand in future. Nevertheless, we need to make those efficiencies, particularly in relation to delayed discharges, as the evidence is that elderly people start to experience functional decline after three days. There is, therefore, an imperative to get people home or into a homely setting as soon as possible.

Given the scale of the issue—it is not marginal; it is a material level of resource—and the clinical and care imperative, partners should, through strategic planning, be able to reorganise the resources and create the capacity that is needed in the community. They should, if you like, be able to prioritise resources to create that capacity. Of course, the question to which we do not know the answer is whether that will simply create capacity for increased demand in future.

**Gavin Brown:** Obviously, such a goal is desirable and everyone wants it but, coming back to my initial question, how likely is it and how long will it take to happen?

**Paul Leak:** The evidence from the integrated systems in Torbay, North East Lincolnshire and the Isle of Wight shows that they do not have delayed discharges and that that is possible through the redirection of resources.

**Gavin Brown:** The projected £12 million saving from anticipatory care plans is based on the Nairn study. How robust is that study and how likely is it that what happened in Nairn will be replicated elsewhere?

**Paul Leak:** The study is robust. It was published in the *British Journal of General Practice*, is second-tier and has been peer reviewed. However, although its evidence is transferable to other partnerships in Scotland, it is contingent on having an integrated approach. Nairn fostered an integrated approach between health and social care, with locality and integrated teams working closely together and a reactive response to admissions. There is no question but that it is transferable. Indeed, a subsequent study across other settings supports our initial assessment and indicates a £16 million saving.

**Gavin Brown:** The third and largest category of saving is from reducing variation. Malcolm Chisholm has already asked about that, but is the £104 million in efficiency savings to be achieved through having no variation whatever in health boards? Where do we need to get to in order to realise such a saving?

**Paul Leak:** With a four-partnership health board, we assumed that the partnerships with more than the average level of variation would in time be able to get down to the average but there would still be variation within the partnership. The saving is not achieved by removing all variation.

**Gavin Brown:** You say in the financial memorandum that such differences could be “due to differences in local democratic decisions, input costs, prevalence of unpaid care, the relative size of the voluntary sector or inefficiencies.” Are you not relying on almost all variation being down to inefficiencies?

**Paul Leak:** That sentence relates to variation in social care expenditure. For those reasons, we removed that from the analysis and focused on the variation in health board expenditure, controlling for the population’s demographic profile and differences in need—or so-called demand-side
issues. That left historical supply-side decisions as the only explanation for variation.

Gavin Brown: Can you get some of your workings to us? As I said in my opening remarks, the £104 million seems to have been just plucked out. It might be absolutely right, but I have no way of knowing.

Paul Leak: I can prepare an explanation for you.

Gavin Brown: Finally, on the issue of VAT, which is covered in the financial memorandum but has not yet been raised, your view, at least on 28 May when the bill was introduced, was that the bill was likely to be VAT neutral. However, South Lanarkshire Council has said that VAT is “critical”—obviously it will be critical if it costs £32 million—and that the issue “requires to be confirmed in order to inform the formation of the optimum partnership model”.

ADSW has also expressed concern, asking whether the Scottish Government is going to “fund these pressures should they occur”.

Has anything happened on this matter since 28 May? Are you in a position to confirm whether the bill will be VAT neutral?

Christine McLaughlin: I think that my earlier answer stands. We are still having constructive dialogue with HMRC, but we do not yet have a formal position from it on the matter. Its verbal response to the information that we have provided is that it agrees with our logic that takes us to a VAT-neutral position, but I do not want to commit it to anything at this point, because more work still has to be carried out. However, the position is encouraging.

Gavin Brown: I will not ask you to overreach but, just to be absolutely clear, are you saying that, as it stands, HMRC’s verbal position is that the bill will definitely be cost-neutral?

Christine McLaughlin: I am sorry, but that is not what I said. As Paul Leak was at the most recent meeting with HMRC, I ask him to confirm the position.

11:45

Paul Leak: The VAT issue is different for the different models. HMRC has advised us that, in its opinion, the integration joint board—the body corporate model—is not a taxable person because it does not provide services. However, the bill includes provision that, at some point in future, a body corporate might be empowered to do so. In that case, in HMRC’s view, the body corporate would become a taxable person and the question of section 33 or section 41 status—in terms of the Value Added Tax Act 1994—would need to be decided on.

For the lead agency model, the matter is slightly more settled, as there is existing HMRC guidance that relates to the Department of Health in England. With HMRC, we have been developing a Scottish version of that. In fact, NHS Highland has recently had a decision on the basis of that model that has allowed it to achieve a VAT-neutral position. We will build on that to produce Scotland-wide guidance.

Gavin Brown: For the financial memorandum, your position is that it is likely that the arrangements will be cost neutral. Is that a fair description?

Paul Leak: Yes.

Christine McLaughlin: That is certainly our working assumption, if I may put it like that. Our working assumption is that the arrangements will be VAT neutral. From our discussions so far with HMRC, there has been nothing that would change our position on that.

Jean Urquhart (Highlands and Islands) (Ind): Many of my points have already been answered in responses to earlier questions, but I have a couple of questions.

Nick Kenton mentioned earlier that NHS Highland and Highland Council have a 400-page agreement. He seemed to say that, on reflection, that was probably too detailed. Given the Scottish Government’s culture around looking at outcomes through single outcome agreements and so on, is there a bit of a mismatch in respect of agencies such as health boards? In what is a very complex situation, could such matters be simplified?

Also, the language of “integration joint boards” slightly conjures up the idea that we are creating another tier of governance. Having been associated a wee bit with the Highland experience in its early days, I cannot remember that being an issue, although that was perhaps because there was already joint working in other areas. The creation of a joint board seems to be an option, whereas I would have thought that we would be anxious for that not to happen.

Alison Taylor: Fortunately, as we have developed the policy underlying the bill, we have had the opportunity to reflect on evidence from elsewhere. As my colleagues have mentioned, evidence from one or two places in other parts of the United Kingdom demonstrates that there are significantly better outcomes from what we might describe in informal terms as better integrated working. We have been able to learn from those places.

A key lesson from all the evidence that we have reviewed—both from the written evidence and
from talking to and visiting people—is that there are no fixed structural models that will deliver better integration just by virtue of being imposed on an existing system. None of us would expect that, and I think that common sense and experience tell us that. However, there are characteristics of successful systems that we can pick up on, which is what we have tried to do in the policy and the bill. Four key characteristics, which we always return to in our discussions with people, are that better outcomes come from integrated systems where people plan together for their populations of need, where they bring their resources together, where they bring clinical leadership to the forefront of what they are doing and where they exhibit strong general leadership.

Regarding the detail that needs to be covered in what one might describe as the partnership agreement between the health board and the local authority, an important lesson that we have learned from other places is that the partnership agreement needs to be as detailed as it needs to be for local circumstance but it needs to be given thorough consideration. As Mr Kenton reflected, it is hard to anticipate every eventuality that might arise, but at the same time we do not want to end up with a massive new bureaucracy. We are currently investing effort in starting to look at the sort of guidance that will be beneficial to local partnerships to ensure that their partnership agreement captures sufficient information to deal with future challenges and to nail down the parameters of the partnership arrangement without being overwhelming. As Christine McLaughlin reflected, for financial matters, the fact that we have a living example in Scotland in Highland is tremendously helpful. We have quite a lot of work under way and we recognise the risks that are involved, but we need to offset those against the risk of failing to act.

On the language of “joint boards”, we all recognise that there is a potential tension. The reason why I have reflected on evidence from elsewhere is because the idea of planning for the population of need and bringing resources together—not just money, although that is tremendously important, but the human resources that support service delivery—seems to be what helps to shift outcomes. There are good reasons in some areas why people might not want to use the lead agency model, so we needed to provide an alternative. In describing an integration joint board, we have attempted to describe an arrangement that knits together the health board and local authority to provide the focus for that population-based planning and bringing together of the two sets of resources for delivery.

The Convener: That has exhausted questions from committee members, but I want to ask a couple more questions before we wind up. First, what target, if any, is there for delayed discharges under the national performance framework?

Alison Taylor: Ministers have established a new target for delayed discharge this year. Local partnerships are currently working towards delays of no more than 28 days—I look to Paul Leak to confirm that—and we are moving towards a 14-day target. If Paul Leak can check the timescale, that would be helpful.

Paul Leak: I will just check.

Alison Taylor: A considerable amount of effort is being invested in trying to shift the pattern of delayed discharge, in part because there is anecdotal evidence—this would apply to any such situation—that having a target makes it easier for people to focus on the issue. There is also an opportunity for improvement. Would it be best if we wrote to the committee on that point?

The Convener: Yes. I asked the East Dunbartonshire Council representative about the issue because its submission expresses concern about how realistic the 14-day target might be for some local authorities and health boards to achieve.

Alison Taylor: Ministers have reflected quite carefully on the improvement in delayed discharge over recent years in Scotland. There has been a tremendous degree of progress.

The Convener: The financial memorandum includes a dramatic graph to illustrate that.

Alison Taylor: Yes, the graph is dramatic. Evidence from elsewhere suggests that there remains opportunity for improvement. We shall write to the committee with details of the timescales for the new targets.

The Convener: Thank you.

The point of the bill is to provide improved efficiency, better outcomes and lower costs to the taxpayer, but is the bill not a bit of a halfway house? Is it not time—I am not asking for a political answer on this—to cut the Gordian knot? For example, in Ayrshire, where we have three local authorities and a health board, the local authorities already work closely with the health board and they share among themselves functions such as payroll and council tax collection. Given that they are already coming closer, could we not be more responsive to people’s needs if we had one organisation that fully merged local authorities with health boards? Could that not provide more strategic overview and reduce costs while perhaps allowing us to resurrect some of the local town councils, which people still talk about some 40 years after they were abolished, to provide locally responsive services? Could you perhaps comment on that? [Laughter.]
I ask you to comment from an efficiency, better outcomes and lower costs perspective rather than a political one.

**Alison Taylor:** Any question on public sector reform more broadly is one that we would refer to ministers.

**The Convener:** Somehow, I thought that that might be your answer, but I decided to take a chance anyway—it has certainly woken up Jamie Hepburn.

I thank committee members for their questions and our witnesses for their answers. That being all that we have on our agenda today, that is the end of today’s meeting.

*Meeting closed at 11:54.*
WRITTEN EVIDENCE TO THE FINANCE COMMITTEE

Written submissions

Association of Directors of Social Work Ltd
British Medical Association
COSLA
Dumfries and Galloway Council
East Ayrshire Council
East Dunbartonshire Council
East Lothian Council
Falkirk Council
Fife Council
Glasgow City Council
Healthcare Improvement Scotland
NHS Dumfries and Galloway
NHS Highland
NHS Lothian
NHS National Services Scotland
North Ayrshire Council
Scottish Borders Partnership
South Lanarkshire Council
West Dunbartonshire Council
West Lothian Council

Supplementary written evidence

Scottish Government Bill Team
1. The Association of Directors of Social Work (ADSW) is the professional association representing senior social work managers and Chief Social Work Officers in local government in Scotland. Health and Social Care Integration is one of two major policy initiatives – the other being Self Directed Support – that will transform adult social care. The financial underpinning for the integration legislation is a matter of some importance. We warmly welcome the Committee’s invitation to all organisations that have an interest in, or which may be affected by, the Financial Memorandum to the Public Bodies (Joint Working)(Scotland) Bill.

2. The implementation costs and financial impacts of the Bill are very difficult to estimate, partly because councils and health boards are still in the process of deciding which services are in scope and which of the two main integration models to adopt. We wish to acknowledge that the Financial Memorandum is a helpful and thoughtful document, drawing upon a wide range of evidence and analyses to help identify the key financial issues and estimate the range of likely implementation costs.

3. Our response follows the questions set out in the Finance Committee questionnaire. In summary, ADSW’s view is that:

- Legislation is likely to be better framed following consultation on draft Bills. In this case there was formal consultation on the policy proposals, but not on a draft Bill.
- For the integration vision to be achieved, health and social care partnerships need to unlock the budgets currently funding emergency inpatient admissions. ADSW is extremely concerned that the Scottish Government may set the minimum inpatient budgets to be transferred to Partnerships at too low a level to deliver the step change required.
- The Financial Memorandum’s estimates of the savings that integration may deliver (between £138m and £157m) are problematic. Even so, they are acknowledged to fall well short of the demographic pressures. According to the Final Business and Regulatory Impact Assessment, published alongside the Bill, “by 2031 total annual costs will exceed today’s by £2.5 billion, at today’s prices” – this is 16 to 18 times larger than the Memorandum’s estimates of savings.
- The Scottish Government is committed (in paragraph 68) to funding one-off implementation costs of around £16.3 million, but it is a matter for regret that there is no funding commitment to the recurring costs for health boards and local authorities arising from the Bill.
- Transition team cost estimates seem reasonable, as do those for CHP leadership redundancy and redeployment costs, but there is no recognition that some local authorities are likely also to face redundancy and redeployment costs for adult social care senior management.
• Some of the recurring costs for health boards and local authorities are likely to be understated and would benefit from further work, especially in relation to locality planning, IT, performance information, and financial and activity analysis.
• The Financial Memorandum correctly identifies the risks to VAT recovery and staff pay and conditions harmonisation, and estimates their potential annual costs at up to £32m and up to £27m respectively. It is a matter for concern that the FM does not commit the Scottish Government to fund these pressures should they occur in future.
• A larger financial risk facing local authorities is that integration will in future erode the basis for charging for non-residential social care services, putting at risk income of around £43m. This issue is not discussed in the Financial Memorandum.
• Finally, integration in tandem with other policies – prevention and more concerted action on health inequalities – is likely to reduce rather than eliminate the financial impacts of demographic change on health and social care. ADSW believes that a wider review of future options for the resourcing of health and care is required in Scotland, similar in scope (but not necessarily in outcome) to reviews undertaken in England by Derek Wanless\(^1\), Andrew Dilnot\(^2\), and others.

**ADSW RESPONSES TO FINANCE COMMITTEE QUESTIONS**

**Consultation**

*Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?*

4. The Scottish Government did not consult on the contents of a draft Bill, but on the integration proposals for integration. The consultation paper\(^3\) did not include “financial assumptions” – that is, the implementation costs of health and social care integration, now covered in the Financial Memorandum to the Public Bodies (Joint Working)(Scotland) Bill. There is therefore a marked contrast with the consultation process for Self Directed Support, which included three\(^4\) formal consultations – one on the policy, and two on the draft legislation. There has been no formal consultation on the draft integration Bill or the associated Financial Memorandum.

5. As a general principle, ADSW believes that legislation is likely to be better framed following consultation on draft Bills.

6. ADSW responded\(^5\) to the Scottish Government consultation in September 2012. Our main comments on financial issues, such as pooled budgets, concerned the need to include a significant share of NHS acute inpatient budgets within the

---


\(^4\) A fourth SDS consultation is currently underway on regulation and guidance following the Act passing into law in January 2013.

scope of the new Health and Social Care Partnerships, and the need for a more fundamental review of the future resourcing of health and social care in Scotland:

ADSW supports the intention to integrate budgets and would seek clarity regarding the establishment of these arrangements and the volume of resource to be included from the acute sector and other forms of institutional care. The Association believes that a wider review of the resourcing of health and care in the context of demographic demand is required, similar to the Dilnot review undertaken in England. Equally, there should be more focus on self-directed support and its impact on budgetary arrangements. Joint outcome based commissioning should continue to be a key driver towards outcomes focused change.

7. We also drew attention to charging issues in social care, compared to NHS services free at the point of delivery.

8. ADSW is represented on the Adult Health and Social Care Bill Advisory Group, and on the working groups that are preparing draft guidance, including the Integrated Resources Advisory Group which is considering the financial issues associated with pooled budgets, rather than the Bill implementation costs. Members of the Association also participated in the five Practitioner Engagement Events organised by the Scottish Government last summer as part of the consultation.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?

9. As stated above, there was no formal consultation on the draft FM. The normal process of government involves civil servants, and sometimes Ministers, meeting with professional associations, to discuss relevant issues in confidence. The Association has been involved with COSLA in such meetings on aspects of the draft legislation and associated documents, including the draft Financial Memorandum. Since there was no formal consultation, it would not be appropriate to comment on whether ADSW’s comments have been accurately reflected in the published Financial Memorandum.

Did you have sufficient time to contribute to the consultation exercise?

10. Yes, the Scottish Government’s formal consultation ran from 8 May to 11 September 2012.

Costs

If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?

11. The Bill has financial implications for adult social care currently provided by councils, as well as for NHS services in scope. For both council and health boards, the financial implications are of two kinds: (1) the substantial issues involved in delegating budgets and other resources on either of the two main models of integration; and (2) the shorter term issue of resourcing implementation. While the latter is the proper focus of the Financial Memorandum, ADSW wishes to draw the Committee’s attention to a key issue of concern about the extent to which acute inpatient resources are within scope of health and social care integration.
12. The Scottish Government clearly stated the case for change in its 2012 consultation paper. Health and social care integration was necessary to address the “two key disconnects” within the system:

The first disconnect is found within the NHS, between primary care (GPs, community nurses, allied health professionals etc.) and secondary care (hospitals). The second disconnect is between health and social care. (para 1.2)

13. Addressing these disconnects would allow the balance of care to shift from institutional care to services provided in the community, and resources to follow people’s needs (para 1.8). This would support more preventative strategies based on “assessment, treatment, rehabilitation and support in the community” (para 1.10) – a strategic change now made urgent by the ageing of the population and by increasing numbers of people with long term conditions or disabilities.

14. The most recent ISD “Integrated Resources Framework” information on the balance of care for older people (we do not yet have this for all adults) is shown below – hospitals and care homes account for nearly 60% of spend, and nearly 31% of all health and social care spend is on acute emergency admissions (£1.4 billion):

![IRFScotland - 65 plus health and social care 2011/12](source)

Source: available on request from Christine.Mcgregor@scotland.gsi.gov.uk

15. For the integration vision to be achieved, health and social care partnerships need to unlock the budgets currently funding inpatient admissions. They would do this by having control over a significant proportion of inpatient budgets – focussing
on specialities with high rates of emergency admissions – which in the short term would be returned to hospitals to manage current bed capacity, but in the medium to longer term would be used to take beds out of the system to fund the expansion of preventative and community based health and social care services. This would be achieved by joint strategic commissioning which would specify the hospital and community based services needed over the forward planning period to deliver better outcomes for public expenditure on health and social care.

16. There are three potential problems with this delivery model, all with potential solutions:

- First, funding. If successful, the model will reduce future demand for inpatient care but is unlikely to eliminate the need for more funding to address increased demand due to demographic change. Change funding is also needed to cover double running costs enable the expansion of community health and social care that is necessary to provide less expensive alternatives to inpatient admission. Unless demographic and change funding continues, these shifts in the balance of care will be difficult to make on the scale required. We return to this issue at the end of this submission.

- Secondly, many hospital catchments cover several local authority areas. Transferring relevant parts of hospital budgets between different health and social partnerships carries risks of destabilising hospital management. ADSW believes that these risks can be managed but that further work is required on mitigation measures as a matter of some urgency.

- Thirdly, there are issues of power. Health Boards are reluctant to lose control over in-patient budgets, and local authorities have analogous concerns about loss of control over social care. Within the medical profession “acute specialties often have the loudest voice”6. These are serious challenges that the national and local work underway on governance and cultural change needs to address.

17. While these three problems are all challenging, ADSW believes that they can be resolved, given political will and leadership. The acid test will be the quantum of acute budgets transferred to partnerships. ADSW believes that there is general agreement that all or most mental health and learning disability inpatient budgets, and those for non-obstetric GP beds, and any other continuing care or community hospital beds, should transfer to health and social care partnerships. In 2009-10, all of general psychiatry, psychiatry of old age, learning disability, and non-obstetric GP beds, accounted for adult spend of around £621 million, or about 18% of total inpatient spend on adults (aged 15+ for this illustrative modelling).

18. At the time of writing there is less agreement about the budgets for other inpatient specialisms. However, if we are serious about the resource following the person, and establishing commissioning budgets genuinely capable of reducing emergency admissions and shifting the balance of care, then our focus needs to be

---

on redesigning the emergency care pathway. This would mean transferring inpatient budgets for range of acute and other inpatient resources including: front door (accident and emergency), general medicine and receiving services, and those specialisms which are mainly emergency-driven: such as medicine of the elderly, rehabilitation medicine, and palliative medicine— all of which currently spend more than 70% of their annual budgets on unplanned admissions. Their combined spend on adults in 2009-10 was just under £1 billion. With the £621 million mentioned earlier, the combined budgets of £1.6 billion amount to 46% of the total inpatient spend but 64% of expenditure on emergency inpatient admissions. (In time, there is also a case for further extending the commissioning budgets to include other specialism such as respiratory medicine, renal medicine and cardiology, which also currently spend more than 70% of their annual budgets on unplanned admissions).

19. The Scottish Government is currently preparing guidance on this issue. We are extremely concerned that this may set the minimum inpatient budgets to be transferred to Partnerships at too low a level to deliver the step change required. Without control over a significant proportion of inpatient budgets, the new Health and Social Care Partnerships will not be able to commission the changes to the whole system of care that are necessary to achieve the vision for integration; by itself “joint strategic planning”, without responsible power over budgets, will prove to be insufficient.

20. This is now the most important financial issue concerning health and social care integration. Our comments on the implementation costs and savings in the Financial Memorandum are in the next section.

Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?

21. The FM does not project costs and savings over 15 years for each service. The timescale for the Scottish Government costs in Part One is the five years 2012/13 to 2016/17; for recurrent costs to health boards and local authorities in Part Two, the timescale is 2014/15, then recurring costs from 2015/16. The earlier “Background” section of the FM mentions demographic cost pressures to 2030 arising from the ageing of the population, which paragraph 34 implies are much larger than “potential efficiencies” arising from health and social care integration. We comment first on demographic cost pressures and the potential savings from integration described in the “Background” section of the FM.

Demographic cost pressures and savings

22. Paragraph 34 states:

The Bill will enable Health Boards and local authorities to plan and deliver holistic integrated health and social care services and to improve efficiency in allocation and utilisation of their joint resources. In summary, it is estimated that the potential efficiencies for partnerships from the combined effect of Anticipatory Care Plans, reducing Delayed Discharge and reducing variation, to be between £138m and £157m. These potential efficiencies should be considered in the context of the scale of the projected increase in expenditure
attributable to demographic change, noted in paragraph 17, and will need to be reinvested within the partnerships in order to help meet demand.

23. ADSW welcomes this acknowledgement that any savings require to be reinvested. The FM refers in paragraph 17 to demographic projections of the increasing numbers of older people in Scotland but does not give data on costs. That can be found on page 5 of the Final Business and Regulatory Impact Assessment published\(^7\) by the Scottish Government alongside the Bill:

The challenge for health and social care services is seen in projections for demographic change in terms both of the expected growth in the older population and in terms of rising costs for health and social care for all ages. Over the next 20 years health and social care costs in Scotland are expected to rise by a total of £2.5 billion, so that by 2031 total annual costs will exceed today’s by £2.5 billion, at today’s prices.

24. The figure of £2.5 billion is consistent with the figures on page 11 of the Finance Committee’s recent report on Demographic change and an ageing population (February 2013) for the middle estimate (scenario 3) for health and social care demand projections. It is considerably larger than the savings estimates of between £138m and £157m contained in the FM.

25. The FM savings estimates are problematic. The anticipatory care savings of £12m per year are modest and are based on grossing up a small pilot project\(^8\) in Nairn (para 29). Anticipatory care planning\(^9\) is used to support people living with a long term condition to plan for an expected change in health or social status. It also incorporates health improvement and staying well. Completion of a common document called an anticipatory care plan is suggested for both long term conditions and in palliative care. The results of the Nairn pilot were encouraging, but grossing up potential savings to Scotland from a study of 96 patients receiving ACP in Nairn is bound to involve a wide margin of error.

26. Delayed discharge: Chart 1 at paragraph 25 of the FM shows a dramatic fall in the number of people in hospital whose discharge is delayed from over 3,000 in early 2002 to under 500 in April 2008, since when numbers have fluctuated. The FM acknowledges that “progress has been more difficult in recent years” but does not explain why. The Final BRIA identifies “Savings from reduced cost shunting e.g. reduced delayed discharges” as one of the benefits of integration (also mentioned at para 159 of the Policy Memorandum). Certainly for some individuals with high cost care needs there have difficulties in securing the joint NHS and council funding to support timely discharge from hospital; however, such “cost shunting” cases are not sufficiently numerous to explain the difficulty in making further progress to reduce

---

\(^7\) Final Business and Regulatory Impact Assessment (May 2013) http://www.scotland.gov.uk/Publications/2013/05/3959
delayed discharges. Data from Edinburgh, for example, suggests other causes: a 5.4% increase in home care hours in 2012-13, compared to the previous year, still left delayed discharge numbers at much the same levels. As more people are discharged, their beds are filled with new admissions who in turn become delayed.

27. The FM states that delayed discharge can be reduced by “by reallocating expenditure from hospital to community based health and social care to facilitate timely departure from hospital and provide alternatives to admission to hospital”. If no-one waited for more than 14 days £22m per year could be saved, increasing to £41m if no-one waited for more than 72 hours (paragraph 27). These calculations are based on the cost differences between inpatient beds and a weighted average of residential and home-based care. However, unless longer term investment capable of reducing future admission to hospital is increased, these savings are unlikely to be realised. The goal must be to ensure that GPs can get direct access to services or resources to care for someone at home as easily as it is currently to admit someone to a hospital or care home. In turn this requires that all GPs know about the services and resources available in Partnerships, and know that using them will deliver better outcomes for their patients.

28. The £104m savings modelled in the FM from “reducing variation” in health spend per weighted population down to the average are even less convincing. The statement that “For healthcare, the variation cannot be explained by differences in need across partnership populations or in input costs and may be due to inefficiencies” (para 30) assumes that populations weighted by the “NRAC” resource allocation variables adequately reflect all spending needs – a bold claim for any resource allocation formula, however good. Moreover annual health board budget allocations still reflect the phased changes from the previous “Arbuthnot” allocation formula to the current National Resources Allocation Committee (NRAC) formulae. So variation in NRAC standardised spend per head could reflect imperfections in the measures of need, transitional allocations, or externalities such as council spend (acknowledged in para 30), levels of unpaid care, inputs by of the third sector, etc

Implementation costs

29. The first point to note is that the Scottish Government is committed (in paragraph 68) to funding one-off implementation costs of around £16.3 million (table 1 on page 28) in “Part One” of the FM, but makes no similar commitment in relation to the “recurrent cost implications to health boards and local authorities set out in “Part Two”. ADSW discussions with civil servants indicate that these will not be funded. Part Two also contains some potentially high, if uncertain, costs from VAT exposure and potential staff pay and conditions harmonisation. Finally, throughout the FM there is a sense in which NHS costs are better understood and supported than local authority costs.

30. In Part One, the largest non-recurring transitional cost is for “Transition Team” costs intended to cover “leading and overseeing the transition arrangements” in each partnership. These are modelled for the 31 partnerships (Highland is already funded), using Highland’s costs adjusted for services out of scope, and potential savings from “opportunity costs” (ie part-use of existing posts) and potential
“economies of scale” (in Health Boards covering more than one partnership). Three scenarios are modelled (para 45):

- **“Prudent likely case”**: all 31 partnerships adopt the body corporate model with economies of scale – **£9.8m** over the two years 2014/16 (this is the figure shown in the FM tables);
- **“Lowest cost case”**: as above but able also to realise “opportunity cost” savings – **£6.4m** over the two years 2014/16;
- **“Highest cost case”**: all 31 partnerships adopt the delegation between partners model but with no economies of scale or opportunity costs – **£22.6m** over the two years 2014/16.

31. In reality the scope for opportunity cost savings will vary between individual councils and health boards. Councils for example are busy with implementation planning for Self Directed Support, as well as developing prevention strategies and service redesign to balance budgets: funding to release senior management staff time to plan for integration is both needed and welcome. The “prudent case” estimates included in the FM appear to be around the right size, but would need to be increased if, as seems likely, 2-3 partnerships adopted the delegation between partners model which has higher implementation costs. Further work is also required on the fairest distribution approach for these funds.

32. The remaining non-recurring Scottish Government investment (in FM Table 3) is either targeted to Health Boards (eg CHP leadership redundancy/redeployment costs) or retained to fund central government support or third sector initiatives. While we understand that CHP leadership posts (25.6 WTE) will be deleted by the Bill, other management posts, including those in some local authorities, are also at risk of deletion as partnerships develop integrated management structures (even if employment contracts for joint posts remain for a time with one or other of the parent bodies). Therefore we think that the potential redundancy and redeployment costs will be significantly larger than those contained in the FM.

33. The FM rightly notes the need to improve management information and to develop IRF jointly linked patient/client activity and cost datasets. However, all costs are seen as ISD’s, with partnerships accessing data remotely. This under-states the need for greater analytical and intelligence capacity within partnerships, and also the need to invest in IT improvements locally.

34. Part Two of the Financial Memorandum concerns the recurrent cost implications to Health Boards and Local Authorities from provisions in Part 1 of the Bill. The amounts depend on which integration model is chosen, and have been modelled, it would appear, as two scenarios: all 31 partnerships (excluding Highland) adopt the body corporate model or all adopt the delegation between partners (lead agency) model – for ease of reference these are shown together in the table below:
## Recurring costs to health boards and councils (future years as for 2015/16)

<table>
<thead>
<tr>
<th>Ref (amended)</th>
<th>Item</th>
<th>Body corporate</th>
<th>Lead agency model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2014/15 Recurrin</td>
<td>2014/15 Recurrin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>g</td>
<td>g</td>
</tr>
<tr>
<td>Para 68</td>
<td>Appointment of chief officer</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>Para 85</td>
<td>Financial recording and reporting</td>
<td>0.15</td>
<td>0.15</td>
</tr>
<tr>
<td>Para 87</td>
<td>Financial costs teams</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Para 89</td>
<td>Clinicians’ involvement in locality planning</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Para 94</td>
<td>Health and social care dataset and information system</td>
<td>0</td>
<td>0.25</td>
</tr>
<tr>
<td>Para 95</td>
<td>Economist and analytical support for health and social care activity information</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>5.35</strong></td>
<td><strong>5.6</strong></td>
</tr>
</tbody>
</table>

Source: Finance Memorandum Tables 5 and 4.

35. The **Chief Officer** costs are based on 30WTEs for Scotland – presumably the assumption here is that one other partnership will follow Highland in opting for a lead agency model – and are net of deleted CHP General Manager costs. The £150k for **financial recording and reporting** is for additional internal audit work under the body corporate model. The £800k for financial costs teams is for additional NHS finance staff to deal with the additional complexity of financial management following the inclusion of some hospital services within integrated budgets. There are no additional sums for increased complexity of local authority reporting. Clinical involvement in locality planning has been costed on “best practice” but appears to consider only NHS clinicians, not social work professionals. The linked dataset and analysis costs (together £750k) support both strategic planning and commissioning and performance management.

36. As already mentioned, the FM does not state that the Scottish Government funding would be provided to cover these recurrent cost implications for Health Boards and Local Authorities, and we understand that these costs will not be **funded**. While the sums are small, both health boards and local authorities are under severe fiscal pressure and it is reasonable to expect the Scottish Government to fund these additional costs of legislation to assist effective implementation.

37. The table above does not include **risks of £32m** per year associated with the possible change in **VAT recovery status** for integrated services which depends on whether HMRC considers body corporate partnerships as service providers, rather than the parent Health Boards and Councils (see para 73-79). The table also does not include potential savings from **asset rationalisation** between Health Boards and
Councils (paras 90-92). Costs associated with **harmonisation of staff terms and conditions** are also not included in the table and are seen in the Financial Memorandum as only applying to partnerships that adopt the delegation between partners (lead agency) model. But if all partnerships adopted that model then staff harmonisation costs are estimated nationally at **£27m per year** (paragraph 121). ADSW believes that the FM understates the impacts on staff conditions of service, including pension arrangements, of the inevitable mergers of NHS and council social care operational and management teams in the future under both models.

38. The FM regards the extension of the Clinical Negligence and Other Risks Indemnity Scheme (**CNORIS**) to social care in Part 2 of the Bill to be “cost neutral” (para 82), presumably because CNORIS is based on pooled self-insurance. ADSW would require a better understanding of the risk and cost implications for local authorities of using CNORIS before it could comment on whether this is cost-effective compared to other approaches to risk management.

If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?

39. Local authorities, and health boards, are under severe fiscal constraint yet face rising demand. The Scottish Government is funding one-off costs, but not recurring costs. The recurring costs identified in the FM are modest (although some of them appear to be under-estimates) but the big unknowns are the risk of £32m per year if VAT recovery status changes, and up to £27m per year if harmonisation of staff terms and conditions proves necessary as integration progresses. There is also a risk to social care charging income (discussed further under Question 9 below).

40. Local authorities and health boards are funded mainly or wholly by the Scottish Government, who, as a matter of principle, should adequately fund legislative changes.

**Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?**

41. **Margins of uncertainty** are acknowledged in the FM. The authors have clearly made as much use as possible of Highland’s implementation costs, adjusting them for potential differences between the delegation between partners and the body corporate models, and attempting to show the impacts of varying assumptions about opportunities costs and economies of scale.

42. The **timescales** adequately reflect the Scottish Government’s expectation about the progress of the Bill through Parliament and the likely implementation date. On that basis implementation costs are expected to be higher in 2014/15 and then taper off over the following two years. This seems reasonable.

43. However, much of the detail about integration is not set out in the Bill but is dependent on Ministerial regulations and guidance that have not yet been issued for consultation (at the time of writing). It is understood that these will set out **de minimus** expectations on such matters as the services and budgets that shall be in scope. Partnerships are likely to vary in the extent to which they move forward
beyond the bare minima, and in the timescales involved, and in turn this will affect the phasing of their requirement for implementation funding. The FM does not describe how funding will be released to partnerships, and whether it can be carried forward if local phasing does not fit that assumed in the FM tables.

44. It would be useful if further work could be done jointly on the implementation cost estimates, perhaps overseen by the Integrated Resources Advisory Group, in the run up to the actual spending decisions for 2014/15.

**Wider Issues**

**Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?**

45. Our responses to earlier questions cover this point, with the exception of an issue raised in the **FM Annex**, which covers wider Scottish Government investment relevant to the Bill. Here the largest item is for the **Change Fund for Reshaping Care for Older People**, described in para 130 as “bridging finance”. These funds total £300m over the four years 2011/12 to 2014/15 (£80m/£80m/£80m/£70m) and in addition are being topped up by local authorities. The Fund is currently set to end on 31 March 2015.

46. The Change Fund has been an essential and very welcome development. However the fundamental problem of temporary funding was identified in ADSW’s submission to the Committee’s recent inquiry into the fiscal implications of demographic change, and was quoted at paragraph 103 in the published final report:

> New services funded by the Change Fund for Older People are financially sustainable only if they support a shift in resources from acute, emergency inpatient bed use to community- and home-based health and social care, thus allowing some hospital resources to close. Such changes are likely to be contentious. It is essential that closures are not perceived as service cuts, and this will require strong leadership and high profile public debate. During the period of transition, the need for double running costs for hospital needs and increased community and home based services is likely to be larger than the total Change Funds made available.

47. The Change Fund should not end in 2015 but is needed to continue to provide bridging finance to enable in-patient bed reductions to be achieved in order to release monies to support the expansion of preventative initiatives and more community-based services capable of reducing future needs for acute hospital in-patient care. The level of Change Funding will need to be increased to allow innovation to be further developed for adults aged 18-64 with complex care needs.

---

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

48. At the time of writing it is not clear whether or not there will be other future costs associated with the health and social care integration policy, apart from those identified earlier (particularly the VAT and pay harmonisation issues). However, there will be issues around charging for social care as integration progresses, and more joint teams and posts are established and in future it will be less and less clear what is “health” and what is “social care”: indeed, the policy intention is for care to be seamless. Not only will social care charges become more difficult to understand for service users, apart perhaps from charges for residential care, they will become more difficult for partnerships to levy for integrated services. As the FM notes (pars 12), income from charging for local authority charging for adult social care was £43m in 2010-11, a significant sum for partnerships.

49. Future costs that might arise from the subordinate legislation associated with the current Bill will need to be assessed when the draft regulations and guidance are available for comment (if not consultation).

50. Finally, depending on how the Scottish Government deals with the issue of acute inpatient budgets, discussed earlier, health and social care integration, together with the wide range of prevention work-streams and more concerted action on health inequalities, could do much to reduce the financial impact of increasing numbers of older people and people of all ages with disabilities and long term conditions. However, these policies are most unlikely to reduce the fiscal impacts of demography to zero. If GDP growth rates returned to their 30-year pre-austerity average, then the full cost of additional services required by 2030 would be affordable, provided there was appropriate political leadership and sufficient societal support for increased spending on care. If the long boom is past, then tougher choices are inevitable. Either way, ADSW believes that a wider review of future options for the resourcing of health and care is required in Scotland, similar in scope (but not necessarily in outcome) to reviews undertaken in England by Derek Wanless, Andrew Dilnot and others.
Introduction
1. BMA Scotland welcomes the opportunity to provide the Finance Committee with written evidence on the Public Bodies (Joint Working) (Scotland) Bill which requires NHS boards and local authorities to integrate adult health and social care services.

2. The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 16,000 members.

3. In responding to the financial memorandum supporting this Bill, it is important to consider the context within which plans for integration are taking place.

4. The single biggest challenge to health and social care services now and in the long term is the increasing number of elderly people with multiple physical problems, cognitive impairment and increasingly complex care needs. Projected future demand for elderly care services indicate that there will be 21% more people aged 75+ in Scotland by 2016, compared with 2006, and 83% more by 2031. Assuming demand increases in line with this growth and that current service models remain the same, this would require an average real increase in the NHS budget of 1.2% per year, every year. Healthcare spending is concentrated in the last year of life, but as people live longer, they are more likely to have more complex needs for both health and social care over extended periods. Older people’s social care budgets will also need to be increased significantly. An aging population combined with a difficult public spending environment poses a very significant challenge.

5. The Financial Memorandum sets out the costs associated with the introduction of the structures required to facilitate the introduction of integrated working, however it does not address the subsequent detail of the cost of integration of services and whether or not additional funding will be allocated to provide quality health and social care to local populations. The BMA believes that while considering the primary legislation to establish the structures that will facilitate integration, it is vital that politicians consider the subsequent financial consequences of this significant reform of health and social care services. The primary focus of integration of care must be about improving outcomes for patients, not a cost saving measure.

6. The British Medical Association has been involved in the consultation process in the lead up to the publication of this Bill, two BMA representatives also sit on the Government’s Bill Advisory Group.

---

1 “Funding health and social services for older people – a qualitative study of care recipients in the last year of life”, Hanratty, B et al, *Journal of the Royal Society of Medicine, May 2012*
7. During the consultation process we raised the following points which have not been adequately reflected in the Bill or supporting information.

**International experience/evidence**

8. The current evidence regarding the impact of integrated care is comparatively limited. While evidence from North America and Europe does indicate that integrated health and social care systems for older people demonstrate positive results on many indicators, researchers have highlighted specific and significant gaps in the existing evidence base in relation to costs, patient experience and clinical outcomes. It is essential that care for individual patients is funded and provided as a whole package, for example that there are comprehensive and fully funded care plans in place and improved co-ordination following hospital discharge; fragmented care for older people should be replaced with an integrated care pathway co-ordinated across the spectrum of care providers, including the third sector.

**Shifting the balance of care**

9. We support the aspiration to reduce acute hospitalisation, however the promotion of admissions avoidance, particularly of older people, must not restrict the appropriate access to the best care at times of medical need, and patient safety and quality of care must be prioritised at all times. The overall intention should be to maintain as many people at home as is possible, safe and appropriate, but there also needs to be recognition of, and planning for, an expansion in the number of those requiring some form of residential care. While an increased proportion of patient assessment and care will be community based, quality hospital-based health care will need to be maintained and developed for those who need it. No matter how well community-based services are planned and delivered, many patients will continue to require hospital assessment and treatment. Growing numbers of frail elderly patients with multiple physical co-morbidities, and often with dementia, will produce significant pressure on hospital-based services, undermining the perception that the funding necessary for quality community-based healthcare can be found solely through the transfer of resources from secondary care. There is an often an assumption that the only way to develop community services is to move funding from secondary to primary care, or health to social care, rather than considering the overall resource envelope and whether that needs to change.

10. Due to already excessive levels of workload there is no capacity for general practice to take on any further planned (or unplanned) work without the addition of new resources, including significant investment in infrastructure. A comprehensive assessment is needed of the likely resources, required to meet the needs in both primary and secondary care of a population with a higher proportion of elderly and very elderly patients and a rising prevalence of long term conditions. Without adequate planning and investment for both sectors, Scottish Government to shift the balance of care and integrate adult health and social care may be unachievable.

---

2. *Clinical and service integration: the route to improved outcomes*, The King’s Fund, 2010

3. *Integrating services without structural change*, June 2012, Health Policy and Economic Research Unit, BMA


5. *General Practice in Scotland: the way ahead – progress report*, BMA Scotland,
Comments specific to key points in the Financial Memorandum

Support to third sector

11. According to the financial memorandum, it is intended, via regulations, that integration authorities will be required to fully involve the third sector as key partners in strategic commissioning, locality planning and service delivery activity. We would agree that there is a need to engender closer working relationships between health boards, local authorities and the third and independent sector, but 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.

Delegation

12. The Financial memorandum supporting the bill highlights the intention to delegate resources between partners to create an integrated budget (paragraph 65). However the BMA believes that it would be essential for locality structures 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 local structures.

Clinical Leadership

13. The financial memorandum has set out specific costs for ‘clinicians’ involvement in locality planning’ (Table 5) that is required for clinical leadership.

14. An Audit Scotland review of Community Health Partnerships\(^6\) highlighted the lack of engagement of GPs as a key factor in the failure of many of these organisations and unless this is explicitly addressed during the legislative process, then there is a risk that the failures will be repeated. During the consultation process, BMA Scotland has welcomed the Scottish Government’s commitment to a strengthened role for clinicians, but it must ensure that the new Joint Integration arrangements are clinically driven and supported by management to avoid the pitfalls of CHPs.

15. It is vital, therefore, that this funding for clinical leadership is protected and sustained, in order to allow clinicians to both be involved with and drive planning at a local level, there must be a clear commitment to value senior doctor time sufficiently and make time available in secondary care job planning or commission GP time. It is essential that to ensure that doctors are supported to engage with the new the Joint Integration Boards or locality structures, that this resource is provided to back-fill their clinical absence and ensure that patient care is not compromised as a result of clinical engagement. For example, in the case of a GP, they may require to provide locum cover for time spent away from the practice undertaking their ‘integration role’.

\(^6\) Audit Scotland Community Health Partnerships, June 2011
Harmonisation of terms and conditions

16. In our evidence to the Health Committee, we have sought clarification that appointment of staff by a body corporate will be in line with current arrangements for negotiated TCS. In relation to Section 2.4 of the Financial Memorandum, it makes it clear that under harmonisation of TCS, transfers will be made via TUPE rather than using a public sector exemption. The flexibility within the legislation over the transfer (or not) of staff could result in a piecemeal picture of different structures across Scotland with some areas virtually unchanged, some with transfers between the pre-existing employers in either direction and some with transfers into the new body corporate.
Analysis of the Financial Implications

1. In giving thought to the financial implications of the bill, three broad areas need to be considered: the potential of integrated arrangements to deliver efficiency savings; the mechanics of operating integrated budgets in pursuit of those objectives; and the additional cost to public authorities as a result of the bill.

Potential Efficiency Savings

2. A common definition of an efficiency saving is doing more for the same resource or doing the same with less resource. The financial memorandum makes clear that in respect of health and social care integration, the objective is to do more with the same:

   potential efficiencies should be considered in the context of the scale of the projected increase in expenditure attributable to demographic change... and will need to be reinvested within the partnerships in order to help meet demand.¹

3. This is because our ageing population is predicted to increase demand for health and social care services by between 18.4% and 28.7% between 2010 and 2030.² This equates to a potential funding gap in the order of £2.5billion against current levels of investment. So the context for developing integrated services is not about being able to reduce public expenditure on health and social care – no serious commentator thinks that is advisable; rather, it is about doing more (i.e. dealing with increasing demand) within existing resources to improve outcomes.

4. Even then, the financial memorandum presents something of a conundrum. The main areas it identifies which are capable of using resources more efficiently are in respect of delayed discharge; anticipatory care; and reducing per capita cost variation. However, all of these efficiencies are contingent on being able to reallocate resources currently tied up in institutional settings. Delayed discharge efficiencies can be achieved by ‘reallocating expenditure from hospital to community based health and social care’;³ anticipatory care plans could result in lowering emergency admissions ‘if alternative care options were available to local care professionals, patients and carers’; and reducing per capita variation – which depends on reducing consumption of health and care resources to the average cost per head for the partnerships – will likewise depend on alternative care pathways being available.

¹ Financial Memorandum, paragraph 34
² Financial Memorandum, paragraph 18
³ Financial Memorandum, paragraph 27
5. COSLA wholeheartedly agrees with the need to shift the balance of care. However, some would argue that the impact of increasing demand has not been fully factored into the Scottish Government’s analysis. Our colleagues in NHS Scotland continue to believe that a more efficient health and care system will be able to stifle demand for secondary care – but not reduce it below current levels. If that supposition is accurate, then we will be unable to make the cash-releasing savings from the acute sector in order to invest upstream in community based alternatives; and if we cannot invest in community based alternatives, we will not be able to stifle demand for acute care. In other words, there is a very real risk of a vicious cycle emerging over the next few years in circumstances of flat or limited growth in public expenditure.

6. However, if we are simply using the NHS acute sector inefficiently, and there is a capacity to disinvest, then a different set of challenges emerge, which are more political in nature: we are going to have to close services. Now this may be the right thing to do – it may improve outcomes and deliver higher quality care – but we can anticipate these being highly unpopular decisions. We need to be able to inhabit this new landscape – and bring the public with us.

7. Even then, however, we are calling on the Scottish Government and Parliament to resolve the longer-term funding challenges associated with the cost of health and social care to the public purse in Scotland. We are confident that the pressures building on the health and care system over the next twenty years cannot be met by better integrated services alone: the integration of health and social care is necessary but ultimately insufficient as a means of eliminating the £2.5billion funding gap that is likely to emerge.

The Mechanics of Integrated Budgets

8. COSLA agrees that a fully integrated budget – and the use of the ‘total resource’ - is necessary to give effect to integrated service planning and commissioning in pursuit of a common set of outcomes. However, there are a number of operational challenges which flow from the delegation of resources.

9. The policy memorandum sets out three main risks to Local Authorities and Health Boards as a result of operating an integrated budget:

- Budget setting;
- In-year financial performance management; and
- Management of acute sector provision.

10. Taking these matters in turn, there are a range of practical considerations that require some thought. For example, in delegating a budget to another party (whether the Health Board or a body corporate), the local authority would need to be assured that the duties of the Section 95 Officer can still be adequately performed.

11. In addition, the actual budget-setting process will need to be further considered. It will be important that the management of efficiencies/uplifts is agreed by both parent bodies and takes into account of the broader Scottish Government
settlement and inflationary/demand pressures before coming to an agreement. It will be also be necessary to synchronise the formal budget setting timelines between councils and Health Boards.

12. For Health Boards with more than one local authority in their area, budgets will need to be discerned for each partnership area, and tensions may emerge as we move from historical spending patterns to weighted capitation. It is vital that the delegated budget from both parent organisations is completely transparent.

13. In terms of in-year financial management, the potential for cross-subsidising activity would be heavily proscribed for both councils and NHS Boards (both councils and NHS Boards currently use cross-subsidisation as a tool to manage pressures) and this would require greater levels of discipline in spending – and, importantly, solutions to be developed for the management of over-spend. While this is clearly a job for partnerships locally, it is arguably too simplistic to suggest that overspend in social care budget lines becomes a council problem or overspend on prescribing an NHS problem.

14. Finally, on the stability of the acute sector, our NHS colleagues are concerned about their ability to manage District General Hospitals which serve a regional population base (across several local authority areas). The route of this concern would seem to be in the requirement to distribute a significant part of the acute hospital resource to the body corporate, which will then ‘commission’ the level of acute care that reflects population need. Were some of those partnerships to identify a different usage pattern in respect of the consumption of acute resource, it is argued that this could leave these institutions having to build a budget from several different sources without an over-arching strategic plan for usage. What is more, there is concern about what happens in the event that the commissioning partnership uses more acute resource than it had intended to under the joint commissioning plan.

15. We recognise that the scenario of a single Health Board with an irregular spread of District General Hospitals spread across a number of Local Authorities (the most common position in Scotland) is a particular challenging environment in which to progress the integration agenda and does not come without operational risk to the acute sector. However, it would be wrong to insulate the NHS acute budget from partnerships’ commissioning objectives and therefore we need to develop solutions that are capable of managing that risk. For example, there will need to be a supra-partnership agenda around the strategic development of the acute sector within and between Health Boards. We would suggest that this supra-partnership agenda is linked to individual Partnership Agreements. We also need to develop analytical capacities to map cost and activity data across health and social care partnerships. The Integrated Resource Framework pilots are instructive in this regard but now need to be rolled out to ensure that all partnerships have the requisite ability to examine cost and activity within the system.

16. In light of all of the technical challenges set out above, COSLA believes that National Guidance will be required to assist in the delegation of budgets to partnership level.
17. In addition to the issues set out in the policy and financial memorandum, COSLA has worked with local authority Directors of Finance and we would want to draw the Committee’s attention to a number of additional technical issues which are subject to on-going work with the Scottish Government:

- Accounting treatment and VAT
- Financial recording and reporting
- Financial controls, assurance and risk
- Financial planning, financial performance management and finance function
- Capital and assets

18. 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.

Costs of the Bill

19. In general terms, we welcome the Scottish Government’s commitment to funding one-off implementation costs of around £16.3 million, but we are disappointed that there is no funding commitment to the recurring costs for health boards and local authorities arising from the Bill.

20. Having consulted with Local Authority Directors of Finance, we would offer the following observations on the costs of implementing the bill:

- We anticipate that there will be an increased audit burden on statutory partners and therefore the stated additional cost of £150k across Scotland seems too low. The financial recording and reporting costs are likely to increase, irrespective of the integration model adopted;
- We are unsure that funding for the Chief Officer can be met from the current CHP General Managers’ salary.
- We are also disappointed to note that financial provision is being made to the NHS for CHP leadership post-holders who are displaced as a result of the development of partnerships, yet no similar resources, either recurring or non-recurring, are being made available to local authorities.
- We think that other management costs could emerge 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 has been identified for the health sector only;
- It is unclear whether any assumptions have been made around remuneration for Board Members;
• The assumption that support services for the joint boards can be funded from existing CHP support services is unrealistic; not all CHPs currently have the full range of support services that will be required in the new Partnerships.

• Section 45 talks about extension of schemes for meeting losses and liabilities for health service bodies. We have a concern that this will allow NHS to carry reserves from one year to another.

• The Financial Memorandum correctly identifies the risks to VAT recovery and staff pay and conditions harmonisation, and estimates their potential annual costs at up to £32m and up to £27m respectively. We are concerned that the Financial Memorandum does not commit the Scottish Government to fund these pressures should they occur in future.

• Should staff transfer be required, we believe that the TUPE implications are significant and potential financial solutions may not meet TUPE regulations.
Consultation

Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?

1. Yes, Dumfries and Galloway Council contributed to the Strategic Partnership’s (our Community Planning Partnership) joint response to the Scottish Government’s consultation on proposals for the Integration of Adult Health and Social Care in September 2012; no specific comment was made on any financial assumptions.

Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum (FM)?

2. N/A.

Did you have sufficient time to contribute to the consultation exercise?

3. Yes.

Costs

If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?

4. The FM reflects a range of estimates and assumptions which, understandably at this stage, are at a high level. The approaches outlined to explain the basis of the estimates are reasonable but the limited supporting information on the underlying calculations and assumptions makes it difficult to assess their accuracy at this stage.

5. The FM (paragraph 35) does recognise that there is considerable uncertainty around the estimates in relation to projected efficiencies. It is important to recognise that this qualification also applies to the cost estimates reflected in the document.

6. One particular point is that the FM focuses mainly on those costs likely to be incurred by the Health sector and does not sufficiently recognise those costs likely to be incurred by local authorities. For example:

- Paragraph 50 indicates that while there will be displacement costs associated with displaced Community Health Partnership posts, it is assumed that no such costs should be incurred by local authorities; and
- Paragraph 89 provides an estimate of costs associated with clinical involvement in locality planning but does not recognise potential costs associated with the involvement of other care professionals.
Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?

7. It is recognised that projecting estimated costs and savings over a 15 year period is extremely difficult, particularly in an area of service which will be impacted upon by a range of issues including demographic pressures. One concern regarding the accuracy of the estimates is the risk that, as is often the case where significant change/reform is being advanced, there is a tendency to overstate the potential savings and understate the potential costs.

8. As reflected at 4 above, the range of estimates and assumptions reflected in the FM, understandably at this stage, are at a high level. Greater detail on the basis of the estimates, and the underlying assumptions, would help support an assessment of their reasonableness and accuracy.

9. It is noted that the transition costs estimates are based on the integration of adult health and social care functions only. Where a wider set of services are considered for integration this may obviously impact on the cost and savings estimates.

If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?

10. Assessing the ability of organisations to meet the costs associated with the Bill requires to take into account the wider consideration of the appropriate level of funding available to support adult health and social care. Given the increasing level and complexity of demands, the level of Scottish Government funding available to support this area of service will obviously have a key impact on Councils’ and NHS Boards’ ability to meet the costs of the Bill.

11. Dumfries and Galloway Council and NHS Dumfries and Galloway are jointly focused on maximising opportunities to deliver improved service provision together with greater efficiencies. At this early stage it is difficult to assess the extent to which the costs associated with the Bill can be met by the Council and NHS Dumfries and Galloway.

Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

12. At paragraph 35, the FM recognises that there is considerable uncertainty around the estimates in relation to projected efficiencies. It is important to recognise that this qualification applies not only to the projected efficiencies but also to a range of other estimates and timescales reflected in the document. This uncertainty is not unreasonable at this stage.

Wider Issues

Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?

13. The FM provides useful information and reasonably based estimates for the costs associated with the Bill. However, it is important to recognise that there are
significant risks associated with a number of areas, including those where the FM has assumed that the impact will be Nil or cost neutral.

14. For example, the FM at paragraphs 73 - 79 assumes that the VAT implications of integration under both the Delegation Between Partners and the Delegation to a Body Corporate approaches will be cost neutral. While this may not be an unreasonable assumption at this stage, it should be recognised that there are risks associated with this assumption, particularly given the amounts involved.

15. Similarly, the estimated costs associated with potential staff transfers and the harmonisation of terms and conditions indicate that these issues/costs are expected to be relatively small. Again, given the potential amounts involved and the uncertainty associated with issues such as potential equal pay claims, it should be recognised that there are significant risks associated with this assumption.

**Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?**

16. Given the extent of change associated with the Bill and the complexity of the areas of service being covered, there is the potential for subsequent/subordinate legislation to be required. At this stage it is very difficult to assess the potential financial implications of such further change.
1. No provision made in the FM for Council staff redundancy costs, with only CHP leadership displacement costs included. There is a possibility depending on the shape and extent of integration that management structures will be designed that could result in Council chief officers also being displaced.

2. The issue of ensuring appropriate VAT structures and compliance remains a fundamental risk to IHSC. Development of procedures etc with HMRC is the extent of the VAT "costs" within the FM. Failure to achieve appropriate VAT status / dispensations could result in £30m+ additional costs to IHSC. “It is likely that a VAT neutral position is attainable” – this must be confirmed as soon as possible, as failure to achieve this position will present real financial difficulties to each partnership.

3. Development of a joint information management system has been identified as necessary, with initial development costs of £750k assumed to fall to the Scottish Government, and ongoing recurring costs of £250k thereafter falling to partnerships. I have two initial concerns with this:

   - Timescales to develop, test and deploy the system will be extremely challenging and based on previous IT system implementations must be a risk. The implication of failing to hit the target would be a need for alternative options to be implemented as an interim measure. No cost provision has been assumed for this.
   - The cost of £750k appears to relate to a national system that will provide information to local partnerships. Is this a sufficient “budget” to deliver? What about local information sharing systems – these have not been costed. Will the SG system also deliver local opportunities or will 32 other systems also be required to be developed and subsequently supported?

4. External audit fees (additional) have been estimated at £150k (i.e. approx £5k per partnership). Is this based on Audit Scotland estimates as it seems very low.

5. Additional costs of £800k per annum are included for financial costing teams at NHS level. One of the over-riding principles of integration was that the cost of supporting it should not be greater than that already in place to support current delivery models. This must be a concern; although availability of robust, reliable and accurate data will be an absolute must for effective management of the IHSC partnerships.

6. The support functions (HR, finance, etc) are assumed to be cost neutral (other than costing teams noted above), and this accords with the approach we are taking locally.
7. Efficiencies from asset rationalisation have been excluded – these may take a longer timeframe to be achieved and will be a key element of future year savings proposals and targets.

8. The use of the Common Services Agency to deliver for all public sector organisations has been “permitted” in the Bill. This is quoted as offering potential for savings / efficiencies. Great care will require to be taken before use is made of the CSA by local authorities, where currently expertise is maintained in-house (at a local level). Issues around legal and contractual advice are of major importance and a poor decision can have a significant financial and reputational impact.

9. The development of CNORIS to include social care functions delivered by Local Authorities will require significant and detailed consideration by Council risk management / insurance teams. Savings on premiums will need to be carefully balanced against the indemnity provided and the underlying financial risks this might present to the organisation.

10. Use of HubCo while not unexpected, will require to be carefully managed as there remains concerns over the capacity of HubCo to deliver on the scale that is currently anticipated before adding in additional developments. Equally, detailed analysis needs to be carried out on each project to ascertain if additional revenue savings can indeed be achieved through the use of HubCo.

11. The accounting treatment of pensions will be a crucial factor, particularly when you consider the statutory mitigation local authorities currently “enjoy”. This assumes that staff who transfer will retain the right to be LGPS members – is this a given?

12. The additional costs of performance and inspection is worrying as this implies there will be increased activity. In the post-Crerar landscape we would expect less onerous inspection activity. I fully accept it will be different, but do elements of current work not drop off to be replaced by the new work?
Consultation
Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?
1. The Council contributed to and supported the consultation responses from COSLA and CIPFA Directors of Finance Section and contributed to the consultation on the integration policy generally as opposed to specific elements of a draft bill.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. The five workstreams being taken forward by the Integrated Resources Advisory Group will fully inform the development. For reference these are:-

- Accounting Treatment and VAT
- The Financial Reporting
- Controls and Assurance
- Financial Management, Planning and Finance Function
- Capital and Assets

3. Individual Council comments were not provided to the financial memorandum (per above) so we would not be able to determine whether responses were reflected in the bill.

Did you have sufficient time to contribute to the consultation exercise?
4. Yes – timescales for responses to the consultation on the integration policy were extended for wider consultation and this gave ample time to respond and seek political input into the process.

Costs
If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?
5. The FM focuses on the resourcing issues in relation to the implementation of the agenda and in this regard, the range of financial implications has been accurately reflected. There is no focus on the issues arising from the delegation of budgets and resources under each of the 2 options available which is a key area of concern and will have far reaching implications in the medium / longer term and the realism attached to releasing resources from budgets tied into acute budgets without destabilising hospital provision.

6. A significant omission appears to be an estimate of the cost of the rising demographic of older people requiring a service (per paragraph 18 of the FM) given
there are savings predicated on the way this will be delivered into the future. In terms of the costs associated with the Bill implementation there is provision for the displacement of CHP leadership staff, however an absence of any provision for the displacement of local authority staff which if management teams are to come together to deliver on joint outcomes there will inevitably be management efficiencies on both sides of the partnership. The establishment of transition arrangements is predicated on being able to realise opportunity costs, but it is not clear what these relate to. Support to develop strategic plans and inform performance management requires a linked patient/client level health and social care dataset and information system and the costs built in to establish this across Scotland appear low given the experience with MGF funding which sought a solution to this issue without any real success. There are costs built in for the appointment of a chief officer but no recognition of other posts which will require to be appointed to support this role where evidence across already established CHCP constructs shows an overall increase in the costs associated with establishing new structures, including start-up and recurring ICT costs.

Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?

7. The range of cost considerations seems reasonable, however without having the detail on the underlying assumptions and costs associated each area, it is not possible to determine if these are accurate.

8. The savings assumptions are predicated on a 3 key areas:
   • Delayed Discharges – predicated on a maximum 14 day delay in hospital – is this realistic and achievable? Look to success of change fund programmes and partnership performance against the current 28 day target.
   • Anticipatory care planning needs to be effective – limited success locally from this initiative and the basis for estimating the likely savings from this area being predicated on a small study undertaken in Nairn may be problematic.
   • Reducing variations in cost per head across partnership areas without any clarity on what causes these variations and the fact that these variations may be justifiable. Requires more in depth analysis to establish the reasons for variation.

9. Accordingly to fully assess these figures further detail should be released.

10. Work is ongoing within the IRAG workstreams and VAT presents a significant uncertainty.

11. The harmonisation of terms and conditions is also an area with cost implications which needs to be considered and quantified.

If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?

12. Cost implications should be further refined and if further set-up costs or bridging finance is required this should be provided by Scottish Government.
Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

13. Range of cost provided but without the detail on the underlying factors which sits below these assumptions it is hard to form a view as to whether they are accurate. The estimates fall within wide ranges with an acknowledgement of the uncertainties which may be present, however how this leads to effective planning is unclear and individual partnership experiences will vary greatly in terms of allocation of any funding.

Wider Issues
Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?

14. As per 4.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

15. Potential equal pay claims for staff working more closely together doing broadly the same role but within differing organisation on different terms and conditions.

16. Investment in research analysis to provide an robust evidence basis for assumptions being made across a number of areas.
1. In providing this written evidence to the Finance Committee, Council officers have answered the Committee’s written questionnaire further below. By way of introduction, the Council supports the overall drive to improve outcomes by integrating health and social care services which it believes can build upon the improvements already made through joint working with our partners, and that integration should bring further benefits for service users, carers and communities.

General points
2. Officers have a number of concerns about the governance and accountability arrangements of the mechanisms proposed in the Bill, which they believe will break the link of local accountability if left unaltered. They also are concerned about Ministers being able to make decisions that affect local authorities without the agreement of the authorities concerned. Officers consider there may be scope for better use of consultative guidance rather than prescription. They acknowledge that one of the stated aims of Ministers is for consistency in health and social care across Scotland, but at the same time they would like the Committee to bear in mind the current ability of councils to make decisions as to how to profile their spending, and the accountability of elected members ultimately through the ballot box. Local democratic oversight is important if we are to avoid a collection of localised quangos making decisions, or having decisions made for them by Ministers, without reference to local needs, plans, priorities and strategies. There must be flexibility to respond to local need and produce an appropriate balance of care for local communities.

3. Officers are concerned for example that the full incorporation of a body corporate and the possible use of subordinate legislation by Ministers, as proposed in the Bill, will remove democratic local accountability from the process.

4. Given that the decisions of the body corporate can impact directly on the Council and on the Health Board and, crucially, on the services they provide to local people, officers think it appropriate that the Council should have the capability to have decisions of the body corporate “called in” and scrutinised by Council. For example, if the body corporate decided to close a local care home, we would expect there to be some democratic scrutiny of this decision. We note that community health partnerships were a formal subcommittee of the Health Board but no such arrangement is proposed for the body corporate. The fact that elected councillors will be members of the body corporate is not sufficient, as they will be required to act in the best interests of the body corporate (however those interests may be defined) and not of the Council as a whole (nor of the people of the area).

5. Officers are also concerned about the management of integrated budgets, in particular budget-setting, in-year financial performance management and the
management of acute sector provision. They believe that national guidance will be required to facilitate the creation of delegated budgets at partnership level.

6. One particular governance issue for local authorities is the potential for conflict relating to the statutory role of a council’s S95 officer if budgets are passed to an independent body corporate. Council officers would like to explore the continuing role and influence of GP Services in models of care. They also would be interested to participate in acute service redesign with the aim of supporting reinvestment in preventative social work and primary care services.

Consultation
Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?

7. Yes, East Lothian Council responded to Scottish Government consultation on this issue. We commented in very general terms on financial issues.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?

8. It is difficult to say as it is not clear how figures have been calculated.

Did you have sufficient time to contribute to the consultation exercise?

9. In the opinion of Council officers, the consultation exercises could not themselves have delivered the detail required for the implementation of this Bill; it is still very much a “work in progress”.

Costs
If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?

10. Officers believe that the FM has not made sufficiently clear the financial implications for local authorities (and possibly others). It is not clear as to how the figures have been calculated and we cannot say whether they accurately reflect implications for this Council. (It might have been more helpful if the FM had laid out the implications for each Council/health board and come to a total as a result.) It would not be appropriate to make the assumption that all local authorities will be affected to a similar degree. In East Lothian, for example, we have a particularly high (and growing) proportion of the population who are older people:

- the number of people aged over 65 is forecast to grow by 77% between 2010 and 2035;
- the number of households is projected to grow by 39% between 2010 and 2035 compared to a growth of 23% in Scotland as a whole;
- the main component of the increase in the number of households is forecast to be a large increase in the number of households containing one adult;
- the number of households in which the head of household is aged over 75 is forecast to double between 2010 and 2035;
the numbers of long-stay residents aged 65+ in care homes have stayed relatively stable over a ten-year period;
the numbers of people receiving free personal care at home in East Lothian have increased by around 50% in the past 7 years;

Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?

11. See above.

If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?

12. No, officers do not believe the Council can meet extra costs. It has no extra resources and its Adult Wellbeing budget is already under significant pressure. An ageing population will only increase demand. Much more work needs to be done on modelling the costs and resources.

Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

13. No. There is insufficient information in the FM to do this.

Wider Issues

Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?

14. It is unlikely that the FM has captured all the costs associated with the Bill. The cost of integration itself will also include:

- partnership development;
- accommodation moves;
- transition to appropriate (shared) IT systems and equipment;
- development of financial information;
- increased audit costs;
- reskilling the workforce.

15. These costs will be incurred by local authorities and health boards.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

16. In the case of this Bill, the proposed powers for Ministers to prescribe by regulation are so wide-ranging that it is difficult to quantify the costs that might be incurred through the potential use of subordinate legislation. This is of real concern and deserves more attention.
Consultation

Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?

1. Falkirk Council commented on the consultation, however, there was a lack of specific financial assumptions in the consultation and there was a lack of clarity about how the costs associated with implementing any new requirements would be funded. There are now more specific assumptions laid out in the FM but it is acknowledged that there is considerable uncertainty around the estimates.

Did you have sufficient time to contribute to the consultation exercise?

2. Yes

Costs

If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?

3. Partly. In respect of Clinical Negligence and Other Risks Insurance, the FM notes that the costs of obtaining indemnity from the market might be prohibitive but makes no mention of the additional costs that might arise from the extension of the scheme.

Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?

4. Most of the estimated costs and savings are based on information which is currently available however patterns and trends can be highly volatile and so we would urge consideration caution around these figures. In particular we would suggest that:–

• The estimated costs of providing a linked patient/client level health and social care data set and information system in our view are seriously under estimated. Despite significant investment nationally and locally a solution to the challenge of providing a linked information system is still no in sight.

• The potential efficiency savings of between £138m and £157m arising from combined effect of Anticipatory Care Plans, reducing delayed discharge and reducing variations lack sufficient detail to enable reliance to be placed on these figures.
If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?

5. In view of the comments in relation to question 5, particularly those relating to anticipated efficiencies, Falkirk Council will have some concerns about how the costs associated with the Bill would be met.

6. In respect of recurring costs, there is no specific mention of additional funds being made available. This could only be accommodated by re-directing or reprioritising existing resources. In the current climate of limited resources and increasing demand, it is important that any costs arising from implementing new requirements are met by the Scottish Government.

Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

7. Paragraph 35 of the FM notes that there is considerable uncertainty around these estimates and that the eventual outcome and phasing will be dependent on local decisions taken by partners on resource allocation and utilisation through strategic plans. The extent to which anticipated efficiencies can be relied upon is also of concern. Under the circumstances, it would give partners greater comfort if there was an undertaking to review costs in the light of experience, with an undertaking that any increase would be fully funded by the Scottish Government. This is particularly true in the case of VAT where there is a presumption that a VAT cost neutral solution will be found but a potential additional costs of £32m per annum is anticipated if such a solution is not found.

Wider Issues
Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

8. The costs identified by the FM are wide ranging but other costs may become apparent through experience. Also, paragraph 119, assumes that no staff will transfer under the body corporate model and there would therefore be no harmonisation costs. However, paragraph 117 notes that partners may nonetheless choose in time to transfer some staff between each other and the cost risk of harmonisation is contingent on future decisions to transfer staff. Paragraph 78 also confirms that should Scottish Ministers decide at a future point to extend the remit of the body Corporate to have employment and contracting powers, the VAT status of the body corporate in less clear and potentially £32m per annum could be at risk.
FINANCE COMMITTEE CALL FOR EVIDENCE
PUBLIC BODIES (JOINT WORKING) (SCOTLAND) BILL: FINANCIAL MEMORANDUM

SUBMISSION FROM FIFE COUNCIL

Comments requested on
1. The wider financial impacts of the health & Social Care Bill
2. Any technical financial issues which the bill presents
3. Specific commentary on the Financial Memorandum. Including views on whether we are content that the integration Agenda will actually deliver everything that the Financial Memorandum sets out.

The wider financial impacts of the health & Social Care Bill
• The bill seems to go way beyond that which is necessary for the proposed “Integrated Budget” for the “Corporate Body” for Integration of Health & Social Care. Advice from Colin Crawford (SG) is that the “Corporate Body” will not have employees, will not have assets, and will not enter into contracts.
• The bill mentions transfer of staff (19) but I am unsure if this refers only to where staff are transferred between NHS and Local Authorities, or also includes the “Corporate Body”.
• The bill appears to cover far more than simply NHS and Social Work.
• The bill (Section 44) would allow the Common Services Agency for the Scottish Health Service to enter into agreements with, amongst others, Scottish Public Authorities.
• Section 45 of the bill mentions extension of schemes for meeting losses and liabilities of health service bodies. I do not understand if this allows NHS to carry reserves from one year to another.

EXPLANATORY NOTES
Integration Plans – same local authority and Health Board area
Four models, including
• The local authority and the Health Board delegate functions to an integrated joint board established as a body corporate. (The other three models cover delegation of functions from one to the other or both to both).
• Scottish Ministers can approve an integration plan which sets out that functions will be delegated to the integration joint board, which will have the functions specified in the integration plan delegated to it.
• Chief Officer – Section 10 (of the bill) requires the integration joint board to appoint a member of staff to be its chief officer (but might be seconded to the integration joint board). The integration joint board will not necessarily be given powers to employ its own staff.

• Other staff – Section 11 – Scottish Ministers might give integration joint boards the ability to appoint other staff.

• Section 12 – subsection (3) provides for Scottish Ministers to make schemes for the transfer to an integration joint board of staff, property, rights, liabilities, or obligations of a local authority or a Health Board, where considered appropriate.

SECTION 19 – Transfer of staff effect on contract of employment -
46. Subsection (2) provides that where, before the day of transfer, a person who is to be transferred informs their original employer that they do not wish to transfer employment, the person’s contract of employment is terminated on the day before the day of transfer. The effect of this is that a person who does not wish to transfer does not have to do so but instead his or her contract will end immediately before the transfer would have taken place.

SECTION 37 – Information-sharing – allows information-sharing.
SECTION 38 – Grants to local authorities may be made by SG for costs incurred under Part 1 of the Bill.

FINANCIAL MEMORANDUM
Chart 1, on page 25 seems to show a great improvement in reducing the number of days between a patient being ready for discharge and being discharged, over the period from April 2001 to January 2013.

Para 27 states what seems to me to be the crux of the matter.
27. For this estimate, the bed days used by delayed patients (excluding those who are complex cases) were converted into bed weeks. For the baseline expenditure the bed weeks used by delayed discharge patients were costed at an adjusted cost per bed day, and for the projected expenditure post integration, those bed weeks were costed at a weighted average rate of residential care, home care, and care at home. These estimates suggest that reducing delayed discharge by reallocating expenditure from hospital to community based health and social care to facilitate timely departure from hospital and provide alternatives to admission to hospital, could generate potential efficiencies of around £22m per annum for a maximum 14 day delay. If partnerships wish to be more ambitious and move beyond the target, a further £41m of potential efficiencies may be generated for a 72 hour limit for delays.

33. The costs per head are adjusted for local population need, using the resource allocation formula weightings, to ensure that it does not include variation that is driven by differences in local population need. If costs per head in the higher cost partnerships are reduced to the average cost per head for the partnerships with the relevant Health Board, this could generate potential efficiencies of around £104m per annum. (HE – depends on robustness of costs and definitions).
34. The Bill will enable Health Boards and local authorities to plan and deliver holistic integrated health and social care services and to improve efficiency in allocation and utilisation of their joint resources. In summary, it is estimated that the potential efficiencies for partnerships from the combined effect of Anticipatory Care Plans, reducing Delayed Discharge and reducing variation, to be between £138m and £157m. These potential efficiencies should be considered in the context of the scale of the projected increase in expenditure attributable to demographic change, noted in paragraph 17, and will need to be reinvested within the partnerships in order to help meet demand.

**VAT**

(HE – much of this is not required if the Corporate Body is not to have assets and contracts).

58. Health Boards and/or local authorities will be required to delegate resources and functions, under delegation between partners arrangements, to the host organisation, that is the partner that will be responsible for the delivery and management of functions on behalf of the other partner, or to the body corporate. Health Boards and local authorities will incur a number of non-recurrent and recurrent costs associated with financial governance of the delegated functions and resources.

These documents relate to the Public Bodies (Joint Working) (Scotland) Bill (SP Bill 32) as introduced in the Scottish Parliament on 28 May 2013.

59. Different VAT arrangements pertain in Health Boards and local authorities. Health Boards are section 41 bodies (VAT Act 1994) for VAT purposes, such that they can only reclaim VAT on certain specified services. In contrast, local authorities are section 33 bodies (VAT Act 1994) and, with a few minor exceptions, have full VAT recovery. The different VAT status of the partners complicates the recovery of VAT on goods and services purchased through the resources in an integrated budget and this introduces risks for recurrent resources. This is considered in detail in the recurrent costs section below. There is existing HM Revenue and Customs (HMRC) guidance for the delegation between partners model, and the Scottish Government will work with HMRC to tailor this to the Scottish context and to develop new guidance for the delegation to a body corporate model. Professional advisors have been appointed by Scottish Government at a non-recurrent cost of £35k.

60. In addition, each partnership will have to obtain agreement from HM Revenue and Customs on a case-by-case basis, which will involve preparation of financial statements. Based on experience in Highland, this will be marginal and is covered by the non-recurrent transitional costs outlined above. There will be a cost to HM Revenue and Customs for the process of application and approval of the integrated VAT arrangements for each partnership. Scottish Government officials are working with HM Revenue and Customs on these matters.
VAT: delegation to a body corporate

77. Unlike with the delegation between partners model, where HMRC guidance allows a VAT neutral solution, there is no guidance available for this model. Consequently, there is a risk that VAT currently reclaimed by local authorities is no longer able to be recovered under the VAT arrangements in the body corporate. However, 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 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 that a VAT neutral position is attainable. (HE – this might also affect the ability to charge rental income (mostly funded by HB, as the corporate body would become the landlord, and if the corporate body is not a local authority or a Registered Social Landlord, then higher levels of rent are not allowed)

78. Note that should the Scottish Ministers extend, at a future juncture, the remit of the body corporate to be allowed to take advantage of employment and contracting powers, then there is a risk that HMRC will revise their view and conclude that the body corporate is in fact providing services. Under this contingency, the VAT status of the body corporate is less clear and the recovery of VAT is at risk. 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.

79. The Scottish Government is working with its advisors and HMRC to develop new guidance for the delegation to a body corporate model, based on the same principal of VAT neutrality that informs the guidance for delegation between partners. The likely position, therefore, is that there will be no additional cost under the new arrangements for VAT.

Support to the third sector

62. It is intended, through secondary legislation, that integration authorities will be required to fully involve the third sector as key partners in strategic commissioning, locality planning and service delivery activity. The Scottish Government recognise the key role non-statutory, not-for profit providers of health and social care services play in the provision of care, working in partnership with statutory partners. It is expected that there will be a degree of overlap between these activities and those currently required for third sector participation in community planning and in developing change fund commissioning plans. (HE – there are lots of large and medium sized providers that are registered as Scottish Charities, most of which make a profit – are these to be considered as “not for profit”? Approx 80% of current providers of Adult Placements are registered as Charities).

Capital and assets

66. There are likely to be non-recurrent costs associated with carrying out due diligence reviews on assets and liabilities transferred to the host partner in the delegation between partners model. The estimate for these, based on the Highland experience, is included in the transition costs noted above. Under delegation to a
body corporate, it is not intended that the new bodies will own capital assets, so there is no need to provide for costs associated with carrying out due diligence reviews on transferred assets and liabilities as is the case for delegation between partners model. This will result in a small reduction in the cost required for the transition team, but this will be offset by the small additional cost required for developing the Standing Orders etc. for the new body.

Health and social care activity information

67. To provide partnerships with information for developing their strategic plans and to inform performance management, a linked patient/client level health and social care dataset and information system will be required. It is likely to be more efficient that this be developed as a national solution by Information Services Division and for partnerships to access their data remotely. Non-recurrent estimates for the development of this, based on a preliminary assessment by ISD, are £250k in 2013/14 and £500k in 2014/15. (HE – does this include costs to be carried by Local Authorities? If so, then I suspect that the estimated cost is low).

Other financial governance: for both models

87. The inclusion of hospital services in the integrated budget will necessitate a greater emphasis on hospital activity and cost in Health Board financial management and financial planning systems, which will require investment in costing teams. The estimate for this is £800k p.a. based on increasing the capacity of Health Boards costing teams to a proportionately consistent level. (HE – I do not understand why this would have a greater impact on Hospital Boards than Local Authorities).

99. It is difficult to accurately gauge the level of uptake off the Common Services Agency’s shared services across the wider public sector as this is not a mandatory measure - rather it is for public bodies themselves to determine the benefits of using the services provided by the Common Services Agency. However, what is apparent is that the costs to the public sector will be cost neutral. There will be no increase in the level of the Common Services Agency budget as a result of it delivering services to the wider public sector. (HE – but, if some work left Las and was done by CSA, then there would be a saving in LA costs).

114. Where staff transfer to the Health Board, the initiative for harmonisation would be with the Board; experience from Torbay and North East Lincolnshire, where staff transferred to the Care Trusts, was that the Trusts encouraged transferred staff to migrate onto the same terms and conditions as their new colleagues and that this helped to establish multi-disciplinary co-located teams and deliver truly integrated services. Although staff would be free to remain on TUPE terms and conditions, it is unlikely because migration of staff onto NHS terms and conditions would be to their individual advantage.

115. Where staff transfer to the local authority, the initiative for harmonisation would be with the local authority in the same way as in the case above, but there would also be a risk of an equal pay claim from the existing local authority staff. (HE – There are other staff issues re pay and pensions, but until there are employees in the corporate body, there is no problem).
Data sharing and information technology

137. The Scottish Government eHealth budget currently includes a dedicated budget of £2m p.a. to support Health and Social Care IT integration (HE – how much support is this? What are the likely costs for NHS and Las?) The NHS and local authorities have invested significant amounts in previous years to put in place modern IT systems. The focus of future work will be on exploiting the capabilities of these systems to improve information sharing.

138. The eHealth Strategy17 published in Autumn 2011 included a commitment to produce a Health and Social Care IT strategy (by early 2014) in partnership with local authorities. In addition, a Data Sharing Technology Board (DSTB) has been established under local authority chairmanship and is meeting regularly. This Board is responsible for decisions on the existing infrastructure and the development of consensus on the way forward. The Board undertakes this role in a broader context of co-operation between stakeholders through their role in the development of the Health and Social Care IT Strategy.
1. Given the diversity of arrangements across health board and local authorities it is recognised that assessing the financial implication of the Bill is likely to have been challenging. The provision of information on the underlying assumptions, while certain aspects are challenged below, is helpful in understanding the initial assessment of additional costs. The diversity of current arrangements will make distribution of any additional funds across Partnerships complex.

2. Focus of the financial memorandum is on the additional recurring and non-recurring costs likely to be incurred by health, with an incorrect underlying assumption that all additional local authority costs can be met from within existing resources.

Consultation
Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?
3. Yes, however as no indicative costs were quoted in the consultation, we did not comment.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?
4. N/A

Did you have sufficient time to contribute to the consultation exercise?
5. Yes.

Costs
If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?
6. We do not believe that the FM accurately reflects all the costs. Provision is being made for funding CHP leadership post holders who are displaced as a result of the development of partnerships, with no similar resources, either recurring or non-recurring, being available to local authorities.

7. Whilst the staffing impact may not be as easily identifiable for local authorities as it is for CHPs, leadership posts may be impacted by the appointment to the Chief Officer posts in local authorities and a provision should be made for this.

8. Our experience of CHCPs in Glasgow resulted in additional costs for staffing to manage and support the integration agenda. There has not been any consideration either to the loss of economies of scale for other management costs.
where only elements of the current services are included within the new HSCP. We also had a number of challenges in relation to equal pay, all of which resulted in increased costs.

9. There is insufficient ICT development and recurring costs to allow for improved data sharing of information held on Health and local authority information systems. We need to integrate our IT systems so that information is only recorded once to improve the experience for the service user.

10. The financial IT systems will require to be adapted for the new reporting arrangements and to allow additional information and analysis to be provided by local authorities. The FM only makes provision for additional costs for the health sector.

11. There is likely to be additional costs associated with locality planning, increased levels of consultation and engagement of wider stakeholders. Additional funding should be made available for this.

12. VAT continues to be a significant risk for the HSCPs budget.

13. The FM also understates the costs associated with governance and audit (both internal and external). Our experience is that over the initial set up period and first thee to five years of the partnership, audit reviews will be required more frequently.

**Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?**

14. The savings that have been projected are based on a number of assumptions and the average costs used in the calculation appear on the low side. A significant number of clients who are discharged back into the community require a nursing input and it appears that this has not been costed.

15. Also to shift resource out of the Acute sector will require ward and/or hospital closures and the government has stated that there will not be further closures. The calculation does not appear to take account of the demographic challenges and the additional costs that this will bring. The savings are over optimistic.

**If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?**

16. The Scottish Government should be providing sufficient funding to local authorities to fund this change. At this point in time, the FM does not make sufficient provision for local authorities.

**Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?**

17. The FM has understated the complexity and risk that could come with some of the areas, i.e. around VAT and equal pay. Some of these challenges may only arise over time as the partnerships develop.
Wider Issues

Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?

18. As detailed above, the costs appear to be understated for local authorities and potentially other stakeholders.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

19. There may well be further costs associated with the Bill, for example through subordinate legislation, however it is not possible to quantify these at this stage.
Consultation
Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?
1. Healthcare Improvement Scotland responded jointly with the Care Inspectorate to the Scottish Government's consultation document published in May 2012. Our response focussed on the broader financial assumptions but did refer to the need to understand how the integrated services will manage a budget and potential financial pressures, as well as for the need for the powers (including financial authority) to be set out.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. The comments made were general in nature.

Did you have sufficient time to contribute to the consultation exercise?
3. Yes. Healthcare Improvement Scotland and the Care Inspectorate were closely involved with the evolution of the Bill and contributed to a number of the working groups.

Costs
If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details.
4. Part Three of the Financial Memorandum refers specifically to the joint work of Healthcare Improvement Scotland with the Care Inspectorate. The costings included within Part Three are estimates that were based on particular assumptions at the time of the consultation. In practice those assumptions may change and this may impact on Healthcare Improvement Scotland’s financial requirements.

Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?
5. Healthcare Improvement Scotland is concentrating on a specific scrutiny role in this response and would not comment more widely on the costs and savings throughout the Financial Memorandum.

If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?
6. For Healthcare Improvement Scotland to comply with the Bill, it will be necessary to review the appropriate skills and resources to conduct the required inspections. We will consider the associated financial implications in the context of
our broader financial strategy. Additional costs may require some uplift to our baseline funding which is currently reducing on an annual basis and any uplift will have to be agreed with Scottish Government Finance colleagues.

**Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?**

7. The estimates in Part Three reflect current estimates but there will be a need to carefully consider implications as scrutiny evolves. We will involve Government colleagues in this.

**Wider Issues**

**Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?**

8. Healthcare improvement Scotland does not have the experience to comment on other aspects of the costs within the Bill.

**Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?**

9. Healthcare Improvement Scotland provided a response to the Health and Sport Committee call for evidence on 2nd August 2013. This makes it clear that the role of scrutiny is central to ensuring high quality services and outcomes and could be enhanced. There will be a need to consider how any shift in scrutiny impacts on the costs incurred by Healthcare Improvement Scotland.
Consultation
Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?
1. The Dumfries and Galloway Strategic Partnership submitted a joint response to the consultation on the Scottish Government’s proposals to integrate adult health and social care. The response made no specific comment on the financial assumptions as set out in the consultation process.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. N/A

Did you have sufficient time to contribute to the consultation exercise?
3. The timescale for responding to the consultation was sufficient to provide a detailed response. The initial consultation document was based on a number of generic models for integration which have since been analysed to provide a greater level of detail. It would have been more beneficial had the initial consultation given greater clarity on the detailed options available for consideration.

Costs
If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?
4. The NHS Board and Council have yet to formally agree on the appropriate model for social integration in Dumfries and Galloway and therefore, cannot yet produce a robust financial model to quantify the costs of integration. The FM provides a helpful indication of the broad cost parameters forecast as part of the integration agenda. The Bill does recognise that the current costing estimates are at a high level and will require to be refined as part of the implementation process. Clarity on the treatment of VAT, terms & conditions and asset accounting will be emerging challenges that will shape the size of the financial envelope.

Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?
5. The FM has attempted to quantify the cost of the Bill over the medium to long-term. The FM is a reasonable estimate of the cost of its implementation. The complexity of the client group and the 15 year timescale, would indicate that the costs over such a timescale are at best a guide for service provision. The assumptions underpinning the costing work will be refined as implementation progresses to improve the accuracy of the estimate. Other demand issues may
impact on the cost envelope such as the impact of Welfare Reform and the technological advances that continue to be made.

**If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?**

6. While the strategic partnership considers the eventual shape of configuration for Dumfries and Galloway it is too early to confirm the additional cost of integration. It is clear that both the NHS and Council are focused on implementing the bill to maximise the opportunities to deliver improved service provision together with greater efficiencies. The cost envelope is currently being modelled to greater understand the financial impact to the partnership, however, outstanding technical issues still require to be resolved at a national level. The issues are well documented within the FM.

**Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?**

7. The FM identifies the key areas of risk and uncertainty to the introduction of the Bill. The quantification of costs will be dependent on local determination and at this stage can only be utilised as a useful guide.

**Wider Issues**

**Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?**

8. The FM is a reasonable attempt at quantifying the costs of integration at this current time. Experience tells us that during periods of significant change there is a potential that the public sector will under estimate the actual costs of the reorganisation and overestimate the savings generated.

9. In Dumfries and Galloway, the Council and Health Board are working jointly to maximise service improvements from the introduction of the Public Bodies (Joint Working) (Scotland) Bill.

**Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?**

10. With the complexity of the service change it would be anticipated that at some future point additional legislation maybe required which would have a financial impact. At this stage it would not be feasible to quantify the financial impact.
Consultation
Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?

1. Yes we responded. Our comments relating to finance were limited to the questions posed in the consultation. For instance, in our response to question 9 we felt that Health Boards and Local Authorities should be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership and in our response to question 10 we agreed that the two models described can successfully deliver the government's objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support? However, we expressed a view that the Lead Agency model would be more effective model for this.

2. In our response to question 12 we agreed that if Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, it would provide sufficient impetus and sufficient local discretion to achieve the objectives the government has set out.

3. However, we felt that there must be a level of flexibility to enable that local response but if the direction is too limited the desired outcomes may not be achieved. The emphasis should be on functions and not services per se to ensure that the total resource required to deliver that function is included in the integrated pot.

4. In response to question 13 we did not think that the proposals described for the financial authority of the Jointly Accountable Officer would be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care. We felt there was a danger this would continue to lead to decisions made in isolation.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?

5. We are pleased to see that the Bill allows a degree of flexibility in the financial arrangements. There are other matters that may have financial consequences we are aware of (which we did not refer to in our response as they were not really covered in the questions) but we are pleased to see these reflected in the Bill - such as an acknowledgement of the need to review the Clinical Negligence & Other Risk Insurance Scheme, the issue of harmonisation of terms and conditions plus the potential issue of pension deficits transferring along with staff under the delegation between partners model.
Did you have sufficient time to contribute to the consultation exercise?

6. Yes

If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?

7. The direct costs of integration for the north Highland model are already largely quantified and accounted for. There are outstanding issues regarding IM&T provision. There is also an outstanding issue regarding the potential leasing of Care Homes from Highland Council to NHS Highland (or a full transfer of ownership) as the differing accounting regimes between local authorities and NHS bodies are currently proving challenging. The differing VAT regimes have implications for both these outstanding issues but this is acknowledged in the FM.

NHS Highland will incur costs in establishing an integration model with Argyll & Bute Council. These are not yet quantified in any detail but it is reasonable to assume they will be in line with estimates made in the FM.

Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?

8. Forecasting this far in advance is very challenging. The assumptions seem reasonable with the caveat around the potential cost of transfer of assets - see question 6.

If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?

9. As noted above - the majority of the implementation costs are identified and covered for the north Highland model with the exception of IM&T costs (which could be significant) and the potential costs for leasing or transferring Care Homes. The latter could be very significant indeed - in reality this would prevent a transfer being made or a leasing solution from being pursued. NHS Highland continues to be in dialogue with the Scottish Government with a view to resolving this issue.

It is worth noting that the integration of budgets between partner bodies requires a high degree of trust and openness - and this is as much about leadership and culture as legislation.

Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

10. The FM does seem to be clear that the figures are estimates. It is perhaps not quite so clear that the potential efficiencies from reducing delayed discharges, reducing variation and anticipatory care plans are presumably based on 'full cost' estimates which are therefore not fully realisable unless fixed costs are reduced as a result of the changes.
Wider Issues

*Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?*

11. As noted above - the bill does not seem to make provision for the potential costs of transferring ownership of assets (or long term leasing of assets). This could be viewed as an accounting issue rather than a funding issue per se, but the consequences are manifested as funding issues due to the differences in the accounting regime between the partner bodies.

*Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?*

12. Not aware of any future direct transitional costs of integration arising from the Bill. The wider financial consequences of integration are difficult to quantify but our belief is that these will be beneficial rather than a cost burden.
INTRODUCTION
1. Lothian NHS Board and its four local authority partners supported the general principles in their joint response to the May 2012 consultation, and have already appointed Joint Directors for each local authority area. Shadow Health & Social Care Partnership Boards are in place in West Lothian and in Edinburgh, and being established in Midlothian and East Lothian.

EXECUTIVE SUMMARY
2. NHS Lothian believes that integrated functions and resources should produce greater efficiencies. However it is important to note that efficiencies do not always lead to cash-releasing savings. If we were able to reduce the number of people delayed in our system this would release beds, which in itself is an efficiency and is also an important aspect of quality of care for the patient. If we can free up beds we then have more capacity and this in turn would allow us to reduce the number of people boarding or even the need to cancel elective, scheduled operations due to a lack of available beds.

3. The process of implementing re-design often requires upfront investment, particularly alternatives to hospital admission. Resources across the public sector have been severely constrained in recent years and one initiative that would be important to see continue is that of the investment made through the Change Fund for Older People. This is particularly important given the projected demographic changes in Scotland and Lothian, and the growth in the prevalence in dementia, offer two primary challenges to resources:

- The ability to continue to provide routine services, and
- The inevitability that the overall costs of providing health & social care services to the over 75s will rise in real terms.

5. Integration gives an opportunity to mitigate the impact of some of the growth in demand for specialist forms of care at home, care in residential settings or care in hospital.

6. The rate of admission to hospital will have to be massively reduced just for hospital services to stand still, let alone release resources for alternative methods of service provision. If a material amount of resources is to be released from hospital care, this would require the closure of some acute hospital facilities. There is extremely limited evidence of this being done quickly or successfully in Scotland in recent years and this would require full partnership support, engagement and consultation.
**Did you take part in either the Scottish Government consultation exercise which preceded the Bill and, if so, did you comment on the financial assumptions made?**

7. Yes.

8. Lothian NHS Board submitted a joint response with its four partners to the consultation in September 2012 with an overarching introduction by the Board’s Chief Executive.

9. The response reflected the differences in each local authority area and a commitment to developing a continued local response to national priorities, whilst promoting a consistent and coherent approach to delivery mechanisms in securing improved health and care outcomes.

**Do you believe your comments on the financial assumptions have been accurately reflected in the FM?**

10. Yes.

11. We welcome the acknowledgement of the risk and uncertainty associated with the financial effect in paragraph 35 in the FM and its re-emphasis in the invitation sent out to Boards and other public bodies by the Finance Committee on 2nd July 2013.

12. There are substantial issues with regard to addressing the financial implications of delegation of functions, which can only be properly defined by detailed work in each local authority area.

**Did you have sufficient time to contribute to the consultation exercise?**

13. There was sufficient time to draft a response to the consultation exercise in September, however it was not possible to produce an agreed unified submission by the stated deadline for this review by the Finance Committee. This was because the process of taking the draft through the review process of several local authorities took longer than we had originally anticipated but it is important to state that NHS Lothian and its partners have been consistent in the responses submitted to the recent Call for Evidence through the Parliament’s Health and Sports Committee.

**If the Bill has any financial implications for your organisation do you believe that these have been accurately reflected in the FM? If not please provide details.**

14. Sections 9 to 36 of the FM set out the totality of the financial resource envelope for health and social care in Scotland, and the potential opportunities for efficiencies in utilisation of the resource.

15. In particular sections 27 to 33 set out the assumptions around the calculation of savings of between £138m and £157m that could offset the projected increase in expenditure attributable to future demographic growth pressures on the resources available.

16. In this particular area, the savings assumptions are:-
• Calculated at full cost
• Assume the mix of post discharge care being provided is consistent.

17. These assumptions represent a significant simplification of the issue. The actual delivery of “savings” will be affected by the following factors

• Releasing financial resources from existing infrastructure (e.g. property and other overheads) will take time.
• Release of resource is not necessarily linear in that patients who still require Acute and other Institutional Care but be more frail and ill than the average of patients currently in such institutions.
• It is hoped that integration will reduce delayed discharges. However this will happen on a patient by patient basis and any immediate benefit may be spread over a number of wards and hospitals. The numbers of occupied bed days released from any particular specialty would have to reach a critical mass before any discernible benefits can be achieved i.e. closing a ward or a hospital.
• Many savings will be dependant on initial funding to support the change programme. If the source of that funding is the release of existing resources, then it is subject to all of the points above.

22. The above factors restrict the ability to satisfy the need (identified in paragraph 34) that potential savings are “re-invested within the partnerships in order to help meet demand. Local planning must recognise this restriction in the immediate planning period within the parameters set out in paragraph 36 of the FM.

23. More specifically:
• In paragraph 27 the delayed discharge savings are based on a direct cost per bed day component of excess stays above performance targets. Direct costs consist of the cost of medical, AHP and nursing staff. Once delayed discharges are released, it is more likely that those staff will be deployed into managing the care of the acute patients who have been waiting to re-occupy the bed space rather than closing services down.
• In paragraph 29 the anticipatory care plans savings (£12m) are an extrapolation of the results of a two practice study within one locality. As such it may not be a reliable estimate.
• In paragraphs 30 to 33 the £104m savings estimate relies on a benchmarking technique across the partnerships. It is far more likely that the differential in healthcare costs per person across partnerships reflect differing approaches to the apportionment and allocation of overheads between acute and community care across Boards than major differences in efficiency. It appears to be inequitable that allowance is made for confounders for variation in per capita social care expenditure without similar allowance being made for potential confounders in healthcare expenditure. The research base on which the FM conclusion on healthcare per capita costs was drawn was based on an unpublished research paper that had not been peer reviewed.

26. The conclusion from the above is that whilst there are undoubted efficiencies arising from the integrated management of resource, they may not
be immediately cash releasing. Those resources eventually releasable will derive from a critical mass in beds less occupied becoming available, or through integrated management of workforce cost dynamics such as sickness absence and alignment to activity peaks.

27. Boards and Councils have been gradually exposed to a financial planning tool to compute the totality of resource consumed by the patients/clients of partnerships. This is labelled the Integrated Resource Framework (IRF). The inputs to the IRF model are largely based around the full costs of healthcare provision and as such are unsuitable as a basis for commissioning currency in evaluating the size of the resource flows anticipated in sections 13, 17 and 18 of the Bill.

28. NHS Lothian Board along with its Council partners has set out a resource framework based on direct controllable costs embedded in existing budgets to set the resource envelope being managed across partnerships. This includes Prescribing, Family Health Services costs and “hosted services” (managed by one CHP on behalf of the others across Lothian).

29. In addition, and to meet expectations of local stakeholders, a managed resource element for associated acute services is being identified for performance management reporting purposes. However it is recognised that this acute resource will not form part of the commissioning currency for the HSCP. This should enable stability in management of the residual acute resource across the Health Board area.

30. In conclusion, the resource currency for commissioning of services should be based on direct controllable costs with appropriate risk management arrangements for hosted and shared services across the HSCPs agreed by the partner organisations as part of the planning agreement.

Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?

31. The uncertainties surrounding the transition to the new HSCPs and the underlying assumptions with regard to how these operate in governance and operational terms are recognised in the FM and accordingly we have no reason to dispute the detail of the ranges of costs estimates provided for recurrent and non recurrent costs set out in Tables 3, 4 and 5.

32. Paragraph 73 to the FM set out the risk in terms of VAT recovery in terms of transfers from Council to Health Boards in terms of delegated functions. Tax efficiency should not be the sole arbiter of the service strategy but efforts should be made where possible to mitigate the effects and the Board welcomes the efforts to achieve overall tax neutrality of the service transfers for the delegated functions model. Discussions with Scottish Government in the period up to and including the consultation have revealed a preference for a “four transaction model” of body corporate in the initial stages. The Board is hopeful that this model, if adopted, would help to achieve a VAT neutral solution to the body corporate model in line with paragraph 77 of the FM.

33. The Board notes the variable cost impact of pay harmonisation scenarios set out in paragraph 121 of the FM. Although delegation of function to the Health Board.

4
The Board is of the view that the pension cost scenario set out in paragraph 116 of the FM may be manageable. Whilst transfer into Health Board terms and conditions may give rise to more favourable and thus higher costs the Board has managed its exposure to issues on Equal Pay effectively since the new Agenda for Change pay structures were implemented in 2004. One area not clarified is whether legacy issues on Equal Pay in local authorities have been dealt with and the obligations of the transferor and transferee in respect of such liabilities.

34. The conclusion overall is that the costs set out in the Financial Memorandum for transitional change and recurrent additional costs are not unreasonable but their accuracy will be ultimately determined by the nature of the partnership mix, the resolution of the VAT neutrality issue and the subsequent development of the legislative powers through subordinate legislation.

If relevant are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur. If not, how do you think these costs should be met?

35. Over the long term the costs outlined should be met from the resource identified. In the transitional period, bridging finance will be necessary to manage the impact of non-cash release of resource, the costs of change and the impact of any subsequent change in the nature of the relationships across the HSCPs and the contributor bodies. Additionally the level of flexibility in the use of the Change Fund identified within the Scottish budget up to 2015 will be critical to the contribution towards the bridging of the immediate resource implications, as set out in paragraph 130 of the FM.

Does the FM accurately reflect the margins of the uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

36. Subject to the issues raised in the responses to 4. and 5. above the FM has made reasonable efforts to identify the risks associated with the implementation of the Bill. Each local HSCP will require to undertake detailed work as part of its planning process to identify specific risks and opportunities arising from integration of functions. In addition the Integrated Resources and Advisory Group set up by the SGHSCD has set out a series of preparatory activities to mitigate the financial aspects of implementation risks covering the financial clauses in integration agreements, procurement issues, due diligence and post implementation review of the integrated budgetary management in the shadow year.

Do you believe that the FM reasonably captures costs associated with the Bill? If not what other costs might be incurred and by whom?

37. Yes. The FM has attempted to identify the costs associated with implementation in the initial phases of the Bill. The savings estimates, however, have a greater degree of potential volatility and risk.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?
38. Legislation is likely to be used to change the nature of the relationship between the current Boards and Councils and the new partnerships which will include a more precise definition of the nature and powers of the corporate body, its officers, and Scottish Ministers.

39. In addition, the assumption on the future role of the NSS in managing the transactional elements of integrated financial frameworks without negotiated resource transfers from other (territorial) boards may require to be considered in more detail. There is a body of existing work in NHS Scotland to deliver shared financial services and integrated workforce recording which may be subject to disruption and this needs to be carefully managed.

40. In evidence to the Health and Sport Committee we stated that the legislation in setting out to be wide-ranging and permissive has or appears to have, gone well ahead of the briefing to the service on how the new structure of governance will work. The bill offers many opportunities which Lothian and its partners recognise, however early changes to the governance arrangements have an unquantifiable potential to increase the recurrent costs (beyond the “four transaction” model) and the disruption to established services that are configured to provide a uniform service across Council boundaries within a single board and already developed shared services providing a uniform service across NHS Scotland.
FINANCE COMMITTEE CALL FOR EVIDENCE
PUBLIC BODIES (JOINT WORKING) (SCOTLAND) BILL: FINANCIAL MEMORANDUM
SUBMISSION FROM NHS NATIONAL SERVICES SCOTLAND

Consultation
Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?
1. Yes. We responded to the consultation on the Integration of Adult Health and Social Care. We did not specifically comment on the financial assumptions, but we did comment that a cost impact assessment should be carried out for staff transfers.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. Yes. The likely costs and risks form part of the FM.

Did you have sufficient time to contribute to the consultation exercise?
3. Yes

Costs
If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?
4. We believe that the Bill has implications for our organisation’s revenue and for our costs, in both Part 1 and Part 2.

5. We would also like to clearly state that whilst we identify a number of risks in our response, and in particular in response to this question 4, we are involved in ongoing national work to manage these risks.

Part 1
6. It seems likely that in at least some parts of Scotland, Part 1 will lead to new public sector entities being created – the ‘body corporate’ model. It is not clear if these new entities will be procuring services in the medium or longer term.

7. In the remainder of the country, public sector bodies would opt for the ‘lead agency’ model, which also potentially changes the entity which is currently procuring services from NSS.

8. The implications of Part 1 on NSS future revenue are therefore two-fold:
   - Health Boards are currently required to buy some services from NSS; Local Authorities do not operate with the same requirements – e.g. use of NHS Central Legal Office, National Distribution Centre. If the procuring entity changes, then our revenue may fall and we would need to try to manage our costs down accordingly, which may be difficult if some costs are fixed in the
short to medium term (e.g. staff costs or property costs); conversely there
may be an intended or unintended consequence on any entity requiring it to
buy NSS services when it does not currently do so, with implications for their
current staff and/or third party contracts

- In addition, Health Boards currently source optional goods and services from
NSS within the EU procurement regulations but without the need for a formal
procurement process as it is seen as spending money that is already wholly
within the health service budget. We operate a strategic sourcing team which
procures over £1bn p.a. of goods and services for NHS Scotland and we are
not clear how much of that spend they would continue to need to develop and
service. Under either the ‘lead agency’ or the ‘body corporate’ model, it has
not been made clear to us who the future procuring entity might be and hence
how compliance with procurement regulations would operate and be ensured.
We are of the view that there is a strong risk that without careful planning and
clear guidance up front, these changes may be disruptive and expensive for
all concerned.

9. Costs:
- We buy over £150m p.a. services from NHS Boards for NHS Scotland
patients for nationally commissioned specialist services without having to go
through formal procurements – the opposite of the income point above in
terms of procurement regulations. If any of those services in future are
provided by Local Authorities or by new bodies corporate, will the same
situation persist? If NSS has to go through procurement processes, that will
require additional resource. Also, if a contract is then awarded to a non-NHS
Scotland provider for a service currently provided to patients by NHS Scotland
(or to a non-Local Authority provider for a service currently provided by a
Local Authority), there may be implications for the sustainability of other care
currently provided by those same NHS or Local Authority staff and/or facilities.

10. Part 2
NSS recognises and appreciates the time and dedication shown by Scottish
Government and its officials, and many others to enact the Public Services Reform
Order (“PSRO”) with effect from 29th June 2013. This allows NSS to offer its services
to customers other than health bodies and very clearly lays out our role in the way
we would like to see it reflected in the final Bill.

We are actively pursuing these new opportunities currently and initial discussions
with Scottish Government and a number of public sector bodies suggest that there is
a genuine demand for our services to create public value.

If the Bill were to restrict in some way what has already been put into law through the
PSRO, not only would that, in our view, reduce benefits to the Scottish public sector
together with our associated future income, it could also leave NSS looking to further
reduce capacity and that might be hard to achieve in the short to medium term.
Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?

11. We have had the benefit of reviewing the Financial Memorandum but have not been part of the team developing the extensive and detailed work which sits behind it. Our reading of the FM alone suggests several areas where we would seek further assurances as to how the models have been constructed and these are set out in Appendix A.

12. One overall observation would be around risk and reward. The bill projects costs of c£34m in years 1-5 and an ongoing c£7m p.a. new cost to the public sector. The range of savings compared to those costs is c£138m–c£157m p.a. and would seem to be a good return on that investment. However, paragraphs 9-11 of the FM state the total spend by Health Boards and local authorities on adult social care to be over £11bn p.a. The savings therefore represent only c1% of annual spend. This would appear to be a modest target for a programme which will absorb considerable public sector resource over a number of years. One alternative or activity which could sit alongside the Bill would be to dedicate more resource to prescribing and aim to reduce by c10% only the NHS Scotland prescribing budget and generate similar savings. Other choices or complementary activity might be to look at property costs or workforce costs.

If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?

13. Yes, subject to clarification on the risks mentioned above. We believe that the Bill will not create significant incremental costs for our organization and are therefore content that any costs could be met. However, we are mindful that the creation of additional public sector entities could create a different and more complex landscape for us to work with effectively and may therefore cause incremental costs to NSS.

14. We note that section 99 does not envisage increases in budgets and specifically indicates no increase to that of the Common Services Agency (the legal name for NSS). In a landscape of significant public sector reform, there may be a requirement for NSS to provide further shared services that may increase NSS’ budget whilst offsetting public sector costs in excess of this. NSS, over the last five years, has made CRES of £37m and will continue to do everything possible to increase its productivity and efficiency.

15. The core reason for NSS extending our services beyond the NHS has been to deploy in support of integrated Health and Social Care, making our shared services available where desired. As utilization of our services is completely optional, we only expect growth if it is in the interests of the Public Bodies using our services, i.e. it offsets other larger costs whilst improving quality.

Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

16. Yes, apart from two concerns:
- Paragraphs 64 and 65 of the Explanatory notes set out a requirement for three-year strategic plans. We believe that to energise effective public sector reform on this scale will require vision and dedication to address large elements of how health and social care are delivered - workforce, property, prescribing, IT etc. Many of these staff arrangements, third party contracts, property leases and other costs are relatively fixed in the shorter term. We therefore consider that change will take much more than three years and so a longer planning horizon is essential or at least desirable.

- Paragraphs 104-111 on joint ventures are unclear as to how this will work alongside existing activity – e.g. HubCos – and therefore how the bill provides a further savings opportunity.

**Wider Issues**

*Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?*

17. See 5 above.

*Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?*

18. We have no comment to make.

*In addition to the questions below, please add any other comments you may have which would assist the Finance Committee's scrutiny of the FM.*

19. Our additional comments which do not naturally sit under the specific consultation questions are:

- **Shared services:**
  - This could be seen as a missed opportunity to properly establish a public-sector shared services entity with appropriate governance
  - We are not clear how this bill is linked to the SG shared services agenda – e.g. for support services

- **It is interesting that the invitation has gone out to collective bodies for Local Authorities (COSLA, SOLACE), but not to anything equivalent for Health Boards (e.g. NHS National Planning Forum)**

- **Paragraph 99 of the Explanatory notes states that section 37 allows for information sharing. In order to maximize benefits and best enable person-centred care and access to information about them, what consideration has been given to requiring information sharing rather than only allowing it?**
APPENDIX A

When reviewing the FM, we noted areas where further assurance would be helpful to clarify if benefits and cost have been over-stated or under-stated. Specifically:

- Savings opportunity: It would appear that some savings may not have been included:
  - Paragraph 91 refers to the opportunities from revenue property cost savings but no estimate appears to have been made
  - Paragraph 86 refers to the potential benefits from rationalization of support services, but no estimates appear to have been made and no timescales or ambition set

- Savings risk: Some savings may have been overstated:
  - Paragraphs 24 et seq in the FM deal with delayed discharge. They focus on the impact of transferring costs of care. They project savings of £22m to £41m p.a. from delayed discharge. These would be overstated to the extent that they are not realised as cash savings due, for example, to the increased cost of the care which prevents the delay in discharge and/or other patients consuming those resources instead – e.g. to reduce waiting times
  - In paragraph 30 of the FM, reference is made to the poor data on variation, particularly in adult social care. Paragraph 33 then states a single figure of £104m p.a. as the saving from reducing variation. A range of savings in this area would appear more appropriate, particularly given that total savings (paragraph 34) are only projected to be £138m - £157m p.a. and this is the major element of them

- Cost risk: Some costs may not have been included:
  - Paragraph 78 of the FM highlights a VAT risk of £32m p.a. for VAT currently recovered by local authorities on adult social care. This does not appear to be set out as a cost or a reduction in savings. Equally, there could be a VAT opportunity for costs currently incurred by section 41 bodies which in future are costs borne by section 33 bodies

- Cost opportunity: Some costs may be overstated unless it can be proven that they are actually incremental costs to the overall public purse – e.g.:
  - there is a reported (paragraph 89 of the FM) direct cost of £3m p.a. for clinicians involvement in locality planning, but does this mean that the Scottish public sector would spend £3m p.a. more on clinicians than it does now? Or is some of the cost in fact because the public body paying clinicians changes but the overall public sector cost does not change?
  - The transition team costs of £9.8m (FM paragraph 37). If any of these are existing public sector staff, the incremental cost to the public purse will be lower
  - Scrutiny cost in paragraph 123 of £670k p.a. Again, are there other savings to offset (e.g. internal audit)? Why would more integration and fewer ‘moving parts’ lead to higher scrutiny costs for the system overall?
FINANCE COMMITTEE CALL FOR EVIDENCE

PUBLIC BODIES (JOINT WORKING) (SCOTLAND) BILL: FINANCIAL MEMORANDUM

SUBMISSION FROM NORTH AYRSHIRE COUNCIL

General
1. Given the diversity of arrangements across health board and local authorities it is recognised that assessing the financial implications of the Bill is likely to have been challenging. The provision of information on the underlying assumptions, while certain aspects are challenged below, is helpful in understanding the initial assessment of additional costs. The diversity of current arrangements will make distribution of any additional funds across Partnerships complex.

2. Focus of the financial memorandum is on the additional recurring and non-recurring costs likely to be incurred by health, with an incorrect underlying assumption that all additional local authority costs can be met from within existing resources. The response below focuses on the three areas on which feedback has been requested.

The wider financial impacts of the health & Social Care Bill
Part One Transitional Costs
3. Comments regarding each of the components of the Transition Costs are noted below;

- Limiting transition team costs to the minimum will not encourage partnerships to include a wider range of services
- Provision is being made for funding CHP leadership post holders who are displaced as a result of the development of partnerships, with no similar resources, either recurring or non-recurring, being available to local authorities, this creates an inequity in respect of local authority senior managers who are unsuccessful in securing a post in the new partnership
- Due to the complexities of one health board with multiple local authorities there is a concern that this will result in additional costs rather than deliver economies of scale,
- Insufficient ICT development and recurring costs e.g. within Ayrshire the three local authorities operate different social work management information systems
- Welcome the non-recurring costs for third sector support, but consider this to be insufficient and a requirement for an element to be recurring.

Part Two Recurring Costs
4. Concern that the identified recurring costs are insufficient to meet the requirements of the Bill. Examples include;

- there is an assumption that the balance of funding for the Chief Officer can be met from the current CHP General Managers salary, North Ayrshire
operates a virtual CHP with no services managed by the CHP and no CHP General Manager post,

- consideration is not given to loss of economies of scale for other management costs where only elements of current services are included within the new HSCP
- low value attached to external audit
- additional costs associated with development of financial information identified for the health sector only additional costs associated with clinicians involvement in locality planning is considered insufficient, also unclear why the additional costs relate only to clinicians and not wider stakeholders recurring costs around strategic planning limited to management information, anticipated that additional costs, linked to increased levels of consultation and granularity, will be incurred difficult to comment on the sufficiency of additional investment around care economists due to lack of information on current resources no funding to support governance, unclear the assumptions that have been made around remuneration for Board Members the assumption is that support services for the HSCP can be funded from existing CHP support services is not supported; the North Ayrshire CHP does not have any support services. In addition there are concerns around loss of economies of scale in existing services and the need to support the new partnership.
- VAT continues to be a significant risk for the HSCPs.
- Wider concerns around the emergence of additional staffing cost pressures as integrated teams develop. Specific examples include; harmonisation of terms and conditions – a particular issue where similar services are being provided e.g. support services; jobs being evaluated on different bases; concern re the NHS no redundancy policy and current and future pension risk around potential transfer of employees between funded and unfunded schemes and rising employer contributions.

5. Use of NHS National Services Scotland requires to be considered at an individual partnership level to establish whether it will deliver best value for money. A local concern around use of centralised services is the impact on local jobs and the local economy. This is of greater concern in North Ayrshire where unemployment is the highest in Scotland and health employment is low due to no general hospital in the area and limited local community health services.

6. A better understanding of the risk and cost implications for local authorities of using CNORIS is required.

7. In the section which deals with impact on other agencies additional inspection costs have been identified, it is not clear why this would be additional to rather than different from the current inspection arrangements. Any additional costs for external inspectorates require to be matched with partnership funding to prepare for additional inspection. There is a view that rationalisation of the current inspectorates is possible as the HSCPs develop.

**Any technical financial issues which the Bill presents**

8. The main technical issues were covered in the joint DoFs response to the original consultation. These issues are being pursued across the five work streams.
Specific commentary on the Financial Memorandum. Included in this we would welcome views on whether you are content that the Integration Agenda will actually deliver everything that the Financial Memorandum sets out.

9. A limited number of under developed examples are provided on the anticipated efficiencies from the integration of health and social care; as such it is difficult to place reliance on these. A particular concern is noted around the ability to reduce the per capita variation in health services, elements of which may be justifiable.

10. Management and delegation of resources at a locality level will create challenges for Partnerships, in terms of effective management and potential for further loss of economies of scale.

11. It is clear that there will be challenges in shifting resources from acute to early intervention and prevention with the significance of any savings from the development of the HSCP likely to be lost in the wider demographic challenge. The development of HSCPs will not remove the requirement for a greater level of investment to support rising demographics.
FINANCE COMMITTEE CALL FOR EVIDENCE

PUBLIC BODIES (JOINT WORKING) (SCOTLAND) BILL: FINANCIAL MEMORANDUM

SUBMISSION FROM SCOTTISH BORDERS PARTNERSHIP

Consultation

Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?

1. Scottish Borders Council and NHS Borders welcomed the opportunity to comment as part of the consultation exercises which preceded the Bill.

2. These comments were included as part of the Joint Directors of Finance national response. The comments made were general comment regarding the bill and were not directly around any of the financial assumptions contained within the document.

3. In addition NHS Borders and SBC submitted a joint response as part of the consultation process proceeding the Bill.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?

4. The comments submitted at that time did not cover the detail of the costs/savings, however the response did cover some of the challenges of integration. These included areas around VAT, capital and assets, although we feel these have been picked up, or are confident these will be covered, within the guidelines and regulations that are due to be issued.

5. We would like to note that issues are becoming clearer and we are confident that good progress has been made.

Did you have sufficient time to contribute to the consultation exercise?

6. Yes

Costs

If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?

7. The Partnership notes the figures in the paper are very much estimates at this time and agree that much more research and a robust evidence base will be needed to ensure the financial assumptions accurately reflect the costs and. Importantly, the potential opportunities to both local authorities and the NHS arising from integration. Given the limited information available It is not possible I to comment on the completeness of financial implications at this time. The Partnership is still in early days and continues to develop.
8. The paper focuses on doing more with the same resources. Many efficiencies do appear to be grounded around unplanned admissions to hospital and presumably a reduction in beds. Due to the demographics and increased dependency the release of resource will be challenging. There is a clear challenge to release resources away from hospital based care (including admissions) to elsewhere on the care pathway in line with the need to shift the balance of care.

9. More specifically there are a number of issues that need to be fully explored:

- There is a concern around potential displacement costs across the Partnership and the impact of these.
- Concern around assumptions that savings will be made on CHP general managers. There may also be displacement costs for Local Authority staff that may need to be considered.
- Concern that estimated third sector costs may not be sufficient to support full involvement in the partnership.
- Additional inspection costs are identified for inspection agencies but the associated costs of preparing for inspection both in the NHS and Local Authorities are not factored in. Given the assumption that integrated working will be more efficient and effective it is not clear how this assumption has been applied to the costs identified for inspection agencies where it would be anticipated there will be some efficiencies by applying a joint approach to inspection.
- There is an assumption that through redesign of services NHS and Local Authorities will be able to realise short term efficiencies that can be redirected to fund the implementation of further transitional change. There is clearly no guarantee that this will be the case or indeed that any savings will be sufficient. The Partnership would welcome more detail on this as there will be additional costs to be met in terms of set up the integration plan and the partnership agreement.
- Cost of clinical (GPs and consultants) involvement may be significantly higher as they are key to success and will need to be fully considered.

Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?

10. Please see comments in response to question 4.

11. It would appear that costs seem to be over 6 years rather than 15 years.

12. Potential savings may take longer to be realised within the timescales detailed for example, integrated support services due to different systems and pay Terms & Conditions. It is essential that this is fully considered and scoped before savings are profiled into plans.

If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?

13. Please see comments in response to question 4 and 5.

14. There are still a significant number of risks and challenges which require full consideration. Prioritisation would be essential and would allow impacts to be considered on other key projects.
Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

15. Overall the Partnership feels that the assumptions based on current information are reasonable.

16. It is important to note that costs are already being incurred as preparations have already begun.

Wider Issues

Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?

17. Set up costs will be incurred in moving forward and some of these have already been required, especially in relation to:

- Consultation on the Integration Plan
- Set up costs in relation to the Pathfinder Board
- Joint Integration Director Post
- Double running of the CHCP and the new Joint Board

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

17. Not at this time

Any other comments:

18. The Partnership is disappointed that the Change Fund will not continue into 2015/16.

19. Scottish Government may need to have regard to the implications for Integration when setting budget allocations nationally.

20. Overall we welcome the opportunity to comment and look forward to further guidelines and regulations.
Consultation

Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?

1. Yes.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?

2. No.

3. Some of the issues identified in the response to the consultation exercise which preceded the Bill still require to be clarified e.g.

   - The role of the Section 95 Officer in local government in relation to the operation of the partnership;
   - The recognition of statutory responsibilities in respect of specific social care services and the impact of these on financial budgets and governance arrangements;
   - The impact of performance monitoring on the future use of financial resources to achieve agreed partnership targets as they develop. In this regard, the balance achieved between the autonomy of the partnership, the accountability of local government to the electorate and the authority of the Scottish Government in relation to the activities of the health board still requires to be further considered and agreed.
   - The range of technical challenges associated with managing integrated budgets. It is recognised however that these issues are being progressed by the Scottish Government, COSLA and the Directors of Finance.

Did you have sufficient time to contribute to the consultation exercise?

4. Yes.

Costs

If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?

5. There are financial implications for local government which have not been accurately reflected in the Financial Memorandum.

6. Additional costs incurred by local authorities cannot be met from within existing resources. The Financial Memorandum assumes this and does not recognise this as a key issue for local government. Instead, the Financial
Memorandum concentrates on the additional recurring and non-recurring costs likely to be incurred by health.

7. Additional recurring and non-recurring costs may be incurred as a result of existing post holders being displaced when the new partnership arrangement is established. This will affect both the local authority and the health board however, there is no provision to meet these costs within the Financial Memorandum. The only provision relates to CHP Leadership posts. There is no recurring or non-recurring funding available to meet the cost of staff displaced from local authority posts as a result of the integration. Depending on the model of integration adopted and the detail of the integration plan, there is a probability that existing local authority posts will be affected by the integration. It is not yet possible to confirm which posts will be affected or the number. Funding should be made available to meet any associated costs incurred by local authorities. The strategy to deal with the impact on the recurring cost of displaced staff beyond the first three years of the integration plan would also require to be agreed and funded where necessary.

8. The support arrangements for the new partnership, in particular the transitional arrangements, have not been fully developed at this stage. The additional costs and the timescale associated with these support arrangements cannot therefore be confirmed. These costs would relate to ICT, financial monitoring and reporting and personnel requirements. As the extent of these costs is unknown, the assumptions contained within the Financial Memorandum cannot be relied upon as complete. Only the additional costs associated with the development of financial information have been identified for the health sector only. The assumption has also been made that support services for the new partnership can be funded from existing CHP support services and this may not be sufficient.

9. As highlighted above, the duties of the Section 95 Officer in respect of local authority budgets delegated to the partnership requires to be clarified.

10. The annual budget setting processes of the local authority and the health boards will require to be harmonised.

11. The strategic financial objectives of each partner will require to be addressed to quantify the total resources available to the partnership. Target efficiency savings and annual uplifts for each partner will impact on this.

12. The partnership would require to develop a financial strategy to respond to overspends and underspends which emerge during the year.

13. Further consideration requires to be given to how the duties on local authorities will interface with health duties. An example of this is Self-Directed Support and the imminent requirement to identify individual budgets for service users to use for their support plans.

14. Financial recording and reporting costs are likely to be an additional cost incurred irrespective of the integration model adopted. A provision for these costs should be included in respect of the “Delegation between partners model” detailed at table 4 on page 35.
15. There is no recurring or non-recurring funding available to meet the additional cost associated with new IT requirements including amendments to existing financial systems.

16. Economies of scale have been achieved in respect of the management of a range of services within local authorities. Where only some of these services are now included in the new partnership arrangement, the remaining services will still have to be managed within the local authority. The economies of scale previously secured will be lost and there is no provision for this additional recurring cost for local authorities within the Financial Memorandum.

17. The position in respect of reclaiming VAT is critical and requires to be confirmed in order to inform the formation of the optimum partnership model.

18. It is not clear why additional inspection costs would be incurred. The current inspection arrangements would require to be reviewed to reflect the new partnership arrangements but it is anticipated that the costs associated with this requirement could be met from within existing budgets established to meet inspection costs.

**Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?**

19. No.

20. The Financial Memorandum does not make any provision for demographic growth and the financial impact this will have on both health and social care services in the future. Although better integrated services will improve outcomes for individuals, it will not release sufficient funds to address the full impact of demographic growth. Additional funding must be made available to fund this gap.

21. As the partnership model develops, it is anticipated that new cost pressures will emerge as a result of the more effective integration of teams. Existing terms and conditions may have to be harmonised and pension policies reviewed. There may also be the potential for retrospective equal pay claims. The Financial Memorandum does not make provision for these and there is no recurring or non-recurring funding available. These new costs cannot be met by local authorities.

22. Reliance is being placed on the conclusion that there will be no additional costs associated with indemnifying staff whose roles change as a result of assuming new responsibilities to support integration. The change in staff responsibilities is likely to happen to ensure the development of innovative practice between health and social care services is progressed and the service improvements are achieved.

23. There will be recurring costs beyond April 2015 of the integrated service delivery arrangements already in place as a result of the Reshaping Care for Older People agenda. The Change Fund ends on 31\(^{st}\) March 2015. In order to continue to support the current programme of integrated service delivery, consideration should be given to continuing the Change Fund during the initial period of the transition.
If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?
24. No.

25. Additional investment funding for local authorities and health boards is required.

Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

27. Please refer to the issues raised in response to questions 4 and 5. Until the new partnership model is agreed and the range of issues identified for further consideration is clarified, it is not possible to confirm the accuracy of the Financial Memorandum.

Wider Issues
Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?
28. The role of the acute services within the integrated partnership should be further considered, particularly the impact of unplanned or inappropriate admissions on resources and financial budgets and the opportunities to re-design services to better respond to emergencies. The role of the general practitioners and other medical staff is also critical in this regard given their decision-making responsibilities for hospital referrals and admissions.

29. Before any sound conclusion can be drawn about the effectiveness of reducing delayed discharges, an assessment of the extent of, reasons for and impact of hospital re-admissions needs to be undertaken.

30. The integration of health and social care services will not release sufficient funds in the earlier years of the transition to meet the impact of demographic growth which is already being experienced, particularly within community based health and social care services. As a minimum, the extension of the current Change Fund is required to maintain the progress made to date and to help address the funding gap emerging as a result of demographic growth.

Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?
31. It is not possible to comment on this at this stage. As partnerships develop, it is likely that future cost pressures will emerge, particularly, as highlighted above, in relation to the harmonisation of employee terms and conditions and pensions.

32. Once the initial arrangements are agreed and established, the partnership will have autonomy to make decisions on what the total budget is spent on without reference back to the partners. There is no provision to enable the local authorities to influence these financial decisions as the partnership moves forward. The
outcome of future partnership commissioning strategies may result in additional costs for local authorities and/or health boards.
1. Q1 - In terms of the wider financial impacts of the Bill these are covered in the Background section of the Financial Memorandum (FM). In particular the FM in paras 27, 29 and 33 identify potential savings of between £138m and £159m. It is recognised later, at para 35, that there is considerable uncertainty around these estimates of potential savings, and this is clear due to the number of variables and dependencies that would need to work in the right way in order to see such savings. There is an expectation that by moving more towards early intervention and preventative support that use and cost of more acute services can be achieved, however this would require a freeing-up of resources from these acute provisions to allow the investment in the early intervention services. There must also be a danger that the early intervention does nothing but simply delay the intake to acute provision for a few years and the demand actually does not diminish overall and in fact the total cost of overall provision is actually increased.

2. The main area where potential savings are identified is in relation the variation if cost and by reducing variation costs will come down. This does seem like a potential area for cash savings to be generated by different commissioning or procurement or treatment regimes. However there may be appropriate and justifiable reasons for some or all of the variations. The text at Para 30 advises that for health spend the variation is unexplained and for social care the picture is less clear...and the potential for health being lower due to high social care spend or vice versa suggested in this Para further muddies the position.

3. Given the above vagueness in the FM regarding these potential savings it is difficult to place too much reliance on them. When also taking into account the stated need (Para 34) to be reinvested in partnerships to help meet projected future demand. This gives the impression that the Government feel there is no need to fund the future demand pressures as partnerships will be able to self-fund through efficiencies - despite the efficiencies being clearly described in the FM as being effectively crude estimates with little evidence to support them per Para 30. There must also be doubts about the practical ability of the acute provision (both NHS and social care) to actually provide resource release to non-acute services. This will be particularly difficult in terms of NHS where it is likely that the acute provision will not be part of the future integrated service and even if the acute provision was to be part of future integrated services, based on past experience and future demand pressures these services are more likely to place funding pressures on partnerships rather than bring efficiency / resource release opportunities.

4. Q2 - the main technical issue which remains is in relation to the treatment of VAT, and while the FM suggests there will be solutions developed, it would be better if this position had been finalised and agreement with HMRC in place by now. This remains a risk to the funding of the future integrated partnership and it is difficult to
understand how MSPs can be asked to make a decision on integration while there remains any doubt as to the financial implications in this regard.

5. Q3 - The issues are covered in the response to Question 1 above.

6. In relation to some of the specific cost implications identified:

At Para 85 it had been understood until now that there would be no additional audit burden and that the cost of auditing the financial governance would not increase due to the new legislation. For example in West Dunbartonshire there is a CHCP in place which is audited through the normal audit processes of the parent bodies. If, however there is now expected to be additional financial governance audits required of the new bodies then the additional cost of £150k seems low for the whole of Scotland, given that there will be a number of new complex bodies to be audited. On a linked issue perhaps the Bill would allow for a reduction in the number of currently silo-ed and increasingly over-lapping national audit/inspection/improvement bodies? Such a reduction could be used to free-up much needed resource to be transferred to the new partnerships to assist in meeting the costs of care given the predicted demographic changes over the next few years.

7. Para’s 117 to 121 talks about potential cost in the future arising from harmonisation of employee terms and conditions. This doesn't really consider the level of risk of this actually being required due to future partnership models, and if so it would appear to be a cost that is left to the future partnerships to deal with.
Consultation

Did you take part in either of the Scottish Government consultation exercises which preceded the Bill and, if so, did you comment on the financial assumptions made?
1. The previous consultation paper did not include any financial assumptions resulting from integration but rather asked several questions around integrated budgets and use of joint resources. West Lothian Council as part of the West Lothian Community Health and Care Partnership responded to this.

Do you believe your comments on the financial assumptions have been accurately reflected in the FM?
2. As stated above, there was no previous consultation on financial assumptions or a draft financial memorandum. Therefore, it is not relevant to comment on whether the West Lothian Council’s comments have been accurately reflected in the published Financial Memorandum.

Did you have sufficient time to contribute to the consultation exercise?
3. The consultation was issued on 2 July 2013 for return by 23 August 2013. Given this covered the holiday period this was a relatively short consultation timescale which was adequate for an officer response on financial matters, but if covering policy matters also would have been insufficient time.

Costs

If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the FM? If not, please provide details?
4. The Bill has financial implications for West Lothian Council in terms of both one off costs and recurring costs. The council along with the West Lothian Community Health and Care Partnership are still discussing the format and scope of the future model in West Lothian. The scope of integration remains uncertain and given this it is difficult to quantify the financial implications for West Lothian Council. Given this it is not possible to say if the financial implications to the council have been accurately reflected.

5. The Financial Memorandum is helpful in setting out the key financial issues and providing an estimate of the costs for these. Given the question is to individual organisations, it would have been of assistance to show these costs at a Local Authority and Health Board level although it is appreciated that, in the spirit of integration and genuinely shared resources, this split should not be necessary.
Do you consider that the estimated costs and savings set out in the FM and projected over 15 years for each service are reasonable and accurate?

6. The FM does not project costs and savings over 15 years for each service. The timescale for costs to health boards and local authorities is 2014/15, then recurring costs from 2015/16.

7. One off costs associated with the bill have been estimated at £16.3 million. The largest element of this for Transition Teams is based on the Highland model but this may not be relevant for other partnerships. Costs are included for redeployment and redundancy costs, but only for Health CHP management roles. It is however possible that as a result of integration other management roles will no longer be required in organisations and it is therefore likely that the costs in the FM are understated. It is noted that Scottish Government funding will be made available for these one off costs.

8. The additional recurring costs associated with the Bill to local authorities and health boards have been estimated at between £4.55 million and £5.6 million per annum for the whole of Scotland. There remain risks to these additional cost assumptions, particularly the treatment of VAT under integration models. While this is a relatively small amount, there is no similar confirmation in the FM that Scottish Government funding will be provided for these costs. Both councils and health are under severe financial constraints in terms of funding settlements and very significant demand and demographic driven cost increases, and, as such, it would in accordance with previous practice regarding new legislation it would be anticipated that these costs would be met by additional funding from the Scottish Government.

9. In terms of savings, these are very much focused on the health board area of Partnerships and relate to reducing delayed discharge, anticipatory care savings and reducing variation in health care spend. The estimated savings associated with these areas is between £138m and £157m per annum.

10. West Lothian CHCP has met zero delay discharge targets over a prolonged period and therefore there is unlikely to be savings resulting from this. More widely, savings can only be made in this area through a reduction in the number of beds. If performance against zero delayed discharge is improved across Scotland, but the beds are filled with new admissions to meet other demands or to reduce waiting lists, then there is no saving available. The care costs for the clients who have been discharged will have reduced but cost to community care will have increased with no shift in resource possible from Acute. This is a major issue that needs to be fully considered, and recognised in future funding settlements.

11. The assumptions made in arriving at Anticipatory Care and Reducing Variation are acknowledged to be high level and it is difficult to assess how accurate or reasonable they are.

12. It is noted that the FM suggests that the efficiencies identified will require to be reinvested within the partnerships to help meet increasing cost demands. The Final Business and Regulatory Impact Assessment published by the Scottish Government in May 2013 highlighted that over the next twenty years, health and social care costs in Scotland are expected to exceed today’s by £2.5 billion, at
today’s prices. This is likely to require a full evaluation of public service provision and cost to secure a sustainable model for public services.

If relevant, are you content that your organisation can meet the financial costs associated with the Bill which your organisation will incur? If not, how do you think these costs should be met?

13. Local authorities, and health boards, are under severe fiscal constraint yet face very significant rising demand for care, largely as a result of demographic pressures. The FM notes that the Scottish Government is funding one-off costs, but the same assurance is not given for recurring costs. There remains uncertainty over the recurring costs identified in the FM and it is considered that the Scottish Government should commit to fully funding the cost of legislative changes.

Does the FM accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

14. The margins of uncertainty are referred to in the FM and it is acknowledged that the cost estimates of integration are very difficult to quantify. It is noted that the implementation costs of the Highland’s integration model have been used in several instances, with adjustments made to attempt to show the impact of varying assumptions on integration.

15. The timescales and costs reflect the anticipated progress of the Bill through Parliament and the proposed implementation date.

16. However, there remains a lack of detail around integration requirements and it is anticipated that this will come from Ministerial regulations and guidance that have not yet been issued. Until we have the detailed regulations, it is not possible to forecast the costs with any certainty.

Wider Issues
Do you believe that the FM reasonably captures costs associated with the Bill? If not, which other costs might be incurred and by whom?

17. Responses to questions four to six cover this point.

18. In addition, it is noted that the Reshaping Care for Older People Change Fund is referred to in the Annex to the FM. The Change Fund has been an essential and welcome development. However there is uncertainty over the continuation of the Change Fund beyond 2015/16.

19. It is strongly felt that the Change Fund should continue beyond 2015/16 to provide ongoing finance to help shift the balance of care from Acute services. This will be vital to support the objectives of integration and help release monies to support increased community-based services capable of reducing future needs for acute hospital in-patient care.
Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation? If so, is it possible to quantify these costs?

20. Future costs that might arise from the subordinate legislation associated with the current Bill will need to be assessed when the draft regulations and guidance are available for comment. It is not possible to quantify these costs. As previously noted, the expectation would be that the Scottish Government would fund any further costs associated with legislation.
SUPPLEMENTARY EVIDENCE FROM THE SCOTTISH GOVERNMENT BILL TEAM

Thank you for providing the Bill team with the opportunity to give evidence on the Public Bodies (Joint Working) (Scotland) Bill, under consideration at Stage 1. You asked for further information on two points in relation to the Financial Memorandum:

- To provide an explanation of the methodology used to arrive at the estimated £104 million efficiencies that could be generated by reducing variation, which I attach at annex A, and
- To provide more information about timescales for delayed discharge targets, specifically in relation to the targets under the National Performance Framework (as it ties in with the HEAT targets).

The Scottish Ministers have consistently stated that they do not want a single person delayed unnecessarily in hospital as it is not good for the patient, not good for the NHS and not an effective use of public money.

Patients who are delayed are predominately older, frail people, often with a number of long-term complex care needs. Matching suitable care to their individual needs can often take time, particularly where there are issues regarding the patients capacity, and guardianship needs to be sought through the courts.

An expert group was jointly established to consider delayed discharge by the Scottish Government and COSLA in September 2010. The Group submitted a final report to the Deputy First Minister, who was then Cabinet Secretary for Health and Wellebing, who accepted all the Group’s recommendations. The report recognised the substantial achievement over recent years in achieving the zero 6 week standard for delays, but noted that, from an outcomes perspective, this improvement obscured the fact that a 6 week delay in hospital discharge is too long in nearly all cases. The Group recommended that major cultural and behavioural change is required to move to a position where discharges routinely take place in days not weeks, and that people are discharged either to their own home or to the place from which they were admitted.

The Scottish Ministers agreed revised delayed discharge targets in October 2011, as follows:

- By April 2013, no-one is inappropriately delayed for more than 4 weeks
- By April 2015, no-one is inappropriately delayed for more than 2 weeks

Health Boards and local authorities are now working towards achieving the new targets. Developments in Intermediate Care, along with the Bill’s requirement to integrate health and social care, will go some way to helping achieve this target.

The delayed discharge target is one of a range of performance and improvement measures aimed at improving care pathways and reducing the length of hospital admissions. It links closely with the HEAT target to reduce the rate of emergency inpatient bed days for people aged 75+.
Annex A

Methodology for calculating variation

Intra-Health Board Variation: Quantifying potential reductions in expenditure

1. This note describes the method and results of an exercise to use Integrated Resource Framework (IRF) data to quantify potential reductions in expenditure due to efficiencies arising from integration.

2. The basic approach compares the expenditure per head by partnership, within Health Boards. In order to ensure that the comparison is robust, National Resource Allocation Committee (NRAC) formula weights are used to adjust the crude partnership populations to take account of variation in the need for health care.

3. The NRAC formula weights are constructed to capture the age/sex profile and the Morbidity and Life Circumstances of the local populations, and take account of the variation in the unavoidable excess costs of the provision of health care across urban-rural geographies.

4. The potential reduction in expenditure is defined as the difference between the mean expenditure per (needs adjusted) head across the Health Board and expenditure per (needs adjusted) head in those partnership where expenditure is above that Health Board mean. The proposition is that partnerships, where expenditure per head is above the Health Board mean, will be able to bring expenditure per head down to the (current) mean Health Board expenditure per head.

5. The calculation is illustrated in the table below, using Tayside as an example. This shows that Angus has expenditure per (NRAC) weighted person of £1,674, which is £131 above the mean of £1,544 for the three partnerships. Reducing that spend to the mean of £1,544 would generate potential savings of £14 mn for Tayside.

<table>
<thead>
<tr>
<th></th>
<th>Angus</th>
<th>Dundee City</th>
<th>Perth &amp; Kinross</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expenditure, £</td>
<td>179,779,490</td>
<td>257,749,197</td>
<td>208,064,165</td>
<td>645,592,852</td>
</tr>
<tr>
<td>NRAC weighted population</td>
<td>107,364</td>
<td>174,479</td>
<td>136,305</td>
<td>418,148</td>
</tr>
<tr>
<td>Spend per NRAC wtd population, £</td>
<td>1,674</td>
<td>1,477</td>
<td>1,526</td>
<td>1,544</td>
</tr>
<tr>
<td>Excess spend per head, £</td>
<td>131</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Potential savings, £</td>
<td>14,016,646</td>
<td>0</td>
<td>0</td>
<td>14,016,646</td>
</tr>
</tbody>
</table>

Source: Calculations using IRF data.

6. The potential reductions are set out by Health Board in Table 2 below. The total amounts to approximately £104 mn. Note that there will only be savings
calculated for those Health Boards which have more than one partnership, as this is an intra-Health Board comparison only.

Table 2: Total potential savings by Health Boards, £ 000.

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Expenditure £ 000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>9,500</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>na</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>na</td>
</tr>
<tr>
<td>NHS Greater Glasgow &amp; Clyde</td>
<td>36,700</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>3,700</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>10,200</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>9,200</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>na</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>14,300</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>14,000</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>6,100</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>na</td>
</tr>
<tr>
<td>NHS Dumfries and Galloway</td>
<td>na</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>na</td>
</tr>
<tr>
<td>Sum of above</td>
<td>103,600</td>
</tr>
</tbody>
</table>

Note: na = not applicable; estimates are rounded.
Source: Calculations using IRF data.
Delegated Powers and Law Reform Committee

48th Report, 2013 (Session 4)

Public Bodies (Joint Working) (Scotland) Bill

Published by the Scottish Parliament on 24 September 2013
Delegated Powers and Law Reform Committee

Remit and membership

Remit:

1. The remit of the Delegated Powers and Law Reform Committee is to consider and report on—
   (a) any—
   (i) subordinate legislation laid before the Parliament or requiring the consent of the Parliament under section 9 of the Public Bodies Act 2011;
   (ii) [deleted]
   (iii) pension or grants motion as described in Rule 8.11A.1; and, in particular, to determine whether the attention of the Parliament should be drawn to any of the matters mentioned in Rule 10.3.1;
   (b) proposed powers to make subordinate legislation in particular Bills or other proposed legislation;
   (c) general questions relating to powers to make subordinate legislation;
   (d) whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation;
   (e) any failure to lay an instrument in accordance with section 28(2), 30(2) or 31 of the 2010 Act; and
   (f) proposed changes to the procedure to which subordinate legislation laid before the Parliament is subject.
   (g) any Scottish Law Commission Bill as defined in Rule 9.17A.1; and
   (h) any draft proposal for a Scottish Law Commission Bill as defined in that Rule.

Membership:

Christian Allard
Richard Baker
Nigel Don (Convener)
Mike MacKenzie
Margaret McCulloch
John Scott
Stewart Stevenson (Deputy Convener)
Committee Clerking Team:

Clerk to the Committee
Euan Donald

Assistant Clerk
Elizabeth White

Support Manager
Daren Pratt
Delegated Powers and Law Reform Committee

48th Report, 2013 (Session 4)

Public Bodies (Joint Working) (Scotland) Bill

The Committee reports to the Parliament as follows—

1. At its meetings on 3 and 24 September 2013 the Delegated Powers and Law Reform Committee considered the delegated powers provisions in the Public Bodies (Joint Working) (Scotland) Bill at stage 1 (“the Bill”)\(^1\). The Committee submits this report to the Health and Sport Committee as lead committee for the Bill under Rule 9.6.2 of Standing Orders.

2. The Scottish Government provided the Parliament with a memorandum on the delegated powers provisions in the Bill (“the DPM”)\(^2\).

OVERVIEW OF BILL

3. This Bill was introduced by the Scottish Government on 28 May 2013. The Health and Sport Committee is the lead Committee. The Bill is also being considered by the Local Government and Regeneration Committee.

4. In broad outline, the Bill provides a framework with a view to the improvement of the quality and consistency of health and social care services, through the integration of health and social care services in Scotland. The functions of local authorities and Health Boards which may be integrated are not however limited by the Bill to health and social care functions. Four “models of integration” between local authority and Health Board functions may be used, by agreement subject to the approval of the Scottish Ministers. On default if an integration plan is not submitted to Ministers, they may specify functions to be delegated to an integration joint board (Part 1).

5. The Bill also provides for the Common Services Agency (also known as NHS National Services Scotland) to provide goods and services to public bodies

---

\(^1\) Public Bodies (Joint Working) (Scotland) Bill [as introduced] available here: http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Bill/b32s4-introd.pdf

\(^2\) Public Bodies (Joint Working) (Scotland) Bill Delegated Powers Memorandum available here: http://www.scottish.parliament.uk/S4_Bills/PB_-_DPM.pdf
including local authorities *(Part 2, section 44)*. It also provides for the Scottish Ministers to form a wider range of joint venture structures in relation to persons providing functions and services under the National Health Service (Scotland) Act 1978, to seek to make the most effective use of resources *(Part 3, section 46)*. There is new provision that a Health Board may, with the agreement of another Health Board and the Scottish Ministers, carry out on behalf of that other Board any function of the other Board *(Part 3, section 47)*.

6. The Bill also extends the scheme for meeting losses and liabilities of health service bodies which is run by NHS Scotland on behalf of the Scottish Ministers, to local authorities and “integration joint boards” established under Part 1 *(Part 2, section 45)*.

7. The Policy Memorandum outlines that the Bill is designed to establish “a framework for integration between Health Boards and local authorities of, as a minimum, adult health and social care based on the principles of a person-centred approach to service planning” *(paragraph 32)*. The Scottish Government published its consultation on proposals for such integration in May 2012.

8. At its meeting of 3 September the Committee agreed to write to Scottish Government officials to raise various questions on the delegated powers. This correspondence is reproduced at the Annex.

**DELEGATED POWERS PROVISIONS**

9. As noted above the Committee considered each of the delegated powers in the Bill.

10. At its first consideration of the Bill, the Committee determined that it did not need to draw the attention of the Parliament to the following delegated powers:

Section 5 – Power to prescribe national outcomes

Section 6(2) – Consultation

Section 7(1) – Approval of integration plan

Section 9(2) – Functions delegated to integration joint board

Section 9(3) – Functions delegated to integration joint board- prescribed day

Section 10(5) – Chief officer of integration joint board

Section 11 – Other staff of integration joint board

Section 14 – Functions delegated to local authority or Health Board- prescribed day

Section 21(5) – Effect on delegation of functions

Section 22(8) – Further powers of persons to whom functions are delegated- order by the Scottish Ministers
Section 23(4) – Requirement to prepare strategic plans

Section 26(2) – Establishment of consultation group

Section 27(5) – Steps following establishment of consultation group

Section 32(4) – Carrying out of integration functions: localities

Section 33(3) – Integration authority: performance report

Section 36(2) – Winding-up of an integration joint board

Section 38(2) – Grants to local authorities

Section 41 – Guidance

Section 45(3) – Extension of schemes for meeting losses and liabilities of health service bodies

Section 48(1) – Interpretation

Section 50 – Ancillary provision

11. Subsequently, in light of the written responses received by the Committee, it agreed that it did not need to draw the Parliament’s attention to the following delegated powers:

Section 12(3) – Integration joint boards: further provision- schemes for transfer of staff, etc.

Section 22(1) to (7) – Further powers of persons to whom functions are delegated

Section 39(2)(b) – Default power of Scottish Ministers (establishment of an integration joint board)

Section 39(2)(c) – Default power of Scottish Ministers (prescribed day)

Section 40 (Directions)

Section 52(2) and (3) (Commencement)

12. The Committee’s comments and, where appropriate, recommendations on the other delegated powers in the Bill are detailed below.
Section 1(3)(e) – Integration plans: same local authority and Health Board area- prescribed information about other prescribed matters

Power conferred on: the Scottish Ministers  
Power exercisable by: Regulations  
Parliamentary procedure: Negative procedure

Provision

13. Section 1(3)(e) provides for the power to prescribe by regulations, information about such matters as may be prescribed, for inclusion in an integration plan.

Comments

14. The Committee initially asked the Scottish Government to provide some examples of the information and matters that could be prescribed for inclusion in an integration plan. The response annexed sets out in paragraph 2 the range of such matters which it is intended could be prescribed in the regulations.

15. The Scottish Government provided further explanation to the Committee (paragraphs 3 to 6 of Annex B), as to why this power is needed in principle, and why it is intended that the matters which may be prescribed under section 1(3)(e) would go beyond those set out in section 1(3)(a).

16. Given the underlying policy proposals on what integration plans may contain, the Committee accepted the explanation for the need for this delegated power in principle (as opposed to seeking to set out the additional information in the Bill).

17. The Committee notes however that while this power is to prescribe further information for inclusion in integration plans, the range of matters which could be prescribed as set out in paragraph 2 of the response concern matters which could be of significance, such as the further arrangements for an integration joint board or joint monitoring committee to be implemented in the plan beyond the “model of integration”, arrangements for financial management of an integrated budget, or any arrangements for transfer of staff. The range of further matters that could be prescribed is also not limited to those arrangements.

18. The Committee therefore asks the Scottish Government, in relation to the power in section 1(3)(e), to consider in advance of Stage 2 of the Bill whether the significance of the matters which could be prescribed in regulations under this power is such that the affirmative procedure could be a more suitable level of Parliamentary scrutiny of the exercise of this power, rather than the negative procedure.

19. The Committee asks for further comment on this in the Scottish Government’s response to this report.
Section 1(6) – Integration plans: same local authority and Health Board area-

prescription of functions

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Negative procedure

Provision

20. The regulations under section 1(6)(a) and (b) are intended to prescribe the range of functions of local authorities and Health Boards which either must, may, or may not be, delegated under an integration plan.

Comments

21. The Committee asked the Scottish Government to explain why it is appropriate that section 1(6) provides that the Scottish Ministers have a discretion, rather than a requirement, to make the regulations.

22. It is confirmed in response that the Scottish Ministers intend to use this power to prescribe the minimum set of functions that must be delegated to the integration authority, and also to specify those functions which may or may not be delegated. In line with the policy memorandum, the regulations will set out adult health and adult social care functions which must be delegated.

23. The Scottish Government recognises that given the intention to require the delegation of certain functions, it would be more appropriate to require the Scottish Ministers to make such regulations. The Scottish Government will, therefore, bring forward an amendment at stage 2 to this effect.

24. The Committee also noted that section 56 of the Local Government (Scotland) Act 1973 is not expressly amended by, or referred to in, the Bill. Subsections (6) and (6A) of that section provide that a local authority’s functions with respect to setting amounts of council tax, borrowing money, approving annual investment strategies or reports, and determining applications for planning permission for a certain class of property, shall be discharged only by the authority. By subsection (7), a local authority shall not make arrangements for the discharge for any of their functions under the Animal Health Act 1981 by any other local authority.

25. Section 1 does not provide for any exclusion of those significant functions in the 1973 Act, from the powers to prescribe the functions which may be delegated in terms of an integration plan, and agreed to be set out in a plan.

26. The Committee therefore asked the Scottish Government whether there is any intention to affect the operation of section 56(6), (6A) and (7) of the 1973 Act. If not, it asked whether amendment of the Bill at Stage 2 would be proposed, so that “integration functions” could never extend to those functions. The Government has undertaken to consider this further in advance of Stage 2.
The scrutiny procedure applied to the powers in section 1(6)

27. The Committee considered that the Delegated Powers Memorandum for the Bill has not explained satisfactorily why the negative procedure was the appropriate level of scrutiny of the powers in section 1(6). The powers are very significant within the Bill, as the regulations will provide for the range of functions which must, may, or may not be, delegated under an integration plan.

28. The Scottish Government, in recognition of the significance of these powers, has considered it more appropriate that the exercise of them should be subject to scrutiny by Parliament by the affirmative procedure. It undertakes to bring forward an amendment at stage 2 to this effect.

29. The Committee notes that, in relation to the power in section 1(6), the Scottish Government has undertaken to bring forward an amendment at Stage 2, to require the Scottish Ministers to make the regulations under this power, rather than having a discretion to do so. The Committee will consider the proposed amendment after Stage 2.

30. The Committee also notes that the Scottish Government has undertaken to consider whether any amendments at Stage 2 need to be made to address the operation of the provisions in section 56(6), (6A) and (7) of the Local Government (Scotland) Act 1973, as they relate to the powers in section 1 of the Bill. The Committee asks for further comment on this in the Scottish Government’s response to this report.

31. The Committee also notes that the Scottish Government has undertaken to bring forward an amendment at Stage 2 which would provide that the exercise of the powers in section 1(6) would be subject to Parliamentary scrutiny by the affirmative procedure.

Section 12(1) and (2) – Integration joint boards: further provision

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>the Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>Order</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>Negative procedure</td>
</tr>
</tbody>
</table>

Provision

32. Section 12(1) provides that the Scottish Ministers may by order make provision about various aspects of joint integration boards, including their membership and proceedings. Such boards may be established under section 9. An order may make different provision in relation to different integration joint boards.

33. Any integration joint boards which are established under the Bill will be public authorities which will either undertake or direct the carrying out of functions delegated by the constituent local authorities and health boards.
Comments

34. The Committee asked the Scottish Government why this power needs to be drawn widely, to permit any provisions by order about (and so to determine) the membership of integration joint boards. It also asked why it could not be drawn to contain provision for the permissible number of members of an integration joint board (for instance by stating a minimum or maximum number of members, within which parameters an order could specify the number of members of a particular board); and contain provision for who may be a member.

35. It is indicated in response to the Committee (Annex B, paragraphs 10 and 11) that there are policy reasons for seeking a flexible approach as to the number of members, and who may be a member. It has been considered important that this provision strikes an appropriate balance between establishing a common framework for integration, while at the same time ensuring that it is not prescriptive at such a level of detail as to stymy local innovation. It is considered important that the powers should allow provision as to the membership, proceedings etc. of integration joint boards to be modified, as integration develops.

36. The Committee accepts the Scottish Government’s explanation of the perceived need for proposing a wide power in relation to the membership of joint boards, in principle. It considers it appropriate however to draw the proposed scope of the power in section 12(1)(a) to the attention of the Health and Sport Committee as the lead committee for the Bill.

37. The Committee accordingly draws the attention of the lead committee to the power in section 12(1)(a). This power proposes to enable the 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.

Section 15 – Transfer of staff where functions delegated to local authority or Health Board

Power conferred on: the Scottish Ministers
Power exercisable by: Scheme
Parliamentary procedure: None (and not in the form of an SSI)

Provision

38. Section 15 provides for a power of the Scottish Ministers to make a scheme for the transfer of staff from a person who is to delegate functions under the possible “integration models” between local authorities and Health Boards described in section 1(4), except for the “corporate body” model.

Comments

39. In summary, as in relation to section 12(3), the Committee asked the Scottish Government to explain the reasons for taking this power, the circumstances in which the power might be used to transfer staff between a local authority and a
Health Board, and why it is appropriate that any scheme is not subject to Parliamentary procedure.

40. The Government’s response (Annex B, paragraphs 17 to 20) is to similar effect as for section 12(3), in relation to the proposed contractual and administrative nature of any scheme for transfer of staff, and why it has been considered not appropriate to provide that a scheme should be subject to Parliamentary scrutiny, nor published.

41. However, the response also explains that this power is similar to the current power in the Community Care and Health (Scotland) Act 2002 (“the 2002 Act”), which is repealed by the Bill. It is explained that Highland Partnership has transferred staff under that power.

42. The Committee understands that section 15 of the 2002 Act currently confers powers on local authorities and NHS bodies in accordance with regulations made by Ministers to enter into arrangements for the delegation of certain functions. Specifically in terms of section 15(4)(c) of the 2002 Act, regulations may make provision as respects the provision of staff in connection with any such arrangements, including the transfer and secondment and terms and conditions of staff. (The regulations are subject to the negative procedure in terms of section 23 of the Act).

43. The Committee understands therefore that while there is a current power in the 2002 Act to enable transfer of staff arrangements, the form of exercise of that power is by regulations which are published as a Scottish statutory instrument, not an unpublished scheme. It appears therefore that the Bill proposes a downgrading of the level of Parliamentary scrutiny of the power to transfer staff, where functions are delegated under an integration plan between a local authority and Health Board (by one of the integration models under section 1(4)(b), (c), or (d)).

44. The Committee therefore accepts the power in section 15 to make a scheme for the transfer of staff where functions may be delegated to a local authority or Health Board, in principle.

45. However it draws to the attention of the lead committee that the exercise of this power would not be subject to Parliamentary scrutiny. The 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).

46. 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.
47. 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.

Section 16 – Integration joint monitoring committees: further provision

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>the Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>Order</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>Negative procedure</td>
</tr>
</tbody>
</table>

Provision

48. 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.

49. Any such committees will be public authorities which would monitor the carrying out of “integration functions” for the area of a local authority.

Comments

50. Similarly to the power in section 12 to prescribe the membership of integration joint boards, the Committee asked the Scottish Government for explanation why this power requires to be drawn widely, to permit any provisions by order about (and so to determine) the membership of integration joint monitoring committees.

51. The Scottish Government considers that, as for the power in section 12, flexibility as to the membership of integration joint monitoring committees will enable Ministers to put in place a framework to allow integration authorities to develop governance arrangements that suit local circumstances (Annex B, paragraph 21).

52. The Committee accepts the Scottish Government’s explanation of the perceived need for proposing a wide power in relation to the membership of joint boards, in principle. As for the power in section 12(1)(a) however, it considers it appropriate to draw the proposed scope of this power to the attention of the Health and Sport Committee as the lead committee for the Bill.

53. The Committee accordingly draws the attention of the lead committee to the power in section 16(1)(b). This power proposes to enable the Scottish Ministers by order to make provision about the membership of integration joint monitoring committees, without any limitations as to the number of members of a particular committee that may be prescribed, or as to who may be prescribed as members.
Section 36(3) – Power to make provision in consequence of new integration plan- scheme about transfer of staff, etc.

**Power conferred on:** the Scottish Ministers  
**Power exercisable by:** Scheme  
**Parliamentary procedure:** None (and not in the form of an SSI)

**Provision**

54. Section 36(3) provides that in consequence of the replacement of an integration plan by a new plan, the Scottish Ministers may, by scheme, make such provision about the transfer of staff, property, rights, liabilities or obligations of an integration joint board, a local authority or a Health Board as they consider necessary.

**Comments**

55. In summary, the Committee asked the Scottish Government to explain the reasons for taking this power, and to explain the circumstances in which the power might be used to transfer staff, property, etc., upon a new integration plan being substituted under section 35. It also asked why it has been considered appropriate that the exercise of the power should not be subject to Parliamentary scrutiny.

56. The Government’s written response (Annex B, paragraphs 26 to 29) has provided an explanation to the Committee why this further power to make a scheme is considered to be required.

57. Similarly to the power in section 15, this power in consequence of the substitution of a new integration plan (upon a change of the local authority which prepared the plan, or the integration model), would enable Ministers to make schemes for transfer of staff, property, rights, liabilities or obligations between a local authority and a Health Board (as well as to or from an integration joint board).

58. The Committee accepts the explanation why these powers are required in principle. However it considers it appropriate to draw to the attention of the lead committee the difference between the level of Parliamentary scrutiny which is proposed to be applied to these powers, in comparison with the powers currently available to transfer staff between a local authority and a Health Board in the Community Care and Health (Scotland) Act 2002. As for section 15, it is proposed that a scheme under this provision would not be subject to Parliamentary scrutiny, nor be published as a Scottish statutory instrument.

59. The Committee also asked the Scottish Government why section 19 applies where (by virtue of section 12(3) or 15(1)) a scheme is made for staff transfer, to set out the effects on contracts of employment, but section 19 does not provide that it applies when this power in section 36(3) is exercised.

60. The Scottish Government has considered this further, and concluded that section 19 should indeed apply when this power is exercised. It will consider whether an amendment at stage 2 is necessary to give that effect.
61. The Committee therefore accepts the power in section 36(3) to make a scheme in consequence of the replacement of an integration plan by a new plan, in principle.

62. However it also draws the attention of the lead committee to the same matter as for the powers to make a scheme in section 15, as regards the scrutiny of the exercise of this power. Section 36 similarly proposes to remove scrutiny by the Parliament, in comparison with the analogous power in the Community Care and Health (Scotland) Act 2002 to set out arrangements for the transfer of staff which would be repealed by the Bill.

63. The Committee notes that the Scottish Government will consider in advance of Stage 2 whether an amendment is required, to give effect to the intention that section 19 should apply, when the power in section 36(3) is exercised to make a scheme for the transfer of staff.

Section 39(2) – Default power of Scottish Ministers

Provision

64. Section 39(2)(a) to (e) lists five default powers which the Scottish Ministers may exercise, where a local authority and a Health Board fail before the day prescribed under section 7 to submit an integration plan for approval by them.

65. The functions of a local authority and a Health Board which may be specified under section 39(2)(a) on default to be delegated to an integration joint board are not limited by the prescription of functions by regulations under section 1(6). Section 1(6) relates to the prescription of functions which must, may, or may not be, delegated under an integration plan. Section 39(2) applies where such a plan has not been submitted for approval.

Comment

66. The Scottish Government has confirmed that it does not intend for the functions that may be specified under section 39(2)(a) to go beyond those that would be prescribed by regulations under section 1(6). It undertakes to consider whether a Stage 2 amendment is necessary to effect this.

67. The Committee also sought explanation why there is a difference of approach between the powers contained in section 1(6) and section 39(2). The exercise of the powers under section 1(6) are proposed to be subject to the negative procedure, but the exercise of the powers under section 39(2)(a), (d) and (e) to specify the functions to be delegated to an integration joint board and other matters are not proposed to be subject to scrutiny by the Parliament.

68. The Scottish Government has explained (Annex B, paragraph 31) that the policy intention is in that respect to take a consistent approach with the powers to prescribe by regulation the functions which may be delegated between local authorities and Health Boards in terms of the Community Care and Health (Scotland) Act 2002. The entering of arrangements for the actual selection of
individual functions or parts of a function for delegation by a particular health board or local authority is not subject to further scrutiny by the Parliament under the 2002 Act.

69. The Committee accepted that explanation in principle, given the policy intentions underlying section 39.

70. The Committee notes that the Scottish Government will consider in advance of Stage 2 whether an amendment is required, to give effect to the intention that the functions which may be specified under section 39(2)(a) on default to be delegated to an integration joint board would not go beyond those that would be prescribed by regulations under section 1(6).
ANNEX A

Correspondence with the Scottish Government

On 3 September, the Delegated Powers and Law Reform Committee wrote to the Scottish Government as follows:

Section 1(3)(e) – Integration plans: same local authority and Health Board area- prescribed information about other prescribed matters

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Negative procedure

1. Section 1(3)(e) provides for the power to prescribe by Regulations, information about such matters as may be prescribed, for inclusion in an integration plan.

2. The Committee asks the Scottish Government:
   - To provide some examples of the information and matters that could be prescribed for inclusion in an integration plan?
   - Why the power is drawn to permit any matters to be prescribed (about which prescribed information would need to be included in a plan), without provision that such matters should relate to the matters which the plan will set out in accordance with section 1(3)(a) to (d)?

Section 1(6) – Integration plans: same local authority and Health Board area- prescription of functions

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Negative procedure

3. The regulations under section 1(6)(a) and (b) are intended to prescribe the range of functions of local authorities and Health Boards which either must, may, or may not be, delegated under an integration plan.

4. The Committee asks the Scottish Government:
   - To explain, therefore, why it is appropriate that section 1(6) provides that the Scottish Ministers have a discretion, rather than a requirement, to make the regulations?

5. Section 56 of the Local Government (Scotland) Act 1973 is not expressly amended by, or referred to in, the Bill. Subsections (6) and (6A) of that section provide that a local authority’s functions with respect to setting amounts of council
tax, borrowing money, approving annual investment strategies or reports, and determining applications for planning permission for a certain class of property, shall be discharged only by the authority. By subsection (7), a local authority shall not make arrangements for the discharge for any of their functions under the Animal Health Act 1981 by any other local authority.

6. Section 1 does not provide for any exclusion of those significant functions in the 1973 Act, from the powers to prescribe the functions which may be delegated in terms of an integration plan, and agreed to be set out in a plan.

7. The Committee asks the Scottish Government:

- To confirm, in relation to the scope of the powers therefore, whether there is any intention to affect the operation of section 56(6), (6A) and (7) of the 1973 Act.

- If not, would amendment of the Bill at Stage 2 be proposed so that “integration functions” could never extend to those functions?

8. The Committee considers that paragraph 12 of the Delegated Powers Memorandum has not explained satisfactorily why the negative procedure rather than the affirmative procedure (or super-affirmative procedure) is a more appropriate level of scrutiny of the powers in section 1(6). The powers are very significant, as the regulations will provide for the range of functions which must, may, or may not be, delegated under an integration plan.

9. The Committee asks the Scottish Government to explain this further.

Section 12(1) and (2) – Integration joint boards: further provision

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>the Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>Order</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>Negative procedure</td>
</tr>
</tbody>
</table>

10. Section 12(1) provides that the Scottish Ministers may by order make provision about various aspects of joint integration boards.

11. The Committee asks the Scottish Government:

- Why this power needs to be drawn widely, to permit any provisions by order about (and so to determine) the membership of integration joint boards?

- Why could this power not be drawn more narrowly, to-

  (a) contain provision for the permissible number of members of a joint board (for instance by stating a minimum or maximum number of members, within which parameters an order could specify the number of members of a particular board), and
(b) contain provision for who may be a member (given that any joint boards will be public authorities which will either undertake or direct the carrying out of functions delegated by the constituent local authorities and health boards)?

Section 12(3) – Integration joint boards: schemes for transfer of staff

Power conferred on: the Scottish Ministers
Power exercisable by: Scheme
Parliamentary procedure: None (provided by section 49), and not in the form of a Scottish statutory instrument

12. Section 12(3) provides that the Scottish Ministers may by scheme make provision about the transfer to an integration joint board of staff, property, rights, liabilities or obligations of a local authority or a Health Board.

13. The Delegated Powers Memorandum explains that (as a matter of policy) it is envisaged that any integration joint board established under the Bill will not necessarily require to employ staff, the delivery of functions is likely to be carried out by the constituent local authorities and health board, and the option of direct employment of staff by a joint board is included as a safeguard, if locally agreed arrangements fail to work.

14. The Committee asks the Scottish Government:

- To explain the reasons for taking this power, and explain the circumstances in which the power might be used to transfer staff, property etc. to an integration joint board?

- To explain why it is necessary for this power to include the transfer of property, rights liabilities or obligations as well as staff, when the similar power proposed in Section 15 in relation to the other “integration models” between a local authority and Health Board is restricted to the transfer of staff?

- To explain why it has been considered appropriate that the exercise of this power should not be subject to Parliamentary scrutiny, nor provision made for publication of a scheme, nor that it should be made in the form of a Scottish statutory instrument?

Section 15 – Transfer of staff where functions delegated to local authority or Health Board

Power conferred on: the Scottish Ministers
Power exercisable by: Scheme
Parliamentary procedure: None (and not in the form of an SSI)

15. Section 15 provides for a power of Ministers to make a scheme for the transfer of staff from a person who is to delegate functions under the possible
“integration models” between local authorities and Health Boards except for the “corporate body” model.

16. The Committee asks the Scottish Government:

- To explain the reasons for taking this power, and explain the circumstances in which the power might be used to transfer staff between a local authority and a Health Board?

- To explain why it has been considered appropriate that the exercise of this power should not be subject to Parliamentary scrutiny, nor provision made for publication of a scheme, nor that it should be made in the form of a Scottish statutory instrument?

Section 16 – Integration joint monitoring committees: further provision

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>the Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>Order</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>Negative procedure</td>
</tr>
</tbody>
</table>

17. 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.

18. The Committee asks the Scottish Government:

- Why this power need to be drawn widely, to permit any provisions by order about (and so to determine) the membership of integration joint monitoring committees?

- Why could this power not be drawn more narrowly, to—
  
  o (a) contain provision for the permissible number of members of such a committee (for instance by stating a minimum or maximum number of members, within which parameters an order could specify the number of members of a particular committee), and
  
  o (b) contain provision for who may be a member (given that any such committees will be public authorities which will monitor the carrying out of “integration functions” for the area of a local authority)?
Section 22(1) to (7) – Further powers of persons to whom functions are delegated- directions

Power conferred on: An integration joint board, local authority or Health Board (as the case may be)
Power exercisable by: Directions
Parliamentary procedure: None

19. Section 22(1)(a) enables integration joint boards to direct the local authorities or the Health Board that have delegated functions to it in accordance with an integration plan, to carry out a function on its behalf. Section 22(1)(b) enables a local authority or Health Board which has had functions delegated to it in accordance with an integration plan to direct the local authority or Health Board which delegated the function to it to carry out the functions on its behalf.

20. The Committee asks the Scottish Government:

- To explain the reasons for taking the powers, and the circumstances in which directions could be used?
- To explain why it has been considered that the powers are appropriate to be exercised in the form of written directions, rather than a form of subordinate legislation such as an order.
- Whether it is intended that the directions would be published on being made, and if so, should this be provided for?

Section 36(3)– Power to make provision in consequence of new integration plan- scheme about transfer of staff, etc.

Power conferred on: the Scottish Ministers
Power exercisable by: Scheme
Parliamentary procedure: None (and not in the form of an SSI)

21. Section 36(3) provides that in consequence of the replacement of an integration plan by a new plan, the Scottish Ministers may, by scheme, make such provision about the transfer of staff, property, rights, liabilities or obligations of an integration joint board, a local authority or a Health Board as they consider necessary.

22. The Committee asks the Scottish Government:

- To explain the reasons for taking this power, and explain the circumstances in which the power might be used to transfer staff, property, etc., upon a new integration plan being substituted under section 35?
- Why it has been considered appropriate that the exercise of this power should not be subject to Parliamentary scrutiny, nor provision made for publication of a scheme, nor that it should be made in the form of a Scottish statutory instrument?
• Why does section 19 apply where by virtue of section 12(3) or 15(1), a scheme is made for staff transfer, to set out the effects on contracts of employment, but section 19 does not provide that it applies when this power in section 36(3) is exercised?

• To explain why it is considered appropriate that the power in section 15 enables schemes about the transfer of staff (only), where an integration plan sets out one of the 3 integration models apart from the model where an integration joint board is established, and yet this power in section 36(3) extends to making provision about transfer of staff, property, rights, liabilities or obligations, when a new integration plan setting out one of those models is substituted under section 35?

Section 39(2)(a)– Default power of Scottish Ministers

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>the Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>Order</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>Negative</td>
</tr>
</tbody>
</table>

23. Section 39(2)(a) to (e) lists 5 default powers which the Ministers may exercise, where a local authority and a Health Board fail before the day prescribed under section 7 to submit an integration plan for approval by them.

24. It appears that the functions of a local authority and a Health Board which may be specified under section 39(2)(a) on default to be delegated to an integration joint board are not limited by the prescription of functions by regulations under section 1(6). Section 1(6) relates to the prescription of functions which must, may, or may not be, delegated under an integration plan. Section 39(2) applies where such a plan has not been submitted for approval.

25. The Committee therefore seeks clarification from the Scottish Government as to whether that is in the intended position?

26. Contrary to the exercise of the powers under section 1(6) (which are proposed to be subject to the negative procedure), the exercise of the powers of the Ministers under section 39(2)(a), (d) and (e) to specify the functions to be delegated to an integration joint board and other matters are not proposed to be subject to scrutiny by the Parliament. The specification of these matters by the Ministers does not require to be made in a Scottish statutory instrument, nor is there provision for publication, nor consultation requirements prior to the specification.

27. The Committee therefore seeks an explanation as to why that difference of approach has been considered appropriate, as between the powers in section 1(6) and section 39(2)?
Section 39(2)(c)– Default power of Scottish Ministers- prescribed day

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Negative

28. Section 39(2)(c) provides that on the failure of a local authority and Health Board to submit an integration plan for approval, the Ministers may require the authority and Health Board to delegate the specified functions to the joint board before the “prescribed day” which is prescribed by Regulations.

29. The Committee asks the Scottish Government:

- To clarify whether this provision is intended to be a power to prescribe a day, which is separate from the power in section 9(3), or whether it is intended only to refer to that power?
- Whether this could be clearer, given that section 39(1) and section 9(1) state that the sections apply to different circumstances and it appears that “the prescribed day” is not defined in the Bill?
- If section 39(2)(c) is intended to be a separate power, to explain the reasons for taking the power, and why it is considered appropriate that its exercise is subject to the negative procedure.

Section 40– Directions

Power conferred on: the Scottish Ministers
Power exercisable by: Directions
Parliamentary procedure: None

30. Section 40 enables Ministers to give binding, written directions to a Health Board, local authority or an integration joint board.

31. The Committee asks the Scottish Government:

- To provide full explanation is sought of the reasons for taking these powers (which could be applied generally across a range of functions as well as to specific delegated functions), how the power to direct could be used, and the choice of direction as the appropriate procedure?
- To please explain in what circumstances this could introduce powers of direction by the Scottish Ministers over functions which are presently either not subject to such power, or subject to direction by another authority, and why this would be appropriate?
Section 52 – Commencement

Power conferred on: Scottish Ministers
Power exercisable by: Order
Parliamentary procedure: Laid only

32. Section 52(2) provides that the provisions of the Act (other than the general provisions in sections 49, 50, 52 and 53) come into force on such day as the Scottish Ministers may by order appoint.

33. The Committee asks the Scottish Government:

- If it is agreed that the effect of section 49 of the Bill read with section 30 of the Interpretation and Legislative Reform (Scotland) Act 2010 is that it is proposed that a commencement order under section 52(2) will be laid in Parliament (and would be scrutinised by this Committee)?

34. Section 49 proposes that an order making transitional, transitory or savings provisions for the purposes of or in connection with the coming into force of the Bill is subject to the negative procedure (except where textual amendment of an Act is proposed). However section 49 also proposes that a commencement order made under section 52(2) which contains transitory or transitional provision or savings would be laid, but not subject to further procedure. This appears to be inconsistent, as the Parliamentary procedure will depend on whether the Scottish Government chooses to make a commencement order or a separate order under section 50(1)(b).

35. The Committee asks the Scottish Government asks to consider this further.
ANNEX B

Correspondence with the Scottish Government

On 10 September 2013, the Scottish Government responded as follows:

1. This letter sets out the Scottish Government’s response to the Delegated Powers and Law Reform Committee’s letter of 3 September. The Scottish Government thanks the Committee for their comments and the opportunity to consider these matters. In doing so, this letter seeks to provide an explanation of the following matters:

Section 1(3)(e) – Integration plans: same local authority and Health Board area- prescribed information about other prescribed matters
Power conferred on: the Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Negative procedure

To provide some examples of the information and matters that could be prescribed for inclusion in an integration plan?

2. The Scottish Government consider that a range of matters additional to those set out in subsections (3)(a) to (d) may require to be prescribed for inclusion in the integration plan. These matters will set out the integration partnership arrangements by which a Health Board and Local Authority agree to implement and deliver the aims of the Bill and which the Scottish Ministers will wish to be assured are in place. These include—

- The arrangements for the Integration Joint Board or the Joint Monitoring Committee (respectively, depending on which model of integration is used); The arrangements for clinical and care governance;

- The arrangements for financial management of the integrated budget;

- The arrangements where any staff are transferring between statutory partners;

- How the integrated arrangements will interact with such of the health and social care functions and responsibilities of the Health Board and Local Authority as are not delegated to the integrated arrangement.
Why the power is drawn to permit any matters to be prescribed (about which prescribed information would need to be included in a plan), without provision that such matters should relate to the matters which the plan will set out in accordance with section 1(3)(a) to (d)?

3. The intention is for the prescribed matters to go beyond those set out in section 1(3)(a) to (d).

4. It is important that the Health Board and local authority, in setting out the matters in section 1(3)(a) to (d), take a collaborative approach to how the integrated arrangements will work, specifically around practical issues such as clinical and care governance, financial governance and staffing resources. Such matters are essential to the success of, and building confidence in, the arrangements entered into by the Health Board and local authority, and to the engagement and confidence of a wide range of key local stakeholders such as clinicians. Experience from integration of health and social care in Highland and evidence from across the UK suggests that whilst a number of the matters set out in the integration plan will relate to the matters which the plan will set out in accordance with section 1(3)(a) to (d), to assure effective joint working arrangements, it may be necessary to require Health Boards and local authorities to set out their agreed arrangements on a broader range of matters which go beyond those specified in section 1(3)(a) to (d).

5. It would be possible to attempt to define these and set them out in the Bill, but this is likely to be futile as (a) it may stifle innovation by requiring that certain matters are addressed in the plan, implying that a particular approach must be adopted to integration at a micro level, and (b) as integration develops, so too are models of integration (within the broad framework established by the Bill). It is difficult to predict what those developments will require in terms of matters which should be addressed in an integration plan in 5 or 10 years’ time.

6. It is for those reasons that there is no restriction that matters prescribed under section 1(3)(e) must relate to the matters which the plan will set out in accordance with section 1(3)(a) to (d).

Section 1(6) – Integration plans: same local authority and Health Board area-prescription of functions

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Negative procedure

To explain, therefore, why it is appropriate that section 1(6) provides that the Scottish Ministers have a discretion, rather than a requirement, to make the regulations?

7. The Scottish Ministers intend to use this power to prescribe the minimum set of functions that must be delegated to the integration authority, and also to specify those functions which may or may not be delegated. In line with the policy memorandum, the regulations will set out adult health and adult social care functions which must be delegated. The Scottish Government recognise that
given the intention to require the delegation of certain functions it would be more appropriate to require the Scottish Ministers to make such regulations. The Scottish Government will, therefore, bring forward an amendment at stage 2 to this effect.

To confirm, in relation to the scope of the powers therefore, whether there is any intention to affect the operation of section 56(6), (6A) and (7) of the 1973 Act.

If not, would amendment of the Bill at Stage 2 be proposed so that “integration functions” could never extend to those functions?

8. The Scottish Government are grateful to the Committee for raising this point and will consider whether any amendments at stage 2 need to be made.

*The Committee considers that paragraph 12 of the Delegated Powers Memorandum has not explained satisfactorily why the negative procedure rather than the affirmative procedure (or super-affirmative procedure) is a more appropriate level of scrutiny of the powers in section 1(6). The powers are very significant, as the regulations will provide for the range of functions which must, may, or may not be, delegated under an integration plan.*

*The Committee asks the Scottish Government to explain this further.*

9. The Scottish Government recognises the significance of the powers in section 1(6). In recognition of this, the Scottish Government consider it more appropriate that these powers be subject to affirmative procedure. The Scottish Government will, therefore, bring forward an amendment at stage 2 to this effect.

Section 12(1) and (2) – Integration joint boards: further provision

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>the Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>Order</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>Negative procedure</td>
</tr>
</tbody>
</table>

- Why this power needs to be drawn widely, to permit any provisions by order about (and so to determine) the membership of integration joint boards?

- Why could this power not be drawn more narrowly, to-

  (a) contain provision for the permissible number of members of a joint board (for instance by stating a minimum or maximum number of members, within which parameters an order could specify the number of members of a particular board), and

  (b) contain provision for who may be a member (given that any joint boards will be public authorities which will either
undertake or direct the carrying out of functions delegated by the constituent local authorities and health boards)?

10. In developing this provision, the Scottish Government had regard to the breadth of responsibility which the integration joint board will have to plan and deliver health and social care, and indeed the substantial resources that will be delegated to it. We also took account of the wide range of matters for which provision would require to be made in relation to an integration joint board to ensure its effective and efficient operation, and the desirability of establishing a consistent approach across Scotland.

11. The Scottish Government consider the breadth of this power necessary in order to give the Scottish Ministers flexibility to respond to the different ways in which Health Boards and local authorities approach integration within the framework set out in the Bill. It is important that the Bill strikes an appropriate balance between establishing a common framework for integration across Scotland, whilst at the same time ensuring that it is not prescriptive at such a level of detail as to stymy local innovation. Section 12(2) specifically recognises that a one size fits all approach may not be appropriate for all aspects of the membership, proceedings, general private law powers, etc., of joint boards. In addition, joint boards will operate in a dynamic environment and it is considered important that the structure of the Bill is such as to allow provision as to the membership, proceedings etc. of integration joint boards to be modified as integration develops. For example, the powers required in circumstances where the integration joint board carries out the delegated functions will be different to those where delivery is undertaken through the Health Board and local authority.

Section 12(3) – Integration joint boards: schemes for transfer of staff

Power conferred on: the Scottish Ministers
Power exercisable by: Scheme
Parliamentary procedure: None (provided by section 49), and not in the form of a Scottish statutory instrument

- To explain the reasons for taking this power, and explain the circumstances in which the power might be used to transfer staff, property etc. to an integration joint board?

- To explain why it is necessary for this power to include the transfer of property, rights liabilities or obligations as well as staff, when the similar power proposed in Section 15 in relation to the other “integration models” between a local authority and Health Board is restricted to the transfer of staff?

- To explain why it has been considered appropriate that the exercise of this power should not be subject to Parliamentary scrutiny, nor provision made for publication of a scheme, nor that it should be made in the form of a Scottish statutory instrument?
12. The Scottish Government have taken this power in order to permit the integration joint board to employ staff, and so that, if services are to be delivered by an integration joint board directly, then the Scottish Ministers can make a scheme to transfer staff, property, rights, liabilities and obligations from the Health Board and local authority to the integration joint board. Whilst, it is not currently intended that the integration joint board delivers services but instead directs the Health Board and local authority to carry out the delegated functions, it is possible that, in the future, due to the success and effectiveness of integration and service redesign and innovation, the integration joint board consider it appropriate to employ staff and deliver services. In such circumstances, the Scottish Government consider that it would be desirable to be able to transfer staff, property, rights, liabilities and obligations. Furthermore, it may be appropriate to transfer staff to the integration joint board to carry out administrative and operational support functions.

13. The Scottish Government considers it necessary for this power to include transfer of property, rights, liabilities or obligations as well as staff so as to enable the integration joint board to fully transact in the possible future circumstances described above – for example, having existing contracts transferred to it. Section 15 is restricted to the transfer of staff between a local authority and Health Board to facilitate effective integration in a ‘lead agency’ arrangement where the Health Board and local authority delegate functions to each other or to one another. In contrast, these provisions of the Bill are specifically directed towards the body corporate model of integration.

14. The Scottish Government does not consider it necessary that the exercise of the power in section 12(3) be subject to Parliamentary scrutiny because it relates to what is essentially an administrative matter.

15. Any scheme will be designed to facilitate delivery of a policy which the Parliament will have already approved through passing of this section and section 19 of the Bill. By its nature, any scheme created under this provision will make detailed provision as to the transfer of individual properties, members of staff, contractual rights and liabilities, etc. As such they are likely to contain personal information and commercially sensitive information. It would be unusual for documents of this nature to be subject to Parliamentary scrutiny.

16. It would be possible for the Health Board and the local authority to transfer staff, property, rights, liabilities and obligations to the integration joint board themselves by agreement. That would of course involve no Parliamentary scrutiny as it is simply a matter of contract between the three parties. The purpose of the section 12(3) power is only to facilitate the making of such a transfer without the need for detailed and complicated contractual arrangements which are likely to be costly to create and administer, and may involve a level of uncertainty.
Section 15 – Transfer of staff where functions delegated to local authority or Health Board

Power conferred on: the Scottish Ministers
Power exercisable by: Scheme
Parliamentary procedure: None (and not in the form of an SSI)

- To explain the reasons for taking this power, and explain the circumstances in which the power might be used to transfer staff between a local authority and a Health Board?

- To explain why it has been considered appropriate that the exercise of this power should not be subject to Parliamentary scrutiny, nor provision made for publication of a scheme, nor that it should be made in the form of a Scottish statutory instrument?

17. The Scottish Ministers currently have a similar power under section 16 of the Community Care and Health (Scotland) Act 2002, under which Highland Partnership have transferred staff. Section 16 of the 2002 Act is repealed by section 51(2). Section 15 will be used in similar circumstances where a Health Board and local authority agree to a transfer of staff.

18. The Scottish Government does not consider it necessary that the exercise of the power in section 15(1) be subject to Parliamentary scrutiny because it relates to what is essentially an administrative matter designed to facilitate delivery of a policy which the Parliament will have already approved through passing of section 19 of the Bill.

19. By its nature, any scheme created under this provision will make detailed provision as to the transfer of individual members of staff, contractual rights and liabilities in relation to them, etc. As such they are likely to contain personal information and may contain commercially sensitive information. It would be unusual for documents of this nature to be subject to Parliamentary scrutiny.

20. It would be possible for the Health Board and the local authority to transfer staff between them by agreement. That would of course involve no Parliamentary scrutiny as it is simply a matter of contract between the two parties. The purpose of the section 15 power is only to facilitate the making of such a transfer without the need for detailed and complicated contractual arrangements which are likely to be costly to create and administer, and may involve a level of uncertainty.

Section 16 – Integration joint monitoring committees: further provision

Power conferred on: the Scottish Ministers
Power exercisable by: Order
Parliamentary procedure: Negative procedure

- Why this power need to be drawn widely, to permit any provisions by order about (and so to determine) the membership of integration joint monitoring committees?
• Why could this power not be drawn more narrowly, to—
  o (a) contain provision for the permissible number of members of such a committee (for instance by stating a minimum or maximum number of members, within which parameters an order could specify the number of members of a particular committee), and
  o (b) contain provision for who may be a member (given that any such committees will be public authorities which will monitor the carrying out of “integration functions” for the area of a local authority)?

21. The Scottish Government considers that the same reasoning applies to this provision as applies to section 12 of the Bill. The Scottish Government considers that this power enables the Scottish Ministers to put in place a framework to allow integration authorities to develop integrated governance arrangements that suit local circumstance and have therefore drawn the provisions widely. This flexibility will include creating sub-committees, paying expenses to members and some of the procedural detail similar to that included within the Community Health Partnership (Scotland) Regulations 2004.

Section 22(1) to (7) – Further powers of persons to whom functions are delegated - directions

Power conferred on: An integration joint board, local authority or Health Board (as the case may be)
Power exercisable by: Directions
Parliamentary procedure: None

• To explain the reasons for taking the powers, and the circumstances in which directions could be used?

• To explain why it has been considered that the powers are appropriate to be exercised in the form of written directions, rather than a form of subordinate legislation such as an order.

• Whether it is intended that the directions would be published on being made, and if so, should this be provided for?

22. It is intended that integration will lead to services being planned and delivered in a seamless joined up way. To enable this, functions will be delegated by the Health Board and local authority to the integration joint board, which will then lead preparation of a strategic plan for the delivery of health and social care. It is likely that this plan will result in services being redesigned and delivered by integrated teams within the Health Board and local authority.

23. However, where functions are delegated to the integration joint board, it is not the intention of the Scottish Ministers that the integration joint board will
necessarily deliver the relevant services. Instead the integration joint board may direct the Health Board and local authority in line with the arrangements set out in its strategic plan. Therefore, the Scottish Government considers it necessary for the integration joint board to be able to direct the Health Board and local authority in order for it to be able to ensure delivery of the strategic plan.

24. Careful consideration was given to how the integration joint board would ensure delivery of the strategic plan where this is to be done through the Health Board and the local authority. Taking account of the fact that these directions would be directive only upon Health Boards and local authorities (and not any other person such as a private individual), that the integration joint board would only have such functions as are delegated to it by the Health Board and the local authority, that the Health Board and local authority will be involved in preparing the integration plan which the directions are designed to implement and that the directions are likely to be of a very detailed administrative nature, the Scottish Government considers that the exercise of the power is suitable for direction rather than any form of secondary legislation. A similar approach is taken to the use of direction making powers in both the Scottish health service (see s2(5) of the National Health Service (s) Act 1978) and in social care (see s5 of the Social Work (S) Act 1968).

25. It is not intended that the directions be published, although it is expected that they would be available to anyone who wished to see them by virtue of the Freedom of Information (S) Act.

Section 36(3)– Power to make provision in consequence of new integration plan- scheme about transfer of staff, etc.

- Power conferred on: the Scottish Ministers
- Power exercisable by: Scheme
- Parliamentary procedure: None (and not in the form of an SSI)

- To explain the reasons for taking this power, and explain the circumstances in which the power might be used to transfer staff, property, etc., upon a new integration plan being substituted under section 35?

- Why it has been considered appropriate that the exercise of this power should not be subject to Parliamentary scrutiny, nor provision made for publication of a scheme, nor that it should be made in the form of a Scottish statutory instrument?

- Why does section 19 apply where by virtue of section 12(3) or 15(1), a scheme is made for staff transfer, to set out the effects on contracts of employment, but section 19 does not provide that it applies when this power in section 36(3) is exercised?

- To explain why it is considered appropriate that the power in section 15 enables schemes about the transfer of staff (only), where an
integration plan sets out one of the 3 integration models apart from the model where an integration joint board is established, and yet this power in section 36(3) extends to making provision about transfer of staff, property, rights, liabilities or obligations, when a new integration plan setting out one of those models is substituted under section 35?

26. The Scottish Government have taken this power so that if, for example, a Health Board and two local authorities decide to move from two separate integration plans to a single integration plan with a single integration joint board, then the Scottish Ministers can make a scheme to transfer staff, property, rights, liabilities and obligations from the existing joint boards (and possibly also from the Health Board and local authority) to the new integration joint board. This will facilitate delivery of services by or through the new integration joint board.

27. The Scottish Government considers it necessary for this power to include transfer of property, rights, liabilities or obligations as well as staff so as to enable the integration joint board to fully transact in the circumstances described above – for example, having existing contracts transferred to it.

28. The Scottish Government does not consider it necessary that the exercise of section 36(3) be subject to Parliamentary scrutiny because it relates to what is a detailed administrative matter designed to facilitate delivery of a policy which the Parliament will have already approved through passing the Bill and secondary legislation under it. It would be possible to achieve the same effect as a scheme made by the Scottish Ministers by parties entering into a range of agreements for transfer – reflecting the administrative nature of the scheme.

29. The Scottish Government has considered whether section 19 should apply when the power in section 36(3) is exercised, and concluded that it should, and will consider whether an amendment at stage 2 is necessary to give that effect.

### Section 39(2)(b)– Default power of Scottish Ministers

- **Power conferred on:** the Scottish Ministers
- **Power exercisable by:** Order
- **Parliamentary procedure:** Negative

It appears that the functions of a local authority and a Health Board which may be specified under section 39(2)(a) on default to be delegated to an integration joint board are not limited by the prescription of functions by regulations under section 1(6). Section 1(6) relates to the prescription of functions which must, may, or may not be, delegated under an integration plan. Section 39(2) applies where such a plan has not been submitted for approval.

The Committee therefore seeks clarification from the Scottish Government as to whether that is in the intended position?

30. The Scottish Government does not intend for the functions that may be specified under section 39(2)(a), to go beyond those that are prescribed by
regulations under section 1(6). The Scottish Government will, however, consider whether an amendment is necessary.

Contrary to the exercise of the powers under section 1(6) (which are proposed to be subject to the negative procedure), the exercise of the powers of the Ministers under section 39(2)(a), (d) and (e) to specify the functions to be delegated to an integration joint board and other matters are not proposed to be subject to scrutiny by the Parliament. The specification of these matters by the Ministers does not require to be made in a Scottish statutory instrument, nor is there provision for publication, nor consultation requirements prior to the specification.

The Committee therefore seeks an explanation as to why that difference of approach has been considered appropriate, as between the powers in section 1(6) and section 39(2)?

31. The powers to establish the framework within which functions can be selected for delegation is subject to Parliamentary scrutiny – and that is entirely appropriate. However, the actual selection of individual functions or parts of a function in relation to delegation by a particular Health Board or local authority is not – whether that selection is made by the Health Board and local authority under section 1 or by the Scottish Ministers under section 39. In both cases, the selection of individual functions or parts of a function is not subject to Parliamentary scrutiny. This is consistent with the procedure that currently exists under the 2002 Act.

Section 39(2)(c)– Default power of Scottish Ministers- prescribed day

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>the Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>Regulations</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>Negative</td>
</tr>
</tbody>
</table>

- To clarify whether this provision is intended to be a power to prescribe a day, which is separate from the power in section 9(3), or whether it is intended only to refer to that power?

- Whether this could be clearer, given that section 39(1) and section 9(1) state that the sections apply to different circumstances and it appears that “the prescribed day” is not defined in the Bill?

- If section 39(2)(c) is intended to be a separate power, to explain the reasons for taking the power, and why it is considered appropriate that its exercise is subject to the negative procedure.

32. Under section 39(2)(c) the Scottish Ministers can require a local authority and a Health Board to delegate the specified functions to the integration joint board before the “prescribed day”. Subsection (1) of section 39 provides that the section applies only where a local authority and Health Board fail before the day which is prescribed for the purposes of section 7 to submit an integration plan for the approval of the Scottish Ministers under that section. “Prescribed” is defined in
section 48(1) of the Bill as meaning prescribed by the Scottish Ministers by regulations. So the day prescribed under section 39(2)(c) will be different from that prescribed for the purposes of section 7. As to parliamentary procedure, we consider that the negative procedure is appropriate here given that the section comes into play only as a last resort in cases where the Health Board and local authority fail to comply with the requirements of section 7.

Section 40 – Directions

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>the Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>Directions</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>None</td>
</tr>
</tbody>
</table>

- To provide full explanation is sought of the reasons for taking these powers (which could be applied generally across a range of functions as well as to specific delegated functions), how the power to direct could be used, and the choice of direction as the appropriate procedure?

- To please explain in what circumstances this could introduce powers of direction by the Scottish Ministers over functions which are presently either not subject to such power, or subject to direction by another authority, and why this would be appropriate?

33. The Scottish Ministers already have wide powers of direction in relation to the exercise of their functions by Health Boards (s2(5) of the 1978 Act). The Scottish Ministers also already have wide powers to direct local authorities in relation to the exercise of their functions in the field of social work (including social care) (s5 of the 1968 Act). As such, section 40 only extends their existing direction making powers marginally to take account of the Bill and its effect. That is to say – (1) to confer powers on the Scottish Ministers to direct in relation to new functions arising under the Act and - potentially - a small number of social work functions not covered by section 5 of the 1968 Act and which may be delegated by, or specified in, an integration plan, and (2) to confer powers on the Scottish Ministers to direct integration joint boards, which did not previously exist.

34. Except as regards existing social work functions not covered by section 5 of the 1968 Act. It is appropriate to confer powers as per (1) and (2) as to do otherwise would leave lacuna created by the Bill itself. It is appropriate to extend the range of social work functions in the field of social care to which the Scottish Ministers direction making power extends as that reflects the broad policy which has existed since the 1968 Act was enacted – namely that the Scottish Ministers would have a broad direction making power in relation to the exercise of social work functions by local authorities.

Section 52 – Commencement

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>Order</td>
</tr>
</tbody>
</table>

31
Parliamentary procedure: Laid only

Section 52(2) provides that the provisions of the Act (other than the general provisions in sections 49, 50, 52 and 53) come into force on such day as the Scottish Ministers may by order appoint.

- If it is agreed that the effect of section 49 of the Bill read with section 30 of the Interpretation and Legislative Reform (Scotland) Act 2010 is that it is proposed that a commencement order under section 52(2) will be laid in Parliament (and would be scrutinised by this Committee)?

35. The Scottish Government agree that this is the effect of section 49 of the Bill, read with section 30 of the Interpretation and Legislative Reform (Scotland) Act 2010. This is consistent with usual practice whereby commencement orders are laid in Parliament but are not subject to any further Parliamentary procedure.

Section 49 proposes that an order making transitional, transitory or savings provisions for the purposes of or in connection with the coming into force of the Bill is subject to the negative procedure (except where textual amendment of an Act is proposed). However section 49 also proposes that a commencement order made under section 52(2) which contains transitory or transitional provision or savings would be laid, but not subject to further procedure. This appears to be inconsistent, as the Parliamentary procedure will depend on whether the Scottish Government chooses to make a commencement order or a separate order under section 50(1)(b).

The Committee asks the Scottish Government asks to consider this further.

36. The Scottish Government consider that it is appropriate that there should be two mechanisms for the making of transitional, transitory or savings provisions for the purposes of, or in connection with, the coming into force of the bill. It is anticipated that the provisions of the bill would in the main, be commenced using an order under section 52(2). However, the separate power under section 50(1)(b) would also allow any complex transitional, transitory or savings provisions to be considered by Parliament.
Public Bodies (Joint Working) (Scotland) Bill: The Committee considered the delegated powers provisions in this Bill at Stage 1 and agreed to seek further information from the Scottish Government.
Public Bodies (Joint Working) (Scotland) Bill: Stage 1

10:15

The Convener: Item 5 is consideration of the delegated powers in the Public Bodies (Joint Working) (Scotland) Bill at stage 1. The committee is invited to agree the questions that it wishes to raise in written correspondence with the Scottish Government on the bill’s delegated powers, and the responses that are received will help to inform a draft report on the bill that the committee will consider at a later date.

Section 1(3)(e) provides for the power to prescribe by regulations “information about such ... matters as may be prescribed” for inclusion in an integration plan. Does the committee agree to ask the Scottish Government to provide some examples of the information and matters that could be prescribed for inclusion in an integration plan and to ask why the power has been drawn to permit any matters to be prescribed about which prescribed information would need to be included in a plan without provision that such matters should relate to the matters that the plan will set out in accordance with section 1(3)(a) to (d)?

Members indicated agreement.

The Convener: Given that the regulations under section 1(6)(a) and (b) are intended to prescribe the range of functions of local authorities and health boards that either “must, may or may not be delegated under an integration plan”, does the committee agree to ask the Scottish Government to explain why it is appropriate for section 1(6) to provide that Scottish ministers have the discretion, rather than a requirement, to make the regulations?

Members indicated agreement.

The Convener: The bill neither expressly amends nor refers to section 56 of the Local Government (Scotland) Act 1973, subsections (6) and (6A) of which provide that a local authority’s functions in respect of setting amounts of council tax, borrowing money, approving annual investment strategies or reports and determining applications for planning permission for certain classes of property shall be discharged only by that authority. Under section 56(7) of the 1973 act, “a local authority shall not make arrangements ... for the discharge for any of their functions under the Animal Health Act 1981 by any other local authority.”
Given that section 1 of the bill does not provide for any exclusion of those significant functions in the 1973 act from the powers to prescribe the functions that may be delegated in terms of an integration plan and agreed to be set out in a plan, does the committee agree to ask the Scottish Government to confirm, in relation to the scope of the powers, whether there is any intention to affect the operation of section 56(6), (6A) and (7) of the 1973 act? If not, could the bill be amended at stage 2 to ensure that “integration functions” could never extend to those functions?

Members indicated agreement.

The Convener: The committee might also consider that paragraph 12 of the delegated powers memorandum does not satisfactorily explain why the negative procedure rather than the affirmative or super-affirmative procedure provides a more appropriate level of scrutiny of the powers in section 1(6). The powers are significant, as the regulations provide for the range of functions that “must, may or may not be delegated under an integration plan”.

Does the committee agree to ask the Scottish Government to explain that further?

Members indicated agreement.

The Convener: Section 12(1) provides that the Scottish ministers may by order make provision about various aspects of joint integration boards.

Does the committee agree to ask the Scottish Government why the power needs to be drawn widely to permit any provisions by order about, and so to determine, the membership of integration joint boards and why it could not be drawn more narrowly, to contain provision for the permissible number of members of a joint board—for instance, by stating a minimum or maximum number of members within which parameters an order could specify the number of members of a particular board—and also to contain provision for who may be a member, given that any joint boards will be public authorities that will either undertake or direct the carrying out of functions delegated by the constituent local authorities and health boards?

Members indicated agreement.

The Convener: Section 12(3) provides that the Scottish ministers may, by scheme, make provision about the transfer to an integration joint board of staff, property, rights, liabilities or obligations of a local authority or a health board.

The delegated powers memorandum explains that, as a matter of policy, it is envisaged that any integration joint board established under the bill will not necessarily require to employ staff, that the delivery of functions is likely to be carried out by the constituent local authorities and health board, and that the option of direct employment of staff by a joint board is included as a safeguard, if locally agreed arrangements fail to work.

Does the committee agree to ask the Scottish Government to explain: the reasons for taking the power and the circumstances in which the power might be used to transfer staff, property and so on to an integration joint board; why it is necessary for the power to include the transfer of property, rights, liabilities or obligations as well as staff, when the similar power proposed in section 15 in relation to the other integration models between a local authority and health board is restricted to the transfer of staff; and why it has been considered appropriate that the exercise of the power should not be subject to parliamentary scrutiny, nor provision made for publication of a scheme, nor that it should be made in the form of a Scottish statutory instrument?

Members indicated agreement.

The Convener: Section 15 provides a power for ministers to make a scheme for the transfer of staff from a person who is to delegate functions under the possible integration models between local authorities and health boards, except for the corporate body model.

Does the committee agree to ask the Scottish Government to explain the reasons for taking the power and the circumstances in which it might be used to transfer staff between a local authority and a health board, and why it has been considered appropriate that the exercise of the power should not be subject to parliamentary scrutiny, nor provision made for the publication of a scheme, nor that it should be made in the form of a Scottish statutory instrument?

Members indicated agreement.

The Convener: Section 16(1) provides that the Scottish ministers may by order make provision about the establishment, membership, and 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.

Does the committee agree to ask the Scottish Government why the power need be drawn so widely to permit any provisions by order about, and so to determine, the membership of integration joint monitoring committees, and why it could not be drawn more narrowly to contain provision for the permissible number of members of such a committee—for instance, by stating a minimum or maximum number of members, within which parameters an order could specify the number of members of a particular committee—and provision for who may be a member, given
that any such committees will be public authorities, which will monitor the carrying out of integration functions for the area of a local authority?

Members indicated agreement.

The Convener: Section 22(1)(a) enables an integration joint board to direct the local authorities or the health board that have delegated functions to it in accordance with an integration plan to carry out a function on its behalf. Section 22(1)(b) enables a local authority or health board that has had functions delegated to it in accordance with an integration plan to direct the local authority or health board that delegated the function to it to carry out the functions on its behalf.

In relation to the power to make directions under sections 22(1) to (7), does the committee agree to ask the Scottish Government to explain: the reasons for taking the power and the circumstances in which directions could be used; why it has been considered that it is appropriate to exercise the power in the form of written directions, rather than in a form of subordinate legislation such as an order; and whether it is intended that the directions would be published on being made and, if so, whether that should be provided for?

Members indicated agreement.

The Convener: Section 36(3) provides that, in consequence of the replacement of an integration plan by a new plan, the Scottish ministers may by scheme make such provision about the transfer of staff, property, rights, liabilities or obligations of an integration joint board, a local authority or a health board as they consider necessary.

Does the committee agree to ask the Scottish Government to explain: the reasons for taking this power and the circumstances in which it might be used to transfer staff, property and so on upon a new integration plan being substituted under section 35; why it has been considered appropriate that the exercise of this power should not be subject to parliamentary scrutiny, nor that provision should be made for publication of a scheme, nor that it should be made in the form of a Scottish statutory instrument; why section 19 applies where by virtue of section 12(3) or 15(1) a scheme is made for staff transfer to set out the effects on contracts of employment, but does not apply when the power in section 36(3) is exercised; and why it is considered appropriate that the power in section 15 enables schemes about the transfer of staff only where an integration plan sets out one of the three integration models apart from the model where an integration joint board is established, and yet the power in section 36(3) extends to making provision about transfer of staff, property, rights, liabilities or obligations when a new integration plan setting out one of those models is substituted under section 35? That was a question.

Members indicated agreement.

The Convener: Section 39(2)(a) to (e) lists five default powers that the Scottish ministers may exercise where a local authority and a health board fail before the day prescribed under section 7 to submit an integration plan for approval by them.

It appears that the functions of a local authority and a health board that may be specified under section 39(2)(a) on default to be delegated to an integration joint board are not limited by the prescription of functions by regulations under section 1(6). Section 1(6) relates to the prescription of functions that must, may or may not be delegated under an integration plan. Section 39(2) applies where such a plan has not been submitted for approval.

Does the committee therefore agree to seek clarification from the Scottish Government as to whether that is the intended position?

Hanzala Malik: Why is this only about health boards working with local authorities? Why is it not about local authorities working with local authorities as well?

The Convener: My advice from the clerk is that that is a very interesting question, but it is a question for the lead committee. At the end of the day, it is a policy question; there is no mention of delegated powers in it. I must encourage you to ask that question of the lead committee.

Hanzala Malik: Can I not ask it here?

The Convener: No, simply because it is probably not within our powers to put it.

Hanzala Malik: We are asking a series of questions. I just wonder why we are limiting ourselves to the national health service and not including local authorities. I would be grateful if this committee could ask. We are simply asking a question and saying that there is perhaps an opportunity that we have not explored.

The Convener: I think that may be a fair question. I will take comments from other members.

Stewart Stevenson: Could Hanzala Malik perhaps explain that a little further? I am really not sure what question is being asked. If the question that I am hearing is, “Why are there not delegated powers to allow local authorities to create joint authorities?”, I suspect that I know the answer, which is that the powers already exist. However, I am not sure that that is the question that is being asked. I find it difficult to take a position because I am not quite sure what question is being asked.
The Convener: I think that is the question as I hear it. I think that Hanzala Malik is asking why we are talking only about the integration of local authorities and health boards that are contiguous before they start and why we could not have local authorities joining up with local authorities, which by definition would be neighbouring, in such a way that they could provide joint services. We can think of circumstances in which that would be helpful—indeed, it does happen and such services probably already exist.

Stewart Stevenson’s point might well be a fair one: that power already exists.

Hanzala Malik: I am not sure that it does. That is why I asked the question. We are focusing on two areas: local authorities and the NHS. The convener has alluded to what I was thinking about. Sometimes there are clusters or hubs and it may well be beneficial for local authorities to be clubbing together in that way.

10:30

Stewart Stevenson: The reason why I responded in the way that I did is that Aberdeen City Council and Aberdeenshire Council already do a great deal of that. I am not trying to shut down the question entirely, but I am very familiar with my own area and I cannot identify from my knowledge of one of the local authorities in my constituency what powers are currently lacking, because there is considerable joint working and there are joint arrangements.

The Convener: The powers that we have to consider are the delegated powers within the scope of the bill as it is before us. If it is restricted in the way in which I think it is, we cannot ask that question in the context of the report because that is not in the bill. However, the question is perfectly decent and I am sure that the member will want to explore it outside this committee. The subject committee might want to consider whether all the options that should be available are available, but that is outside our remit, certainly within the context of this particular set of questions.

Hanzala Malik: Okay. I will perhaps take that up with the lead committee.

The Convener: Contrary to the exercise of the powers under section 1(6), which it is proposed will be subject to the negative procedure, it is not proposed that the exercise of ministerial powers under section 39(2)(a), (d) and (e) to specify the functions to be delegated to an integration joint board and other matters be subject to parliamentary scrutiny. The specification of those matters by ministers does not require to be made in a Scottish statutory instrument and nor is there provision for publication or consultation requirements prior to the specification. Does the committee therefore agree to seek an explanation as to why that difference of approach to the powers in section 1(6) and those in section 39(2) has been considered appropriate?

Members indicated agreement.

The Convener: Section 39(2)(c) provides that, on the failure of a local authority and health board to submit an integration plan for approval, the ministers may require the authority and health board to delegate the specified functions to the joint board before the day that is prescribed by regulations.

Does the committee agree to ask the Scottish Government to clarify whether that provision is intended to be a power to prescribe a day that is separate from the power in section 9(3) or whether it is intended only to refer to that power; whether that could be clearer, given that sections 39(1) and 9(1) state that the sections apply to different circumstances and it appears that the prescribed day is not defined in the bill; and, if section 39(2)(c) is intended to be a separate power, to explain the reasons for taking the power and why it is considered appropriate that its exercise is subject to the negative procedure?

Members indicated agreement.

The Convener: Section 40 enables ministers to give binding, written directions to a health board, local authority or an integration joint board.

Does the committee agree to ask the Scottish Government to provide a full explanation of the reasons for taking those powers, which could be applied generally across a range of functions as well as to specific delegated functions, how the power to direct could be used, and the choice of direction as the appropriate procedure; and to explain in what circumstances that could introduce powers of direction by the Scottish Government over functions that are currently not subject to such powers or to direction by another authority, and why that would be appropriate?

Members indicated agreement.

The Convener: Section 52(2) provides that the provisions of the act other than the general provisions in sections 49, 50, 52 and 53 will come into force on such day as the Scottish ministers may by order appoint.

Does the committee agree to ask the Scottish Government whether it is agreed that the effect of section 49 of the bill, read with section 30 of the Interpretation and Legislative Reform (Scotland) Act 2010, is that it is proposed that a commencement order under section 52(2) would be laid in the Parliament and would be scrutinised by this committee?

Members indicated agreement.
The Convener: Section 49 proposes that an order that makes transitional, transitory or savings provisions for the purposes of or in connection with the coming into force of the bill is subject to the negative procedure, except where textual amendment of an act is proposed. However, section 49 also proposes that a commencement order that is made under section 52(2) and that contains transitory or transitional provision or savings would be laid but would not be subject to further procedure. That appears to be inconsistent, as the parliamentary procedure will depend on whether the Government chooses to make a commencement order or a separate order under section 50(1)(b). Does the committee agree to ask the Scottish Government to consider that further?

Members indicated agreement.
Dear Duncan

I very much welcome the 11th Report of the Health and Sport Committee, stage 1 report on the Public Bodies (Joint Working) (Scotland) Bill. In particular, I welcome the support of the Committee regarding the principles of integrating health and social care with the aim of improving outcomes for service users, especially those with multiple long term and often complex needs, carers and their families.

As the report notes, there is a clear need for legislation to provide the framework for driving forward change and improving outcomes for people using health and social care services; not enough progress has been made under the current permissive legislation. As the report also notes, however, the Scottish Government also recognises that leadership and issues of culture are key to effective integration; this is clear from those examples of good practice that can be seen already in Scotland, and from evidence from further afield.

I attach the Scottish Government response to the Committee’s comments in the stage 1 report.

ALEX NEIL
Scottish Government response to the 11th report of the Health and Sport Committee stage 1 Report on Public Bodies (Joint Working) (Scotland) Bill

Para 62 - 63

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.

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 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.

1. The Scottish Government notes the Committee’s comment and request for further clarity regarding governance arrangements in the body corporate model. The Scottish Government is taking forward further work, with partners in the NHS and local government, setting out more fully a description of the Bill’s provisions as they relate to governance and accountability arrangements and, alongside that, explaining the practical effect of these arrangements “on the ground”. It is important that partners are fully engaged in this key piece of work, which will be considered by the Governance and Accountability Working Group for integration, and by other specific key stakeholders such as Chief Executives of Health Boards and local authorities. I attach a copy of the current draft of this paper at Annex A.

2. The Committee will wish to note that the Scottish Government intend to bring forward an amendment at stage 2, which will enable a Health Board and local authority jointly, where the body corporate model is used, to require a new strategic plan where they consider the strategic plan as drafted would prevent them, or is preventing them, from meeting the national health and wellbeing outcomes, the integration planning and delivery principles, or their duties in regard to carrying out the delegated functions.

Para 64-65

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.

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.

3. In developing section 12(1) of the Bill, the Scottish Government had regard to the broad responsibilities that will provide the context in which the integration joint board will plan and oversee delivery of health and social care services, and indeed the substantial resources that will be delegated to it. The Scottish Government also took account of the wide range of matters for which provision would require to be made in relation to an integration joint board in order to ensure its effective and efficient operation, and the desirability of establishing a consistent approach across Scotland, while allowing appropriate “space” for local arrangements to be flexible in response to local needs.

4. The Scottish Government considers the breadth of this power necessary in order to give the Scottish Ministers flexibility to respond to the different ways in which Health Boards and local authorities approach integration within the framework set out in the Bill. It is important that the Bill strikes an appropriate balance between establishing a common framework for integration across Scotland, with full regard for effective and appropriate governance arrangements, whilst at the same time ensuring that it is not prescriptive at such a level of detail as to stymie local innovation. It is these reflections on the importance of ensuring strong, effective and appropriately consistent governance arrangements around Scotland that have influenced the powers set out under section 12(1) that refer to membership, proceedings, supply of services or facilities, and the operation of integration joint boards.

5. The powers set out under section 12(1) also refer to giving integration joint boards general powers, such as, for example, powers to contract, acquire or dispose of property or borrow money. While it is intended that certain limited powers will be given to integration joint boards initially, to allow them to make the necessary arrangements for fulfilling their obligations under the Bill, it is not intended that broad powers will be given to integration joint boards in the first instance. However section 12(1) is drafted in such a way that if, in future, it were considered appropriate for the integration joint board to provide services directly, there is a power for the Scottish Ministers to provide for this by regulations. We envisage different possible circumstances in which the Scottish Ministers might empower integration joint boards in this way to deliver services directly, i.e., by employing staff, entering into contractual arrangements with providers, owning property, etc.:

- The Scottish Ministers might choose to take this step if a local integration joint board were functioning particularly well, and there was local agreement by the three parties to the arrangement – the Health Board, local authority and integration joint board itself – that the integrated arrangement should be empowered to deliver services itself.

- On the other hand, the Scottish Ministers might use this power in light of poor progress towards integration in a partnership area, in order to empower the integration authority to deliver real improvement.
6. These powers reflect the Scottish Government’s belief that Health Boards and local authorities can use the opportunity provided by integration to deliver a step change in outcomes for people. They also take account of the evidence that demonstrates real change in delivering health and social care services is needed now in order to meet the needs of our ageing population – the status quo is not an option – and the reality that delivering major change in the way large organisations deliver their business is challenging and requires, in this context, strong local and national leadership to succeed.

7. The Committee will wish to note that the power at 12(1) does not enable the Scottish Ministers to directly appoint members of the integration joint board as was suggested at the evidence session and as recorded at paragraph 56 of the Report.

8. The Scottish Government acknowledges the Committee’s request that drafts of some of the proposed regulations should be made available for consideration by stakeholders before the Bill has completed its parliamentary passage. The key thing is that the Scottish Ministers’ policy on how they intend to use these powers is set out in a way that is clear and easily understood. Draft legislation is not the best way to achieve that, and may also be misinterpreted as suggesting that the Scottish Ministers have already determined the content of legislation before consultation. With that in mind, officials will progress preparation of a statement of the policy which the Scottish Ministers are minded to deliver (subject to the outcome of consultation) in relation to each of the principle powers to make secondary legislation.

Para 84 – 85

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.

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.

9. The Scottish Government welcomes and agrees with the Committee’s comments that the focus on national outcomes must be to ensure continuous improvement in improving outcomes for individuals. The health and wellbeing outcomes are about improving the lives of all those who have health and care needs. The focus of the national outcomes is therefore generic, relevant and applicable across a broad range of needs. The Scottish Government would expect indicators, which will be set out in guidance, and indeed other outcomes, to sit underneath the national health and wellbeing framework and to set out specific priorities at an individual level.

Para 102 -105

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

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.

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.

10. The Scottish Government recognises that there is a range of views regarding the range of services that the Scottish Ministers should require for inclusion in integrated arrangements, and has been clear that the Bill should permit local flexibility beyond adult health and social care.

Para 116 – 117

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 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.

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.

11. The Committee has asked about the relationship between the provisions in the Children and Young People (Scotland) and the Public Bodies (Joint Working) (Scotland) Bills, as well as the on-going work on community planning and the Social Care (Self-Directed Support) (Scotland) Act. The range of changes shows the Scottish Government’s determination to take forward the principles of the Christie Commission, ensuring that there is more effective, more joined-up planning between bodies at local level. They all share the similar core principles and shared aims with respect to future planning.

12. With respect to Community Planning Partnerships (CPPs), the children’s services plans set out in the Children and Young People (Scotland) Bill will feed into wider community planning processes. As with other public sector bodies, there is a mutual relationship between CPPs and the children’s services plans. On the one hand, CPPs and their constituent partners will take account of the needs of children and young people in local communities, as set out in the children’s services plans. On the other, Single Outcome Agreements (SOAs) will set the framework for planning in children’s services through the local, high-level priorities agreed by each CPP.
13. With respect to the Public Bodies (Joint Working) (Scotland) Bill, while the Children and Young People (Scotland) Bill requires planning for children’s services across the whole range of public bodies, the Public Bodies (Joint Working) (Scotland) Bill focuses on the planning and delivery of health and social care services specifically. The children’s services planning proposals of the Children and Young People Bill build on the existing good practice in planning that local authorities have been taking forward as part of their responsibilities under the Children (Scotland) Act 1995. The new proposals will put in place an overarching framework and a mechanism for strategic coordination of planning of all key services affecting the wellbeing of children and young people. Should local authorities and Health Boards decide to include children’s services in their integration plans, the planning requirements of the Public Bodies (Joint Working) (Scotland) Bill, will feed into developing the plans required of the Children and Young People (Scotland) Bill. Full alignment will be pursued through the parallel development of guidance for the duties in both Bills.

14. Turning to integration of health and social care and reform of community planning; these are both significant and important aspects of public service reform in Scotland, and of the Scottish Government’s response to the recommendations of the Christie Commission – in terms of improving outcomes, assuring efficiency and focussing on preventative action. Like other key public sector bodies, integration authorities will be expected to play a strong and effective role in supporting the work of community planning to achieve better outcomes for communities on shared local priorities.

15. The relationship between Community Planning Partnerships and integration authorities will not be hierarchical. CPPs provide a mechanism for different partners in public service delivery to come together to plan effective co-ordinated provision. Integration authorities, whose function will be to plan for and deliver, as a minimum, adult health and social care services, will be partners in the process of community planning.

16. As with other public sector bodies, there is a two way relationship between CPPs and integrated partnership arrangements. On the one hand, CPPs and their constituent partners must ensure that the new integrated services are connected to their wider assessment of the needs of local communities and that the outcomes to be delivered by partnership arrangements are reflected in SOAs and wider CPP planning. On the other, CPPs and SOAs must support the integration of adult health and social care services and integrated partnership arrangements by, for example, connecting other agencies such as police and fire to the work of the integrated partnership arrangement.

17. The Scottish Government is working to ensure that the key outcomes that partnership arrangements will be working towards complement and fit with the outcomes set out in Single Outcome Agreements. Over time, there will be an expectation on CPPs to reflect the nationally agreed outcomes for adult health and social care in their SOAs, along with such other outcomes and measures as are agreed locally.

18. The Scottish Ministers, COSLA and the Chair of the National Community Planning Group have co-signed an Agreement on Joint Working on Community Planning and Resourcing, which requires CPPs and community planning partners to be clear about total collective resources available, and ensure resources are deployed towards priority outcomes.
19. We expect the Integration Authority, just like other public sector partners, to bring its budget and resource planning assumptions to the CPP and, just like other partners, to consider how those resources can best be used to achieve the outcomes set out in the SOA.

20. Local authorities and Health Boards are undertaking detailed budget and resource planning work to facilitate the integration of adult health and social care services. This will provide important learning for CPPs.

21. The legal duties under the Social Care (Self-Directed Support) (Scotland) Act 2013 (the “SDS Act”) – i.e., the duties to offer and provide specific choice mechanisms such as direct payments or individual services funds – relate to long-standing local authority social care functions found in the Social Work (Scotland) Act 1968 and Children (Scotland) Act 1995. As such, the legal duties on SDS choices are placed on local authorities rather than the NHS (other than where the local authority duties are formally delegated to the NHS). However, the Scottish Government’s national SDS strategy also makes it clear that “health services need to be an integral part of the overall effort to increase self-directed support”.

22. The Public Bodies (Joint Working) (Scotland) Bill will create an integrated health and social care budget and a single set of joint outcomes. In this respect, integration creates a positive policy environment for the Health Boards to play an integral part in SDS policy and practice. If we are to deliver the aspirations set out in the National SDS Strategy it is vital that we take full advantage of this opportunity.

23. The Scottish Government will continue to foster effective links between the two policies via the following activities:

- A national “SDS and integration” working group which will help a) to inform the regulations and statutory guidance in support of the Public Bodies (Joint Working) (Scotland) Bill and b) to develop a national strategy in relation to the role of the NHS in delivering greater choice and control to individuals.

- A dedicated national lead on SDS and Health, based within the Scottish Government’s Self-directed Support policy team

- The potential for Scottish Government to fund dedicated SDS development officers within a small number of volunteer Health Boards will also be explored. This will enable the relevant Health Boards to develop detailed strategies and processes to underpin their role in SDS.

Para 137 – 142

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.

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.

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.

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.

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.

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

24. As I noted at Committee, and have reiterated throughout the development of the Bill, I fully recognise and value the vital role played by the Third and Independent sectors. The Scottish Government continues to have helpful and positive discussions on matters relating to integration with their representatives. The Bill provides for a number of opportunities for the effective involvement of a range of stakeholders including the third and independent sectors and this will also be set out in regulations. I am of the view that, in addition to prescribing their involvement via regulations, the most effective mechanism to assure the sectors’ full engagement in integration is via strong guidance to accompany the legislation, which will provide a thorough underpinning for effective partnership and cross sector engagement at all levels; and through developing further the effective engagement through existing partnership and improvement work, such as that taken forward in relation to Reshaping Care for Older People and the Change Fund for Older People’s Services.

25. I note the Committee’s comment about the need to distinguish between Third sector providers of services and those that represent users and will undertake to ensure this is fully considered in the development of guidance.

Para 151 -153

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.
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.

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.

26. The Scottish Government is committed to ensuring that both carers’ organisations and carers themselves are fully involved in the planning, shaping and delivery of services and support. This is clearly articulated in the policy memorandum, and regulations will set out requirement to include carers in integrated partnership arrangements. Indeed, this is one of the key commitments in the Carers Strategy, Caring Together. We have made clear to local authorities and Health Boards that they must carry out this commitment at local level. We believe that whilst a lot of progress has been made, there is more to do. Guidance on strategic commissioning will make clear that the commitment extends to involvement in the design and delivery of future integrated services. Moreover, as made clear in the Statement of Intent published on 1 October 2013, it is the Government’s intention to bring forward legislation to Parliament to support carers and young carers, subject of course to the outcome of consultation.

27. The Scottish Government believes there should continue to be supported, meaningful and effective involvement of people in service planning and improvement and each Integration Authority should agree the formal structure it will use to involve the public in the planning and design of health and social care services and policies in that area.

28. The Participation Standard developed by the Scottish Health Council currently measures how well NHS Boards communicate with and involve the people and communities they serve. The Scottish Government are content to explore the development of a single standard for participation, as suggested by the Scottish Health Council and to look at the level of detail it might be appropriate to provide in guidance relating to this.

Para 159 – 161

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.

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.

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.

29. The Care Inspectorate and Healthcare Improvement Scotland are developing a new methodology for the joint inspection of adult services. Elements of the new methodology were initially tested in three community partnerships, and a further two
pilots of the full methodology are currently taking place. An important part of this work includes the development of new quality assurance methods that verify and evaluate judgements as part of the scrutiny process. A consultation has sought views on the attached quality indicator framework which takes cognisance of the health and wellbeing outcomes established by the Bill, the Healthcare Quality Strategy and other relevant standards such as the Dementia Standards. The consultation closed on the 11 November 2013. Analysis of views received will now take place and a finalised quality indicator framework will be in place for the start of the new inspection year on 01 April 2014.

30. The Scottish Government established a Clinical and Care Governance working group in May 2013 to consider and develop guidance for Integration Authorities on how clinical and care governance should be assured through the new arrangements. The group last met on 1 November 2013 and agreed to develop a high level document that describes care governance roles and responsibilities for social care to mirror ‘Governance for Quality Healthcare in Scotland – An Agreement’ (http://www.scotland.gov.uk/Resource/0042/00427583.pdf) and develop some fundamental principles that should underpin the development of local arrangements. These two documents will provide local partnerships with the basis from which to develop clinical and care governance arrangements that will assure quality in integrated service delivery. They will support closer working between health and social work services through a shared understanding of the common themes and language that underpin health and social work worlds. The group is aiming to develop these resources by March 2014 and then further consider if other guidance is required. I will provide Committee with this information when it is available.

31. In addition, the Scottish Government is working constructively with a range of stakeholders, including the RCN, on possible amendments to the Bill around the integration planning and delivery principles and embedding quality care principles.

32. Single Outcome Agreements reflect the breadth of activity and national policy priorities across Community Planning Partnerships. The national health and wellbeing outcomes are a specific mechanism for ensuring that Health Boards and local authorities are jointly and equally accountable for planning and delivery of effectively integrated services to support individuals to live healthy independent lives.

33. There is a concerted effort to make best use of currently available national measures such as those collected for Scotland Performs, HEAT and Community Care Outcomes as well as national experience surveys. Whilst there may currently be gaps in information collection at a national level, it is the intention to ensure that any new data is helpful and useful at a local planning level. The performance report by the integration authority will provide the mechanism via which the national outcomes will be monitored.

Para 177 -178

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.

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.

34. As the Committee notes, the Scotland Act enshrines the European Convention on Human Rights as a fundamental standard which the Scottish Parliament and the Scottish Government must respect in all their action, including legislative acts. With human rights firmly entrenched at the heart of Scotland’s existing constitutional, legal and institutional structures, our plans for integration of health and social care have strong foundations to build upon. The integration principles enshrined in the Bill focus on improving individual wellbeing from the perspective of person-centred and population-based planning and provision of care, which adds further value to our commitment to responding to and respecting the needs of the individual. I am therefore of the view that no further legislative provision is necessary to reflect human rights in the Bill. Indeed, I would go further – including specific mention of the need to respect Convention rights in this Bill but not in others may have the undesirable effect of implying that the duty to respect human rights in other fields is somehow diminished, an implication which is clearly to be avoided.

Para 202 - 206

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

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.

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.

The Committee notes the Cabinet Secretary’s announcement on 5 November 2013 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.

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.

35. Embedding professionals and non-statutory partners in shaping the redesign of services is key to the success of these proposals and will be largely driven by two elements of the reform, strategic planning and locality planning arrangements. The strategic planning process sets how the integration authority will deliver improved outcomes for its communities over the medium to long term and locality arrangements drive short term planning, the delivery of services and the response to local in-year challenges. Regulation will require that professionals, the third and independent sectors, service users and carers are the participants in these processes, supported by the Integration Authority, to ensure it is they that lead decision making whilst leaving the actual arrangements to local determination to aid a flexible approach to match local circumstance.

36. The Scottish Government recognises that the legislative framework can only deliver so much and different partnerships, professionals, stakeholders, users are starting from different points, with differing relationships and perspectives and that ultimately it is a change in the culture that will deliver improved outcomes rather than the governance arrangements or consultative duties of public bodies. The Scottish Government is committed to supporting organisational and workforce development and actively supporting partnerships to develop locality arrangements.

37. As the Committee notes, I have announced that the Scottish Government intends to review access to GP practices in partnership with the BMA Scotland, as part of work to “modernise” Primary Care across Scotland. The Scottish Government continues to meet with the Scottish General Practitioners Committee of the BMA in regard to the on-going development of the General Medical Services Contract in Scotland, and how GP Contract supports the move towards the 2020 vision of more services provided in a primary and community setting. The Scottish Government is working with the Scottish General Practitioners Committee of the BMA to reduce the workload and bureaucracy associated with the GP Contract in Scotland to free up time to spend with patients.

38. The issue of GP engagement in the planning and development of the integrated health and social care arrangements forms part of these discussions. The detail of these discussions remains confidential within the contract negotiations.

39. The Scottish Government notes the suggestion that the provision to reimburse members of the consultation group is extended to participants in locality planning process. The policy intention has always been to ensure that partnerships are able to reimburse expenses as this will be fundamental in securing the participation of non-statutory partners and independent contractors. The Scottish Government will take this under consideration for stage 2.

Para 233 -236

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

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.
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.

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.

40. The Scottish Government believe that the Integration planning and delivery principles set out in Sections 4 and 25, and the integrated governance arrangements that Partners must put in place adequately provide for the fundamental principles that underpin successful locality planning arrangements. The Bill provides for some locality planning arrangement and the Joint Improvement Team is co-ordinating a piece of work on behalf of the Scottish Government with a number of national improvement agencies and third sector partners to inform the development of locality planning guidance and learn and share from local practice. The work began in September 2013 and is due to finish in March 2013 and is broken into three stages. The first is to map and link the current improvement and support activities and opportunities. The second is to invite Partnerships to participate in an appreciative inquiry dialogue and thirdly to facilitate a series of focus groups with a cluster of partnerships to reflect on emerging themes. This programme of work will help to identify areas where more support from improvement agencies can add value, create a better picture of how partnerships are progressing with locality planning now and feed into the development of statutory guidance.

Para 247 -248

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.

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

41. Services which are chargeable at present will remain chargeable under the Public Bodies (Joint Working) (Scotland) Bill; this legislation does not introduce any changes regarding which services are charged for and which are provided free at point of delivery. Nevertheless, I recognise the concerns raised by Committee regarding the possibility of cost creep for the individual as service provision becomes more integrated across the NHS and local government, and more care is provided within community settings. The Scottish Government will continue to work with COSLA, local authorities and stakeholders on charging. COSLA’s non-residential charging guidance working group, for example, aims to reduce the variation in charging policies across Scotland, working with stakeholders including disability organisations to...
Para 260 – 264

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.

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.

The Committee also accepts that work and discussions are on-going 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 on-going monitoring. However, the Committee also agrees with witnesses who indicated that further clarity on these matters, as the Bill progresses, would be helpful.

Finally, the Committee welcomes the Finance Committee’s commitment to continue to monitor financial aspects of the implementation of the Bill as part of it’s 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.

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.

42. I acknowledge the Committee’s request regarding provision of further information on financial arrangements as the Bill progresses. In terms of measuring the effectiveness – in terms of outcomes – and the financial implications of integration, our work with ISD to develop a linked patient/client level health and social care dataset and information system will provide a rich evidence base for local strategic planning activity, and for local and national understanding of local performance. I have also asked my officials to establish a working group to consider the medium and long term financial consequences of supporting our ageing population within the context of integrated health and social care arrangements. I will be pleased to provide an update on both of these areas of work in due course.

43. The Committee may also wish to note that, in terms of financial management, the Scottish Government's Integrated Resources Advisory Group, whose members are finance professionals from the NHS and local government, is developing detailed guidance for finance managers under integrated arrangements. I will also provide an update on that work should the Committee find that helpful.

Para 279 – 280

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.

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.

44. I welcome the Committee’s intention to monitor progress regarding inclusion of acute budgets in integrated strategic planning arrangements. There will, as the Committee, notes, be some variation in terms of the proportion of Health Board total budgets that are included in integrated arrangements, depending on the scope of services provided in the Health Board area that fall within areas of activity that will be required for inclusion in integration. Services provided on a national or regional basis will not be included in integrated arrangements, for example, and these are provided by the larger Health Boards, which will mean that, in any comparison between larger and smaller Health Boards, the former will include a smaller proportion of total acute hospital budgets in their local integrated arrangements. However, it is important to note that the same stipulations will apply to all Health Boards in terms of which types of care (and thus which budgets) must be included in the integrated arrangements. These requirements will be set out via regulations. An amendment introduced at stage 2 will set out that only adult social care functions must be included in the integrated arrangement; money will follow functions, with the result that it will be a requirement for all of adult social care spend, as defined in legislation, to be included in the integrated budget.

Para 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.

45. The SG discussions with HMRC are on-going and we expect to reach a conclusion by the end of December. The current position in respect of the two integration models is as follows:

- **Body Corporate** - HMRC have confirmed the Scottish Government view that the Integration Joint Board, as initially empowered in the Bill, is not a taxable person. The Scottish Government will consider carefully the effect stage 2 amendments may have on this position.

- **Lead agency** - this model is the subject of the on-going discussions, in which we are testing the proposed solution with data from four Health Boards and their local authority partners; we expect to conclude this analysis in the next few weeks.

46. The Scottish Government remains reasonably confident that the discussions with HMRC will result in there being no VAT implications arising from the Bill’s provisions and will provide an update to the Committee when they are complete.

Para 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.

47. The eHealth Strategy 2011-17 made a commitment to engage with stakeholders across the health and social care community to develop a strategy that clearly articulates the technology related requirements to support information sharing between partners and therefore enable integrated care. An Information Sharing Board (ISB) was established in 2011 to provide overall guidance and governance in this area, and has membership (both business and technical leaders) representing local delivery partnerships across Scotland. The ISB is providing initial oversight of the development of the strategy. A draft document has been developed, with considerable stakeholder engagement over the course of 2013, and defines some key principles for information sharing. It looks beyond the underpinning technology that is needed for effective information sharing and communications and includes areas such as Information Governance and standards. This work has informed some key requirements for the Scottish Wide Area Network (SWAN) procurement. Plans are in place to consult more widely on this initial draft early in 2014.

48. A key principle of the draft strategy is the support for local partnerships to develop innovative technology solutions for information sharing that suits their local ways of working. The general approach will be incremental, re-using existing assets where appropriate. However, locally led developments will be guided by an appropriate set of standards to ensure that information sharing is possible, when required, at a national level. The local partnerships will come together through national groups to promote a collaborative approach and ensure that there is no unnecessary duplication of effort, especially when it comes to systems that are used widely by multiple organisations (as mentioned above, SWAN will become a key technical infrastructure enabler as organisations join the service).

49. Developments in this area are being supported by £2m annual funding in this spending review period, which was agreed prior to the Bill being introduced. This funding is being used to support an existing national information sharing system (EDISON), develop national standards, commission activity by local partnerships that will have wider benefit, and provide all local partnerships with an allocation (based on an agreed formula) to enable local developments (£1m of this has been allocated to local partnerships in 2013-14, and £1.5m is earmarked for 2014-15). This funding is ‘enabling’ in nature and is not intended to meet the full cost of systems development and support for all partnerships across Scotland. Partner organisations are also contributing their own funding based on local business cases that provide local benefits and savings.

Para 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.

50. Healthcare Improvement Scotland is currently developing its six year strategy. This will take into account the workforce and financial implications of meeting all the duties upon it. This will include the effective and efficient use of the total budget allocation to
Healthcare Improvement Scotland. As part of the wider strategy review, Healthcare Improvement Scotland will shortly be consulting on its future scrutiny and inspection plan. This will include joint inspections with other agencies such as the Care Inspectorate.

Para 304 – 306

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.

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.

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.

51. As the Committee report notes, detailed staffing arrangements will be a matter for the integration authorities, Health Boards and local authorities and for local negotiation and decision-making. The Scottish Government does, however, recognise that some of the matters raised by UNISON and others will benefit from national discussions and, potentially, action or guidance. The Scottish Government has established Human Resources Working Group on Integration (HRWG) to consider those workforce issues arising from integration proposals. The group’s members are drawn from local government, the NHS, COSLA, trade unions (including UNISON national officers from both NHS and council settings) and Scottish Government officials. The Group is considering a range of HR issues, including whether each matter needs national agreement – and if so, what the mechanism should be for reaching such agreement – or whether local agreement is more appropriate. Draft guidance has also been developed by the Group and shared with local partners on, for example, joint appointments.

52. In addition, the Scottish Government has established a Workforce Development Strategic Group, which is considering how best to address issues of workforce cultures, practice and development to support development of a workforce that supports and delivers integrated support and services. A number of partners who have responsibilities in this area of work, such as the Scottish Social Services Council, NHS Education for Scotland and the Institute for Research and Innovation in Social Services, have already been working collaboratively over the last year or so on a range of developments intended to support cross-sector and multi-professional training and practice. Many of the new programmes of work for these organisations are being planned with integration as a key driver for their work; for example, the SSSC’s review of the social work degree will take into account the need to develop professionals with the skills and knowledge to work in the context of integration.
Integration of Health and Social Care – Governance, Accountability and Operational Delivery under integrated arrangements

November 2013

Introduction

1. This paper sets out key aspects of governance and accountability arrangements under the Public Bodies (Joint Working) (Scotland) Bill. Its purpose is two-fold:

a) To explain, in outline, the Bill’s provisions as they relate to issues of governance and accountability; and

b) To explore, also in outline, how integrated arrangements will actually work on the ground.

2. Clearly, there must be synergy between these two aspects of integration: practical arrangements on the ground can only work if the legislative framework enables them to do so. However, it is important to remember that legislation itself does not provide a set of instructions for how to make integrated arrangements work. It would be fruitless to examine the Bill for every detail of how practicalities will work; it would also be undesirable to set legislation out on that basis, constraining as it would the opportunity for local innovation and adaptation appropriate to local circumstance. Leadership – at local and national levels – will be key to making integration work, and no legislative provision yet devised can generate or guarantee effective leadership.

3. Legislation can, nonetheless, establish effective requirements for accountability and transparency regarding outcomes. The underlying principle of the Public Bodies (Joint Working) (Scotland) Bill is that Health Boards and local authorities must take joint and equal responsibility for the delivery of nationally agreed outcomes for health and wellbeing, and with this in mind the Bill is written to provide a framework to enable effective local integration of health and social care.

4. The aims of the Bill are:

- to support improvement in terms of the quality and consistency of health and social care services in Scotland;
- to enable local partners to, more effectively and consistently, plan for and provide seamless, joined up quality health and social care services; and
- to ensure that resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs.

5. The focus of the Bill is on establishing cohesive planning and delivery arrangements spanning Health Boards and the social care responsibilities of local authorities, with teams whose members are integrated in relation to their shared objectives, whatever local employment and management arrangements are in place.

6. The Bill also reflects the vital contribution of the third and independent sectors in enabling delivery of better outcomes as well as the statutory roles of Health Boards and local authorities.
7. The purpose of this paper is to set out the practicalities of how these aspirations will take effect within the context of the new integrated arrangements. Guidance will, in due course, set out the Scottish Ministers’ expectations for the factors that should be taken into account when establishing local arrangements.

8. The paper is organised under a series of headings that relate directly to those aspects of integration most relevant to questions of governance and accountability, as follows:

- Accountability
- Planning for integrated services
- Operational delivery of integrated services
- Liability

9. Under each heading, a brief description of the Bill’s provisions is followed by a short explanation of intended practice on the ground.

10. Annex (i) provides further information on financial accountability.

**Accountability**

**Body Corporate Model**

**The Bill**

11. Where partners agree locally to set up a body corporate arrangement, the Bill requires that:

- The Health Board and local authority agree an integration plan, setting out local arrangements for integration, within the parameters established by the legislation. Regulations will set out which functions must be included within the integrated arrangement – these will cover adult social care, adult primary and community health care, and aspects of adult secondary health care.

- The integration plan will be submitted to the Scottish Ministers for approval so that an Order can be laid in Parliament to establish the integration joint board as a legal entity.

- Where Ministerial approval is not given in the first instance, the Scottish Ministers will provide detailed feedback and a timescale for the Health Board and local authority to agree an amended plan.

- Once established by Order, the duties of the integration joint board are to appoint a chief officer, develop and maintain a strategic plan and ensure the delivery of the functions delegated to it, using the resources delegated to it.

- Once the chief officer is appointed and the strategic plan is developed and agreed responsibility for planning and overseeing delivery of the delegated functions passes formally to the integration joint board.

**In practice**

12. A key priority of these reforms is to ensure that the integrated health and social care arrangement is empowered to deliver real change, and, particularly, to shift the balance of care in favour of preventative and anticipatory care based in communities.
13. Incorporating the integration joint board, and then delegating control of functions and resources to it from the Health Board and the Local Authority, gives the integration joint board the power to plan and act as necessary to improve outcomes.

14. Nevertheless, the intention is not to establish the integration joint board as an entity acting separately from the Health Board and local authority, or without regard to wider issues of patient and service user wellbeing and public service effectiveness. The integration joint board is in practice bound to the accountability arrangements of the Health Board and local authority in two ways:

a) The integration joint board is established via agreement between the Health Board and local authority. The terms of this agreement are described in the integration plan, which will set out the context within which the integration joint board must operate. An amendment to the Bill will set out arrangements to allow the Health Board and local authority to revise the integration plan if, as time passes, it becomes apparent that local arrangements could be improved.

b) Voting members of the integration joint board will be drawn from Health Board and Council members. It will be up to the Health Board to decide its members of the integration joint board, and it will be for the Council to decide its members. Regulations will set out rules about the maximum size of integration joint boards, to ensure that they operate effectively and efficiently. If the Health Board wishes to appoint other representatives to the integration joint board, perhaps because it does not have enough non-executive members to serve the various integration joint boards in its area, those appointments will be subject to Ministerial approval. It will be up to the Health Board and local authority to agree, via the integration plan, chairing arrangements for the integration joint board.

15. Integration joint boards need to be empowered to act, which is achieved by giving them legal personality and enabling them to hold the functions and resources delegated to them, but at the same time must retain a close relationship to the Health Board and local authority.

Lead Agency Model

The Bill

16. Where partners agree locally to set up a lead agency arrangement, the Bill requires that:

- The Health Board and local authority agree an integration plan, setting out functions and resources that will be delegated between the Health Board and local authority. The integration plan must also set out which functions of the lead agency will be managed and planned for “in conjunction with” the delegated functions. In other words, the integration plan must set out the same, full range of functions under this model as must be described under the body corporate model. In this way, services will be managed in an integrated way in order to deliver improvement along the entire journey of care. For example, where adult social care is delegated to the Health Board, the integration plan must set out the delegated functions (adult social care functions) and also the functions to be managed in conjunction with those functions (i.e., adult primary and community health care, and aspects of adult secondary health care, as required under regulations).
• An amendment to the Bill will set out that, where the lead agency model is used, in order to assure the integrity of the integrated model, functions must be delegated in such a way that adult health and social care services are managed and led by one statutory body (either the Health Board or local authority).

• The integration plan will be submitted to the Scottish Ministers for approval.

• Where Ministerial approval is not given in the first instance, the Scottish Ministers will provide detailed feedback and a timescale for the Health Board and local authority to agree an amended plan.

• Once the integration plan is approved by the Scottish Ministers, the delegating agency will delegate functions and resources to the lead agency, which is responsible for producing the strategic plan and delivering services.

• An integration joint monitoring committee is established to provide oversight of the integrated arrangement. Membership of the integration joint monitoring committee is agreed by the Health Board and local authority as part of the integration plan.

• An amendment to the Bill will require Health Board and local authority to provide the integration joint monitoring committee with reports, information and assistance about delivery of services, so that it can exercise its duty to provide oversight of the integrated delivery arrangements.

In practice

17. In the lead agency model, functions and resources, and therefore responsibility for delivery, pass from one statutory body to the other.

18. The integration joint monitoring committee’s role is one of oversight, not executive decision making. The Health Board and local authority will be under a duty to provide reports, information and assistance so that the committee is able to provide this oversight of the integrated delivery arrangements. The integration joint monitoring committee will write reports of its findings and make recommendations to the lead agency in those reports. The lead agency will be under a duty to have regard to those recommendations and will need to respond to the committee indicating, what, if any, action it has taken in response.

19. The membership and arrangements for executive support of the integration joint monitoring committee will be left to the Health Board and local authority to agree and set out within their integration plan.
Planning for integrated services

Both models – body corporate and lead agency

The Bill

20. The Bill requires that:

- The integration joint board or lead agency must develop a strategic plan that sets out the arrangements for carrying out of the integrated functions and how these arrangements will contribute to the delivery of the national health and wellbeing outcomes. By “integrated functions” we mean either the functions delegated to the integration joint board, or, where the lead agency model is used, the functions delegated to the lead agency plus the functions that will be managed in conjunction with the delegated functions.

- The integration joint board or lead agency must have regard to the integration delivery principles and the national outcomes set out in legislation in the development of the strategic plan.

- The integration joint board or lead agency must establish a consultation group to support and inform development of the plan. The integration joint board or lead agency must pay regard to the views of the consultation group in the development of the strategic plan.

- Where the body corporate model is used, the integration joint board must consult the Health Board and the local authority regarding development of the strategic plan.

- The strategic plan must establish localities within the geographical area covered by the integration arrangement.

- The strategic plan must be reviewed on a regular basis to ensure that it remains fit for purpose.

In practice

21. Strategic planning is the heart of the Bill and is the mechanism via which integrated arrangements will be able to effect real improvements in service provision and outcomes. It will be particularly important that strategic planning takes account of the views of non-statutory partners and professionals working in local systems.

22. Strategic planning also sets the context for locality arrangements, which will be vitally important in driving forward the required shift in the balance of care in favour of community and preventative provision, and in embedding an assets based approach to service planning and delivery. Locality planning provides the mechanism, in particular, for ensuring primary care practitioners are tied into strategic planning and integrated arrangements.

23. We recognise that it is important that strategic planning for integrated functions and services must work effectively within the broader context of Health Board and Council activity.

24. A challenge arises in this respect where the body corporate model is used. Strategic planning for integrated functions cannot be contingent on Health Board and local authority approval, or the integration joint board will not be empowered to deliver change.
25. Where the body corporate model is used, an amendment to the Bill will enable the Health Board and local authority, acting jointly, to direct the integration joint board to prepare a new strategic plan. Such a direction must explain the Health Board’s and local authority’s reasons for requiring a new strategic plan, and must demonstrate that the Health Board and local authority agree with one another that the existing strategic plan would prevent them, or is preventing them, from complying with:

- the integration planning principles;
- the national health and wellbeing outcomes;
- the integration delivery principles; or
- their duties in regard to carrying out any of their functions.

26. Scottish Ministers do not have a role in the approval of strategic plans, whichever model is used.

**Operational delivery of services**

**Body Corporate Model: role of the chief officer**

The Bill

27. Where partners agree locally to set up a body corporate arrangement, the Bill requires that:

- The integration joint board appoints a chief officer, who oversees development and implementation of the strategic plan, its maintenance and review over time, delivery, and performance reporting, on behalf of the integration joint board. The chief officer is accountable to the integration joint board in relation to the exercise of these duties.
- The chief officer is employed by either the Health Board or local authority, and is seconded to the integration joint board.
- The integration joint board is responsible for appointing the chief officer, and must consult the Health Board and local authority on the appointment.
- The integration joint board is not empowered by the Bill to employ staff or hold contracts, although the Bill makes provision to enable the Scottish Ministers to make an Order enabling the integration joint board to do in so far as that is considered desirable in future.
- The integration joint board secures delivery of the delegated functions by directing the Health Board and the local authority to deliver services in line with the strategic plan.

In practice

28. The role of the chief officer is central to ensuring that integration applies to planning and delivery of services. The practical effect of integration will be that the chief officer will oversee delivery of integrated services, as set out in the strategic plan, by teams whose members are employed by either the Health Board or the local authority.
29. Because the integration joint board is established as a legal entity in its own right, it must appoint the chief officer, who is its accountable officer for the functions and responsibilities that it holds.

30. Nevertheless, we recognise the importance of ensuring that the Health Board and local authority are also closely involved in the process of appointment. The Bill requires that the integration joint board consults with the Health Board and the local authority on the appointment. Local arrangements for the process of appointment will be left to local determination. However, the Scottish Ministers will set the expectation within statutory guidance that the appointment process will include input from senior officers and/or members of the Health Board and the local authority. The formal appointment will be made by the integration joint board.

31. The Bill focuses on the strategic planning and resourcing of adult health and social care services, but says little of how the services will be operationally delivered. Legislative detail on operational delivery would constrict local opportunities for innovation to suit local need.

32. Because the integration joint board holds both the functions and the resources it is responsible for ensuring effective operational delivery. The Scottish Ministers do not at this stage intend to empower the integration joint board to employ staff or hold delivery contracts and so it has to discharge its responsibilities for operational delivery through the Health Board and the local authority. This arrangement achieves the effect of integrating planning and service delivery without the need for large scale secondment or transfer.

33. To further bind planning and operational delivery activity together under the body corporate model, the Scottish Ministers will require that integration plans set out the operational role that the chief officer will hold. The integration joint board will put the chief officer at the disposal of the Health Board and local authority to carry out the operational role. This aspect of the chief officer’s role will also be reflected in the approved description of their responsibilities. As operational director of service delivery, this person reports to the Chief Executive of the Health Board and local authority on a day-to-day basis. On financial matters, the chief officer will be required to take account of the advice of the Directors of Finance of the Health Board and local authority.

34. Locally, it is intended that integration joint boards agree with the Health Board and local authority to put in place operational arrangements that assure the on-going day-to-day interaction between the Chief Executives and the chief officer. These arrangements should assure effective, integrated planning and delivery of services, including sharing of information and reporting on performance. Guidance will be provided on how the terms of appointment of the chief officer should make provision for operational arrangements to help integration joint boards to set out appropriate local descriptions of the responsibilities of the chief officer role.

35. It is important that the strategic and operational roles of the chief officer are secured via a single individual in order to fulfil the key policy objectives of joint working across the Health Board and local authority, and to ensure that strategic planning and delivery of services remain intrinsically linked.

36. This dual role for the chief officer highlights the importance of clear, agreed objective setting and appraisal processes between the Health Board, the local authority and the integration joint board as the chief officer will have responsibilities and a relationship with all three bodies. To avoid a disconnect, the expectation will be that the chief officer’s objectives,
across strategic and operational responsibilities, are agreed and set jointly by the two Chief Executives and the chair of the integration joint board.

**Lead Agency Model**

*The Bill*

37. Where partners agree locally to set up a lead agency arrangement, the Bill states that responsibility for operational delivery of services lies with the body to whom functions and resources are delegated.

*In practice*

38. In the lead agency model, there is no need for a chief officer role. Senior officer responsibility for the discharge of the integrated arrangements is held by the Chief Executive of the lead agency.

39. There is no legislative requirement to transfer staff under lead agency arrangements, although it seems likely that staff would transfer to the lead agency. If staff do not transfer from the delegating body to the lead agency, it will be necessary for the Health Board and local authority to put in place integrated management arrangements to assure integrated service delivery.

**Liability – if something goes wrong**

*The Bill*

40. Where partners agree locally to set up a body corporate arrangement, the Bill as introduced stated that:

- Any legal claim in respect of a delegated function must be raised against the integration joint board.

- Where the integration joint board directs a Health Board or local authority to carry out a function on its behalf, the person directed (i.e., the Health Board or local authority) stands in the place of the integration joint board (s22(4)). Liability then rests with the Health Board or local authority.

41. The Scottish Government intends to bring forward an amendment to the Bill that will have the effect of applying common law to the question of liability for integrated health and social care services. This will ensure that the body that is ‘in control’ of the actions that are taken will be liable for any claims made, rather than only the integration authority. This will apply in both models of integration.

42. Therefore a claim may be raised against any of: the integration joint board, the health board or local authority, which has been directed to carry out the function by the integration authority.

*In practice*

43. The Bill will set out that the integration joint board or a person directed may be held liable for a claim raised in respect of a delegated function. Liability for claims relating to strategic planning is likely to rest with the integration joint board, whereas liability for claims
arising from faults in the way services are delivered is more likely to rest with the body who has been directed to carry out the function.

44. The Scottish Government intend to establish a working group, including representatives from the Society of Local Authority Lawyers and Administrators in Scotland (SOLAR) and the NHS Central Legal Office (CLO) to develop guidance on managing questions of liability locally, through the provisions of the integration plan.

DG Health and Social Care
Integration and Reshaping Care Division
November 2013
Annex (i): Financial Accountability

45. The accountable officers of the Health Board (the Chief Executive) and local authority (Section 95 Officer) are responsible for the proper use of resources by the Health Board and local authority respectively.

46. Their duties are as follows:

   a) Sign the accounts;
   b) Ensure the propriety and regularity of the finances of the body for which they are the accountable officer for;
   c) Ensure that the resources of the body are used economically, efficiently and effectively.

47. They also have a duty to seek direction from the Health Board and the Council respectively, and to alert their auditor where they are instructed to do something which they consider contravenes their duty to ensure propriety and regularity or economy, efficiency and effectiveness.

Body Corporate Model

48. In the body corporate model, the accountable officers of the Health Board and local authority discharge their responsibility, as it relates to the resources that are to be delegated to the integration joint board, by setting out in the integration plan that the money is to be used by the integration joint board to deliver the delegated functions, along with the systems and monitoring arrangements that cover payments and financial performance management. It is the responsibility of the accountable officers of the Health Board and local authority to ensure that the provisions of the integration plan enable them to discharge their responsibilities in this respect.

49. The chief officer is the accountable officer of the integration joint board and discharges his or her duties in respect of the delegated resources by:

   - Establishing financial governance systems for the proper use of the delegated resources;
   - Ensuring that the strategic plan meets the requirement for economy, efficiency and effectiveness in the use of the integration joint board’s resources; and
   - By ensuring that the directions given to the Health Board and local authority for delivery of services are designed to ensure resources are spent according to the strategic plan. It is the responsibility of the chief officer to ensure that the provisions of the directions enable the chief officer to discharge his or her responsibilities.

50. It is intended that the chief officer will be advised by the Directors of Finance of the Health Board and local authority, who will co-sign the financial statements of the integration joint board with the chief officer.

51. In his or her capacity as operational director of service delivery within the Health Board and local authority, he or she has no “accountable officer” status but is:

   - accountable to the Chief Executive of the Health Board for financial management of the operational budget, and is advised by the Health Board Director of Finance; and
   - accountable to the Section 95 Officer of the local authority for financial management of the operational budget.
Lead Agency Model

52. The accountable officer of the lead agency is responsible for the resources delegated to it and discharges this responsibility through the lead agency’s existing financial governance systems.

53. The accountable officer of the delegating partner discharges their responsibilities in respect of the delegated resources through the provisions of the integration plan.
Background

1. The Committee reported on the delegated powers in the Public Bodies (Scotland) Bill\(^1\) on 1 October in its 48\(^{th}\) report of 2013.

2. The response from the Scottish Government to the report is reproduced at the annex.

Scottish Government response

Section 1(3)(e) – Integration plans: same local authority and Health Board area-prescribed information about other prescribed matters

3. Section 1 requires each local authority and Health Board which has the same area to jointly prepare an integration plan for that area. Section 1(3)(e) provides for the prescription, by regulations, of information about such other matters that may be included in an integration plan.

4. The Committee reported that, as the power can prescribe a broad range of significant matters for inclusion in an integration plan, the affirmative procedure may provide a more suitable level of Parliamentary scrutiny than the negative procedure which is currently proposed.

5. In response to the Committee, the Government explained that the prescribed matters are intended to supplement, rather than alter, the core elements of an integration plan. The Government therefore did not consider the use of the affirmative procedure to be necessary.

\(^1\) Public Bodies (Joint Working) (Scotland) Bill [as introduced] available here: [http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20Joint%20Working%20(Scotland)%20Bill/b32s4-introd.pdf](http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20Joint%20Working%20(Scotland)%20Bill/b32s4-introd.pdf)
Section 1(6) – Integration plans: same local authority and Health Board area-
prescription of functions

6. The regulations under section 1(6)(a) and (b) are intended to prescribe the
range of functions of local authorities and Health Boards which either must, may, or
may not be, delegated under an integration plan.

7. The Committee noted that the Bill makes no reference to sections 56(6), (6A)
and (7) of the Local Government (Scotland) Act 1973 (“the 1973 Act”) which provide
that a local authority’s functions with respect to matters such as setting amounts of
council tax and borrowing money, shall be discharged only by the authority.

8. Section 1 of the Bill therefore does not provide for any exclusion of those
significant functions in the 1973 Act from the powers to prescribe the functions which
may be delegated under an integration plan.

9. The Committee therefore asked the Government to consider whether
amendments should be made to the Bill at stage 2 in order to clarify the effect of the
powers in section 1 of the Bill on the operation of the 1973 Act.

10. In its response, the Government agreed to bring forward an amendment at
stage 2 which would make it clear that the provisions in section 1 would not affect
the operation of the aforementioned sections of the 1973 Act.

Section 12(1) and (2) – Integration joint boards: further provision

11. Section 12(1) provides that the Scottish Ministers may, by order, make
provision about various aspects of joint integration boards, including their
membership and proceedings.

12. The Committee drew the power to the attention of the lead committee, noting
that the prescription of the number of joint board members, or who the members may
be, is not subject to limitation.

13. In response to the report, the Government agreed that it would be necessary
to limit membership numbers in joint integration boards but stated its view that, in
order to allow for flexibility, this would be best achieved through subordinate
legislation rather than being provided for on the face of the Bill.

Section 15 – Transfer of staff where functions delegated to local authority or Health
Board

14. Section 15 provides for Scottish Ministers to make a scheme for the transfer
of staff from a body responsible for delegating the functions in the integration plan
(as set out in 1(4) of the Bill) to the body the functions are delegated to.

15. The Committee noted the Government’s intention that the scheme should not
be subject to any form of Parliamentary scrutiny. This is in contrast to the current
power to make provision for any transfer or secondment of staff contained in the
Community Care and Health (Scotland) Act 2002 which is to be repealed by the Bill.
The relevant powers in the 2002 Act are exercisable by regulations which are subject
to Parliamentary scrutiny by the negative procedure.
16. The Committee therefore drew the attention of the lead Committee to this apparent downgrading of Parliamentary scrutiny in relation to the transfer or secondment of staff.

17. In its response to the Committee’s report, the Government emphasised its view that matters relating to staff transfers are administrative in nature, and best dealt with by Health Boards and local authorities.

18. The Government also provided examples of other scheme provisions for transfer of staff, which allow for transfer without the requirement for Parliamentary scrutiny. The Government stated that it did not consider that the powers at section 15 should be subject to any form of Parliamentary scrutiny.

Section 16 – Integration joint monitoring committees: further provision

19. 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.

20. As with the power at section 12(1) which relates the membership and proceedings of joint integration boards, the Committee drew the power to the attention of the lead committee, noting that the prescription of the number of integration joint monitoring committee members, or who the members may be, is not subject to limitation.

21. In response to the report, the Government stated its view that any limitation of the power would constrain the flexibility required in order to deal with the variation of circumstances across Scotland.

Section 36(3) – Power to make provision in consequence of new integration plan-scheme about transfer of staff, etc.

22. Section 36(3) provides that, in consequence of the replacement of an integration plan by a new plan, the Scottish Ministers may, by scheme, make such provision about the transfer of staff, property, rights, liabilities or obligations of an integration joint board, a local authority or a Health Board as they consider necessary.

23. As with section 15 which deals with schemes for the transfer of staff, section 36 is not subject to any form of Parliamentary scrutiny. Again, this is in contrast to the powers currently available to transfer staff between a local authority and a Health Board in the Community Care and Health (Scotland) Act 2002 which is to be repealed by the Bill. The relevant powers in the 2002 Act are exercisable by regulations which are subject to Parliamentary scrutiny by the negative procedure.

24. As with its response on section 15, the Government stated that it did not deem it necessary that the power at section 36(3) should be subject to Parliamentary scrutiny, as it considered matters in relation to staff transfers to be administrative in nature.
25. Section 19 of the Bill regulates the effect on contracts of employment, where there is a scheme for transfer under sections 12(3) or 15 of the Bill. In response to a suggestion in the Committee’s report, the Government acknowledged that section 19 should also apply to schemes made under section 36(3). The Government therefore intends to bring forward an amendment to provide for this.

Section 39(2) – Default power of Scottish Ministers

26. Section 39(2)(a) to (e) lists five default powers which the Scottish Ministers may exercise, where a local authority and a Health Board fail to submit an integration plan for approval before the day prescribed under section 7. Section 39(2)(a) enables the Ministers to specify functions of the local authority and Health Board which are to be delegated to a joint board.

27. The Committee considered that the functions of a local authority and a Health Board which may be specified under section 39(2)(a) are not limited by the prescription of functions by regulations under section 1(6). Section 1(6) relates to the prescription of functions which must, may, or may not be, delegated under an integration plan. Section 39(2) applies where such a plan has not been submitted for approval.

28. The Committee therefore asked the Government to consider whether it would be appropriate to bring forward an amendment which would clarify that the functions specified at section 39(2)(a) would not go beyond those prescribed by regulations under section 1(6).

29. In responding to the report, the Government considered that it would not be possible in practical terms, for section 39(2)(a) to specify any functions beyond those provided for in section 1(6). The Government therefore does not intend to bring forward the amendment suggested by the Committee at stage 2.

Conclusion

30. Unless amendments that will substantially affect the delegated powers provisions are made to the Bill at Stage 2, the Committee will not consider it again. Members are therefore invited to make any comments they wish on the Bill at this stage.

Recommendation

31. Members are invited to note the Scottish Government’s response on the Bill and to make any comments they wish at this stage.
Correspondence from the Scottish Government, dated 19 November 2013:

Section 1(3)(e) – Integration plans: same local authority and Health Board area-prescribed information about other prescribed matters

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Negative procedure

The Committee therefore asks the Scottish Government, in relation to the power in section 1(3)(e), to consider in advance of Stage 2 of the Bill whether the significance of the matters which could be prescribed in regulations under this power is such that the affirmative procedure could be a more suitable level of Parliamentary scrutiny of the exercise of this power, rather than the negative procedure.

The Committee asks for further comment on this in the Scottish Government’s response to this report.

1. The Scottish Government intends to use the power at section 1(3)(e) to prescribe matters supplementary to the core elements of an integration plan, as set out in section 1(3)(a) – (d). The Scottish Government, in its response to the Committee of 10 September, suggested that those supplementary matters may include; arrangements for Clinical and Care Governance; arrangements for financial management and arrangements under which staff may transfer between statutory partners. The Scottish Government also indicated that regulations under section 1(3)(e) may also set out the arrangements for Integration Joint Boards and Integration Joint Monitoring Committees which are to be included in the Integration Plan. The Scottish Government does not intend that matters relating to Integration Joint Boards or Integration Joint Monitoring Committees will go beyond those prescribed by section 12 and section 16 of the Bill, respectively.

2. Given that these prescribed matters will supplement rather than alter the core elements of the integration plan, in order to ensure effective integration arrangements are in place, the Scottish Ministers consider that a greater level of parliamentary scrutiny is not required.

Section 1(6) – Integration plans: same local authority and Health Board area-prescription of functions

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations
Parliamentary procedure: Negative procedure

The Committee also notes that the Scottish Government has undertaken to consider whether any amendments at Stage 2 need to be made to address the operation of the provisions in section 56(6), (6A) and (7) of the Local
Government (Scotland) Act 1973, as they relate to the powers in section 1 of the Bill. The Committee asks for further comment on this in the Scottish Government's response to this report.

3. The Scottish Government, in its response to the Committee of 10 September, undertook to consider whether any amendments at stage 2 need to be made to address the effect of the powers in section 1 of the Bill on the operation of section 56(6), (6A) and (7) of the Local Government (Scotland) Act 1973. The Scottish Government proposes to bring forward an amendment at stage 2 to restrict the functions of local authorities that may be delegated under an integration plan prepared using the powers in section 1 of the Bill. This amendment will have the effect that the powers that cannot be delegated under sections 56(6)(6A) and (7) of the Local Government (Scotland) Act 1973 cannot be included in an integration plan prepared under section 1 of the Bill. The Scottish Government considers that this amendment will make clear that the provisions of the Bill do not affect the operation of sections 56(6)(6A) and (7) of the Local Government (Scotland) Act 1973.

Section 12(1) and (2) – Integration joint boards: further provision

Power conferred on: the Scottish Ministers
Power exercisable by: Order
Parliamentary procedure: Negative procedure

The Committee accordingly draws the attention of the lead committee to the power in section 12(1)(a). This power proposes to enable the 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.

4. The Scottish Government does not consider it appropriate to limit the power in section 12(1)(a) to specify the number of members of Integration Joint Boards. The Scottish Government intends to specify these matters in regulations and considers that limiting the power at section 12(1)(a) could result in constraining future flexibility. The Scottish Government, in consultation with stakeholders, has fully considered the need for membership of the Integration Joint Board to reflect not only the membership size of the relevant Health Board and local authority but also key professionals, practitioners and others, who have a key role in planning integrated health and social care. Whilst the Scottish Government recognises the need for limiting the number of members of the Integration Joint Board to ensure it is effective and not unwieldy, the Scottish Government considers that this is best achieved in regulations.
Section 15 – Transfer of staff where functions delegated to local authority or Health Board

Power conferred on: the Scottish Ministers
Power exercisable by: Scheme
Parliamentary procedure: None (and not in the form of an SSI)

However it draws to the attention of the lead committee that the exercise of this power would not be subject to Parliamentary scrutiny. The 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).

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.

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.

5. The Scottish Government considers that matters relating to the transfer of staff are, in essence, administrative in nature, are designed to facilitate delivery of integration policy and are made available consequentially through the passing of section 19 of the Bill. The Bill does not require the transfer of staff; it will be a matter for Health Boards and local authorities and, where relevant, Integration Joint Boards, to determine whether effective integration of health and social care services is best facilitated by the transfer of staff.

6. Similar powers exist to provide for schemes in relation to the transfer of staff in the Police and Fire Reform (Scotland) Act 2012 schedule 5, paragraph 12. Similar examples are found in the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 (SSI 2006/33) and the Local Government Area Changes (Scotland) Regulations 2007 (S.I. 1977/8). The Scottish Government recognises that these provisions each take different approaches. However, each of these provisions allowed schemes to be made for the transfer of staff without parliamentary scrutiny of the scheme. The Scottish Government considers that these provisions provide a clear precedent for such transfers to be made by scheme rather than by Statutory Instrument, and that the power in section 15 is in keeping with this. Therefore, the Scottish Government does not consider it necessary for the exercise of this power to be subject to parliamentary scrutiny.
Section 16 – Integration joint monitoring committees: further provision

Power conferred on: the Scottish Ministers
Power exercisable by: Order
Parliamentary procedure: Negative procedure

The Committee accordingly draws the attention of the lead committee to the power in section 16(1)(b). This power proposes to enable the Scottish Ministers by order to make provision about the membership of integration joint monitoring committees, without any limitations as to the number of members of a particular committee that may be prescribed, or as to who may be prescribed as members.

7. The Scottish Government considers that, as with the power at section 12(1(a), it is not appropriate to limit the power at section 16(1)(b), for the same reasons. The Scottish Government considers that the powers as set out in the Bill put in place a framework to allow Integration Authorities to develop integrated governance arrangements that suit local circumstances. This power provides flexibility which is appropriate for taking into account variation in circumstances across Scotland. The Scottish Government considers that a more narrow power would be limiting and would inhibit this flexibility.

Section 36(3) – Power to make provision in consequence of new integration plan-scheme about transfer of staff, etc.

Power conferred on: the Scottish Ministers
Power exercisable by: Scheme
Parliamentary procedure: None (and not in the form of an SSI)

However it also draws the attention of the lead committee to the same matter as for the powers to make a scheme in section 15, as regards the scrutiny of the exercise of this power. Section 36 similarly proposes to remove scrutiny by the Parliament, in comparison with the analogous power in the Community Care and Health (Scotland) Act 2002 to set out arrangements for the transfer of staff which would be repealed by the Bill.

The Committee notes that the Scottish Government will consider in advance of Stage 2 whether an amendment is required, to give effect to the intention that section 19 should apply, when the power in section 36(3) is exercised to make a scheme for the transfer of staff.

8. The Scottish Government considers that, as with section 15 of the Bill, it is not necessary for the exercise of the power at section 36 to make a scheme to be subject to further Parliamentary scrutiny. The Scottish Government considers the transfer of staff to be an administrative matter, as parties will have to agree to enter into such transfer arrangements, reflecting the administrative nature of the scheme.

9. The Scottish Government considers that an amendment is required to provide for section 19 to apply to schemes made in exercise of the power under section
36(3) and thank the Committee for drawing this to our attention. The Scottish Government undertakes to bring forward an amendment to this effect at stage 2.

Section 39(2) – Default power of Scottish Ministers

The Committee notes that the Scottish Government will consider in advance of Stage 2 whether an amendment is required, to give effect to the intention that the functions which may be specified under section 39(2)(a) on default to be delegated to an integration joint board would not go beyond those that would be prescribed by regulations under section 1(6).

10. On further consideration, the Scottish Government considers that an amendment is not required to give effect to the intention that the specification of functions to be delegated under section 39(2)(a), would not go beyond those to be prescribed under section 1(6). The Scottish Ministers intend to make regulations under section 1(6), which make broad provision in relation to the delegation of functions as a consequence of an integration plan under section 1. It is intended that the functions that must, or may, be delegated will cover all functions relating to adult health and adult social care exercised by Health Boards and local authorities. The Scottish Government consider that, in practical terms, section 39(2)(a) could not be used to specify any broader functions than those covered by regulations under section 1(6).
Public Bodies (Joint Working) (Scotland) Bill: The Cabinet Secretary for Health and Wellbeing (Alex Neil) moved S4M-08389—that the Parliament agrees to the general principles of the Public Bodies (Joint Working) (Scotland) Bill.

After debate, the motion was agreed to (DT).
Public Bodies (Joint Working) (Scotland) Bill: Stage 1

The Presiding Officer (Tricia Marwick): The next item of business is a debate on motion S4M-08389, in the name of Alex Neil, on the Public Bodies (Joint Working) (Scotland) Bill. I advise members that time for the debate is extremely tight. I ask members to keep to their time limits, which will allow us to call all the members who are to speak.

15:12

The Cabinet Secretary for Health and Wellbeing (Alex Neil): I am pleased to open the stage 1 debate on the Public Bodies (Joint Working) (Scotland) Bill. I thank Duncan McNeil and the Health and Sport Committee for their scrutiny of the bill and for preparing their stage 1 report, which contains interesting and welcome recommendations. I also thank the Local Government and Regeneration Committee, the Finance Committee and the Delegated Powers and Law Reform Committee for their consideration of the bill and for contributing to the Health and Sport Committee’s scrutiny of the bill.

I am grateful to partner organisations across the national health service, local government and the third and independent sectors and to the broad range of stakeholder working groups that have helped the Scottish Government to develop the policy that is reflected in the bill, and I thank the organisations and individuals who provided oral and written evidence at stage 1. I am sure that the Parliament will wish to join me in welcoming those contributions. By definition, integrating health and social care requires a good team effort, and that is exactly what the work by a wide range of people and organisations represents.

I am pleased that the Health and Sport Committee welcomed the bill in its stage 1 report and recommended that the Parliament should approve the bill’s general principles. The committee asked a number of questions on specific issues and asked for further clarification on a range of points. I am grateful for the committee’s careful scrutiny, to which I have responded in my reply to the stage 1 report.

I will begin this debate by capturing once again the essence of what this legislation is about, why it is needed as a matter of urgency and why the principles that underpin it command widespread support.

The 2011 census showed us that, for the first time, Scotland’s population included more people aged over 65 than people aged under 15. We all know that that statistic represents an extraordinary achievement on the part of our health and social care services, which have helped to enable so many people to live longer, healthier lives in Scotland.

However, I need remind no one of the challenges that an ageing population brings as we consider how best we should plan and deliver services in the future. In particular, as more people live longer with multiple conditions and complex needs, we must make sure that the health and social care support on which their wellbeing relies works seamlessly, effectively and efficiently.

That is why we are integrating health and social care: to improve outcomes for the growing numbers of people who need both health and social care support, most of whom have multiple complex needs, some of whom are older and all of whom should have access to the right care, at the right time and in the right place.

Too often, people are admitted to hospital or to a care home when care provision and support in the community would result in better outcomes for them. Too often, the system is not configured to provide the right care in the right place at the right time.

Maureen Watt (Aberdeen South and North Kincardine) (SNP): On that point, does the cabinet secretary agree that adaptations to housing provided by registered social landlords and community transport are just as important to the integration of health and social care?

Alex Neil: Absolutely. It is very important that vital services such as housing and transport are actively involved in partnerships and that they feed into the design and commissioning of the services that we are talking about.

Too often, people’s independence and wellbeing are diminished too early or to too great an extent by an overreliance on institutional care.

We all accept that it is our responsibility as a Parliament to tackle these challenges, not least because the costs and consequences are not limited to the individuals involved. The consequences of our failure in Scotland to use different types of care and support to best effect undermine our entire health and social care system and are shared by everyone as public sector resources are spent on activities that do not deliver maximum possible benefit.

The solution to many of these challenges is strong, effective leadership—from clinicians and care professionals, from people working in the national health service, local government and the third and independent sectors and, by no means least, from parties and Parliament itself, which is why this legislation is necessary and important.
This Government is committed to establishing a public service landscape in which different public bodies are required to work together and with their partners in the third and independent sectors to remove unhelpful barriers and use their pooled resources for the greater benefit of patients, service users, carers and families. That is fundamental to the ethos and ambition of this bill.

I will now spell out some context for the bill’s provisions. As I have stated—and as the stage 1 report by the Health and Sport Committee reiterates—there is a clear need for legislation to provide the framework for driving forward change, because not enough progress has been made under the current permissive legislation.

The purpose of this bill is exactly that: to establish that framework for integrating health and social care and to improve the quality and consistency of services by focusing on improving outcomes for service users, carers and their families.

The bill will foster an environment that encourages constructive culture change by requiring health boards and local authorities to establish integrated partnership arrangements and to work more closely together day to day and via medium and short-term joint strategic planning arrangements.

Evidence shows us that effective integration depends particularly on four key features. First, local systems must plan together for shared populations of need; in other words, health and social care with their third and independent sector partners must plan for people with complex needs together, not separately and in isolation from one another. Secondly, resources must be pooled to deliver population-based plans, which is why integrated budgets will be so important. Thirdly, clinicians and other professionals must be closely involved in and lead the design and planning of local services. Fourthly, both local and national leadership must be strong, effective and consistent. The bill is built directly on those four features of well-integrated systems.

With regard to overarching arrangements for integration, the bill provides for local flexibility and leadership to determine which approach to integration is most appropriate to local circumstances. Two models are provided: delegation between partners—or, in other words, lead agency arrangements—and delegation to a body corporate. It will be up to each area to decide which is appropriate for them.

Having set up the integrated partnership arrangement, health boards and local authorities will then be required to delegate adult health and social care functions and budgets to the integrated partnership. By bringing together integrated governance, integrated strategic planning and integrated budgets, we will create the environment not only for improving outcomes but for greater financial accountability by reducing the opportunities and indeed incentives for cost shunting between organisations. I intend to lodge at stage 2 an amendment that will set out on the face of the bill that only adult social care functions—and therefore budgets—must be included in the integrated arrangement. Regulations will set out the types of adult healthcare—and therefore budgets—for integration, including adult primary and community healthcare and, importantly, aspects of acute hospital care that offer the best opportunities for service redesign in favour of prevention and anticipatory care in the community.

The bill requires each integration authority to put in place a strategic commissioning plan for the integrated services. Strategic planning lies at the heart of this process of reform and the bill is clear on the broad extent of consultation required to ensure strategic planning is robust and effective. A key feature of strategic planning arrangements is the bill’s requirement on the integration authority to establish locality planning arrangements, which will provide a forum for local clinical and professional leadership of service planning. Where the body corporate model is used, a chief officer must be appointed by the integration authority to ensure integrated oversight of strategic planning, budget management and service delivery. To facilitate such changes, community health partnerships will be removed from statute and national outcomes for health and wellbeing will be established via secondary legislation after consultation. Integration authorities will be required to publish a performance report to provide accountability and transparency for delivery against the national outcomes and any further outcomes agreed upon locally.

The bill does not sit in isolation but fits within a wider agenda of public service reform that is currently taking place in Scotland. Reforms in other areas, including those in the Social Care (Self-directed Support) (Scotland) Act 2013 and the Children and Young People (Scotland) Bill and our planned changes to community planning, all serve to complement the work of this bill, which in turn will reinforce that wider programme of reform for the benefit of our population. Through the creation of an integrated health and social care budget and a single set of joint outcomes, integration creates a positive policy environment for health boards to play an integral part in self-directed support policy and practice, and it is vital that we take full advantage of this opportunity.

Should local authorities and health boards decide to include children’s health and social care in their integrated arrangement services, the
planning requirements of the bill will feed into the development of the plans that will be required under the Children and Young People (Scotland) Bill, which the Parliament is considering.

Like other public sector bodies, integration authorities will be expected to play a strong and effective role in supporting the work of community planning to achieve better outcomes for communities on shared priorities.

The bill deals with a number of important and complex issues, and this debate provides an important opportunity for the Parliament to consider, in some depth, the bill and the challenges to which it responds. I think that there is wide agreement in the Parliament and beyond on the aims of integration and the broad principles that underpin the approach. As Bob Doris, the deputy convener of the Health and Sport Committee, put it when the committee’s stage 1 report was published:

“whilst this legislation is not a panacea, it will provide a focus for cementing and reinforcing progress that has already been made”.

I agree with that, and I look forward to working with members of all parties as we take this bill through Parliament.

I move,

That the Parliament agrees to the general principles of the Public Bodies (Joint Working) (Scotland) Bill.

15:26

Duncan McNeil (Greenock and Inverclyde) (Lab): As convener of the Health and Sport Committee, I am grateful for the opportunity to speak in the debate.

I express my thanks and those of committee members to everyone who gave written evidence and who came along to our evidence sessions. I also thank the clerks and the team from the Scottish Parliament information centre for all their help during the process. Members of the committee undertook fact-finding visits to West Lothian and the Highlands, to see integration in action, and we appreciated the welcome that we received. I am also grateful to Lothian Centre for Inclusive Living, which hosted an event for service users and carers representing a wide range of disabled people’s organisations. Finally, I thank the cabinet secretary for his engagement with the committee and for his written responses to our report.

The bill will bring about big changes in how health and social care services are structured and managed. It will require a change in working practices among front-line staff, who must identify new ways of working across teams and departments. The committee has considered the area before. Two years ago, our inquiry into the regulation of care for older people highlighted the increasing shift to the provision of care in a person’s home rather than in a care home setting. In anticipation of the integration process, we called for a review of the national care standards, which would embed principles of independent living in the framework for the delivery of care services. We would welcome progress on that.

The bill reflects the shift in emphasis from acute care to community-based care. The Royal College of General Practitioners recognises the need for integration in responding to the growing older population. However, there remains a good deal of concern that general practitioners might not have adequate resources to enable them fully to participate in the design and planning of the new joint-working arrangements. The cabinet secretary is currently engaged in discussions on a renewed GP contract, and I ask him to report back to the committee in due course on the role that the contract will play in encouraging GPs to immerse themselves in the integration process.

I note the Scottish Government’s intention to introduce legislation to support carers through integration, but I would like more detail on that in the bill.

The bill has been drafted in the spirit of the Christie commission in that it seeks to tackle what Christie referred to as the

“unduly cluttered and fragmented ... public service landscape”.

All that comes against a backdrop of an older population and the increasing demand on our public services to deliver more with less. In a healthcare setting, that marries with the objective of reducing bed blocking.

Christie also suggested that

“changes need to be driven by how we can achieve more positive outcomes”.

That is a theme to which I shall return.

Our report highlighted a number of issues on which we seek clarification from the Government on the effect of the legislation. Andrew Eccles of the Glasgow school of social work suggested a need for

“More subtle and complex engagement with some of the issues”.—[Official Report, Health and Sport Committee, 10 September 2013; c 4193.]

The themes of strong leadership and cultural change came up repeatedly in evidence to the committee. There is a clear need for committed engagement among all involved in the processes. Health boards and local authorities are required to identify the structures that best suit their circumstances. Most areas have opted for the
body corporate; so far, only the Highland region has adopted the lead agency model.

The vast majority of evidence has been supportive of both approaches. However, further clarity is required on how the body corporate model will operate. How will the health boards, local authorities and the new joint boards work together in practice? In particular, there appear to be concerns about a transfer of funding from acute budgets to social services. Concern has also been recorded among recipients of social care services about charging for care services when national health services are free at the point of use.

The committee has heard that around half of the total health board budgets will be under the scope of integrated plans, but there is concern about the potential for cost creep in obtaining social care services. It is important that users of the services receive assurance that they are not going to be hit with additional charges.

The bill contains significant powers for Scottish ministers. In evidence to the committee, the cabinet secretary noted his intention to lodge amendments at stage 2 that would seek to mitigate the fear—held by the Convention of Scottish Local Authorities and others—that too much power was being given to ministers. That is a helpful and constructive offer, and I look forward to those amendments.

I will now move on to what I consider to be the most important aspect of the bill. The legislation seeks not only to encourage health and care providers to work together more closely, but to improve the outcomes available to patients and service users. It is those outcomes that are crucial.

The legislation is to be commended for closing the gap between the provision of health and social care. It is paramount that the bill makes it easier for patients and their carers to access the services that they need. For that reason, our report highlighted the need for a "continuous commitment to improving these individual outcomes."

I look forward to seeing more detail at stage 2 on how that important aim will be achieved.

Although the bill rightly focuses on the provision of services, we should never forget the important role played by the third sector and independent providers. We heard repeated pleas from providers and their service users for assurance that they would be represented in the new integrated board structures. We accept that that is by no means a straightforward issue and that the Government has set out good reasons why that might not be possible. However, I call on the cabinet secretary to give due consideration to how the involvement of the third and independent sectors can be strengthened in the bill.

The process of integration is already well under way, and the committee agrees that we are heading in the right direction. However, the Parliament has a duty to ensure that the bill delivers for all those individuals and organisations that contributed to our report, for all the staff who are affected by the changes and, most important, for the patients and carers whose quality of life depends on high-quality health and care services. We will ensure that its implementation receives appropriate scrutiny.

On that basis, the Health and Sport Committee recommends that the general principles of the Public Bodies (Joint Working) (Scotland) Bill be approved.

The Deputy Presiding Officer (John Scott): As we are tight for time, speeches in the open debate will be restricted to five minutes. I call Neil Findlay, who has up to nine minutes.

15:35

Neil Findlay (Lothian) (Lab): We will support the bill at decision time, as we agree with its broad principles.

As a West Lothian councillor for nine years from 2003, I saw how cultural change, co-operation and political vision from the Labour group on the council in 2003 advanced integration without any need for legislation. However, the issue of social care in Scotland is one of the scandals of our time, which has been swept under the carpet and kept as far away as possible from prying eyes.

We sit in Parliament today pretending that all is reasonably well and that, with the bill, everything will be okay. Well, it will not, and I think that we all know that. Since the summer, I have met dozens of pressure groups, health professionals, trade unions and local authorities who have all, when asked directly, said that the social care system is in crisis. Yesterday, The Herald invited 30 stakeholders to a round-table session to discuss that and other issues. Not one person at that event mentioned the bill or believed that it would make the changes that are needed, and all of them said that the system is in crisis. Let me explain why I agree with their analysis.

At present, councils are bearing the brunt of Government cuts, which is having a direct impact on the front-line services that they provide. That is nowhere more evident than in social care. Contracts that were awarded a few years ago at, say, £14 an hour are now being won at £12 an hour as contractors try to secure work in the face of council cuts that have been passed on from the Scottish Government. That may sound like a good
thing, but the consequence is that, the day after they win the contract, their staff are told that they might have to work two more hours a week for the same money—and they are now in the fifth or sixth year of a pay freeze. That results in a high turnover of staff as people leave to get a better-paid job, maybe in a supermarket, while those who are left behind are demoralised and de-skilled, as training is often cut back to save money.

Many staff members are on the minimum wage. Some have to pay for their own uniforms and use their own mobile phones, and do not get paid for travelling between clients. Those people often work for less than the minimum wage. The result of all of that is that, as one care worker told me, people now work in care only because they cannot find another job and many stay only until they find another job. We simply cannot continue like that.

How we treat staff has a direct impact on the quality of the care that is provided to our elderly, our disabled and our most vulnerable people. I ask the cabinet secretary to reflect on this. In the circumstances that I have described, what quality of service does he expect to be delivered? Does he really believe that, in the words of today’s white paper, Scotland has “world-leading ... social care”? If he does, he is the only person in Scotland who believes that.

At the moment, many providers operate in 15-minute time slots. When those were introduced, if a person needed an hour of care, four 15-minute time slots were provided for them. Now, it seems that one 15-minute slot has become the norm, irrespective of the care that is required. In The Times today, Age Scotland highlights the fact that care visits are now down to seven minutes. Is that a world-class social care service? I think not. What level or quality of care can be provided under such a system? I repeat: we cannot continue like that.

A few weeks ago at my surgery, I spoke to a young woman of 18 who had just left school. She wanted to work in the care sector, so she got a job with a private provider. After being given four days’ training in an office, she shadowed a fellow worker for one and a half days and was then sent out with her own client list. On day 1, she was given 30—I stress 30—visits to do. On her first visit, she was verbally abused by a client who suffered from a mental health disorder. She was quite scared. The second client whom she visited was a male in his 70s who had a catheter in and she did not have a clue what to do; and so things went on throughout her day.

Mary Scanlon (Highlands and Islands) (Con): I thank the member for the points that he raises—we have all heard about similar issues—but I cannot help thinking that the Care Inspectorate is responsible for standards of care and for inspecting care-at-home standards. Does he think that it is doing enough, because there is nothing in the bill that will change what it does? Is the Care Inspectorate doing what it was set up to do?

Neil Findlay: Mary Scanlon has hit on a very good point. I think that care at home is extremely difficult to assess. It is easier to assess care in a care home—the inspectors turn up at the home and they inspect the care that is provided there. Care at home is much more difficult to assess. The fact that the provider that I am talking about got a clean bill of health from the inspectorate did not prevent the person who spoke to me, who worked for that provider, from having the experience that I am describing.

That experience went on throughout the young woman’s day, which lasted from 7.30 in the morning until 10 at night. She was, of course, paid for only the eight hours that she was supposed to work. The princely sum that she was paid was £5.03 an hour. Is that the value that we place on the care of the elderly? I say to the minister that this is a scandal and that, no matter how deeply he puts his head in the sand, it will not be wished away.

The bill is very limited and it is woefully inadequate in addressing the care crisis—not the care crisis that is coming, but the one that is here now.

Bob Doris (Glasgow) (SNP): I am glad that Mr Findlay has started to talk about the bill that is before us. Does he not see that there are opportunities in the bill, such as the opportunity to disaggregate the acute budget for older people and to invest some of that in social care? Surely that is an opportunity. I understand some of the issues that he raises, but surely he should be engaging with the opportunities that exist to improve services rather than just lamenting the poorer practices.

Neil Findlay: I think that we should all be addressing such issues, because they are the fundamental problems with the care system as we know it. Let us not pretend that they are not there.

The bill is inadequate in addressing the care crisis that is here. We will support it, but we need to have a much bigger national debate about how we as a society value our elderly and most vulnerable people. We need to look at the support that is available for those who provide unpaid care and those who simply act as good friends and neighbours. We need cultural as well as legislative integration of health and social care that looks at pharmacies, general practitioners, families and communities, and we need to state clearly whether we are prepared to invest to create a service that is based on dignity, care and respect rather than one that is based on a race to the bottom,
because one thing is certain—we cannot allow the current situation to continue.

At stage 2, issues of governance, staffing, shared services, budgets, service user involvement, scrutiny and the powers of ministers will be considered, and I am sure that the bill will be amended. It needs to be improved and we will contribute to that process. However, the bill should have been about addressing some of the issues that I have raised. It should have been about putting people at the centre, pursuing a rights-based agenda that was focused on high-quality care, and having a skilled and motivated workforce.

Alex Neil rose—

The Deputy Presiding Officer: The member is in his final minute.

Neil Findlay: However, the bill is about none of that. Councils are heroically trying to deliver services in the face of unsustainable pressures and I salute them for their efforts, but a failure to address the real issues is—in my view—a dereliction of the cabinet secretary’s duty and of the Parliament’s.

The Deputy Presiding Officer: I call Nanette Milne, who has up to six minutes.

15:44

Nanette Milne (North East Scotland) (Con): I thank the cabinet secretary for giving us the Government’s response to the stage 1 report last Friday, in good time for today’s debate. However, I am disappointed that we are holding the stage 1 debate on this particular day, because although the bill will be hugely important to the delivery of health and social care to a large and growing number of people in Scotland, sadly it has been totally eclipsed by the launch of the referendum white paper.

I am also disappointed that the bill’s title does not include its main purpose, which is to integrate adult health and social care so as to improve the wellbeing of recipients of that care. The title focuses instead on the public bodies that organise the care, which I think gets things the wrong way round. I know that there were compelling reasons for having that title, but I do not think that it sends out the right message to patients, service users, their families or their carers. Those issues aside, I am happy with the bill’s general purport, and the Conservative group will support the motion on the bill’s general principles at decision time.

In recent years, there have been many initiatives intent on achieving greater integration of health and social care, and excellent results have been achieved in some parts of Scotland. However, concerns remain that joint work between partners to bridge the gap between primary and secondary healthcare, and between health and social care, has not been as effective as it could be and is, at best, patchy across the country. Because the integration agenda has not been compulsory and barriers still exist in terms of structures, professional territories, governance and financial management, the Scottish Government has concluded—rightly, I think—that legislation is required if the balance of care is to be pushed from institutional care to community provision of services, with resources following people’s needs.

The proposed legislation should set the framework for change, but it will be successful only if cultures and attitudes change as well, which will depend on strong leadership at the local level that is committed to improving outcomes for individuals and to true integration that is capable of not only delivering those outcomes, but doing so with more efficient use of the available resources.

As we know, the bill requires each health board and local authority to develop an integration plan setting out proposals for establishing an integration authority that can be set up under either the body corporate model, with a joint board and its own chief officer, or the lead agency model, in which local authority and health board partners can delegate to each other agreed functions, with a joint monitoring committee accountable to both bodies that will scrutinise the effectiveness of the integrated arrangements. Concerns were raised with the committee about governance arrangements, particularly under the body corporate model, so I hope that the on-going work of the Scottish Government and its partners in the national health service and local government will lead to greater clarity around that important issue.

I was fortunate enough to visit both NHS Highland and NHS West Lothian to hear about their experiences of working as integrated adult health and social care services under the different models. Although both would accept that there is still much work to be done on the road to full integration, I was really struck by the enthusiasm of the staff in both areas and their commitment to deliver person-centred care by developing a service with a clear focus on securing the best possible outcomes for people.

My party is generally not in favour of a centralising agenda, but I agree with Carers Scotland’s statement in its evidence that the provision that councils and health boards will be jointly accountable for the local delivery of national outcomes set by ministers after consultation has “the potential to achieve consistency across Scotland in the delivery of holistic health and social care services.”
The provision should also help to reinforce the message that health, wellbeing and care are not the sole responsibilities of any single agency.

The potential to extend integration beyond adult health and social care was raised as an issue, with COSLA wanting to restrict the proposed integration arrangements and others arguing that it was essential that they include housing services, for instance. I look forward to seeing the Government’s promised amendments at stage 2, but I welcome its clarification that the bill should permit local flexibility beyond adult health and social care.

Clearly, in a six-minute speech I cannot cover all aspects of the bill; I will just note that there are significant concerns over the fact that human rights, quality standards and the need to involve rather than just consult patients, users and carers are not expressed in the bill. I have no doubt that there will be some interesting discussions on those matters when amendments are lodged at stage 2. The lack of involvement of non-statutory partners—those in the third sector, for example— with the statutory local authority and NHS partners at the strategic planning stage is another controversial issue that was raised with the committee.

There are concerns about other issues, such as the potential for cost creep, which Duncan McNeil mentioned, the need for partners to be able to share information electronically, and the reallocation of budgets between acute and primary care. Those are all important issues on which there needs to be further discussion.

In the final moments of my speech, I will focus on locality planning and GP involvement. Both are essential elements if services are to be redesigned in a way that engages individuals and local communities in delivering the best possible outcomes for patients and other service users. I saw at first hand the success of local healthcare co-operatives, which were located in a few general practices, and the failure of community health partnerships, which were far too big and toothless as health board sub-committees.

Now we have the opportunity to truly engage again with GPs, who are pivotal in the delivery of care in the community. I welcome the cabinet secretary’s statement that GPs will be embedded in the process as key stakeholders in shaping the redesign of services. I appreciate that current discussions on GP engagement in the planning and development of integrated health and social care arrangements are confidential within contract negotiations, but I am pleased that they are happening and I look forward hopefully to a positive outcome in due course.

I have had time just to scratch the surface of the bill, but I am happy to support its general principles while accepting that a number of amendments will be lodged as it progresses through the next stages of the parliamentary process.

The Deputy Presiding Officer: We move on to the open debate. I call Bob Doris, to be followed by Malcolm Chisholm. Speeches should be of up to five minutes, please.

15:50

Bob Doris (Glasgow) (SNP): I note that Nanette Milne’s thoughtful speech did the job of stage 1 scrutiny very well. I associate myself with Duncan McNeil’s words and the thanks that he gave to everyone who has been involved in scrutinising the bill, those who gave evidence on it and the Government and its civil service team. A lot of positive work has been done on the bill.

I begin by making it clear that I wish that the Parliament did not need to pass the Public Bodies (Joint Working) (Scotland) Bill. The integration of health and social care has been an aspiration for many years, but a reality far too rarely. The bill will set up an overarching framework to deliver integration and, as a last resort, compel health boards and local authorities to get on with the job of integration where that is not happening.

I will go on to talk about structures shortly, but first I will say a bit more about what the bill hopes to achieve. We have already heard a great deal about the demographic challenges that Scotland will face with an ageing population. The objective is to have a unified health and social care strategy for our older population that suits the needs of older people and ensures that the person is put before the pound sign—in other words, that cost shunting between health boards and local authorities becomes a thing of the past. That means having a single budget for the health and social care of older people.

For too long, there has been a suspicion that there is a tension between speedy discharge and delayed discharge from our hospitals. The longer a patient is in hospital, the greater the cost to the NHS, and the earlier an older person is returned into the community, the greater the cost to local authorities. In what way is the patient, rather than the pound sign, at the centre of that? I do not think that the matter is necessarily a high enough priority at present. If we have a single budget, put people before pounds and have a truly integrated health and social care system, we can end that cost shunting once and for all.

We need a disaggregation of acute budgets. I am delighted that the Scottish Government shared with us some estimates of what proportion of
acute budgets may be disaggregated and put towards combined health and social care, but there are still no real projections of what sections of local authority budgets will be put towards that. Will it just be whatever budget lines local authorities identify from their own social care budgets, or do we need to be a bit more sophisticated about it?

I know that we are not going as far as housing at the moment, but an argument could be made that there is a direct link to housing adaptations and policy. If we can get older people in an ageing population back into their houses and they are happy and safe there, they will be content, and sometimes that will be cheaper than having them in hospitals or residential homes. We have to think in a more sophisticated way about joint budgets for health and social care, and we need more clarity about the expectations on local authorities.

As I said, this is not just about saving money. It is about getting older people out of hospital sooner, preventing them from going into hospital in the first place and having them live at home happily for longer. That is not just cheaper but better in relation to outcomes. We have to look at the outcomes that the bill seeks to deliver rather than just structures, but of course we have to look at structures, too.

Mary Scanlon: I have a question relating to my constant theme of care at home. Does the member recognise that, when we are looking at the quality of care, it would be helpful to ensure that all home carers are given the training and support that they need and that they are required to register with the Scottish Social Services Council much earlier than 2019?

Bob Doris: The 2019 target was jointly agreed by the Parliament and it makes us world leaders in the registration of care-at-home employees. However, it is a vexed issue and the Government has already said that if registration could be accelerated in a safe and structured way, there is no reason why we could not do that.

I have only 30 seconds left, and there is so much more that I wanted to say. On structures, if it ever comes down to a vote between health boards and local authorities, we will have lost the case for positive and constructive health and social care integration. Whether or not they have voting rights, we have to make sure that the third and independent sectors, allied health professionals, GPs and the like are involved in drawing up the strategic plans. Assurances need to be given that they will have proper and suitable engagement with any strategic board.

The exciting part for me is localised strategic planning, in which local communities and older people are not just told what the priorities are for their care in their local area, because they also get to decide those. Some information on how that would work would be welcome.

15:55

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I was lucky enough to be on the Health and Sport Committee temporarily and so was able to read much of the written evidence as well as hearing all the oral evidence. I was particularly struck during the first session of oral evidence when we heard from Professor Alison Petch, who is probably the leading Scottish academic on community care. She said:

“The bill per se will not make any of what is proposed happen”

and

“legislation is not really what drives day-to-day delivery.”

She was not the only person who gave evidence who said that the issues were culture change, leadership, bringing teams together on the ground, and so on. She also said:

“the most important aspect of the bill is that it states the integration principles”.—[Official Report, Health and Sport Committee, 10 September 2013; c 4193, 4204, 4196.]

She and several other witnesses said that they would like to see that section of the bill strengthened, so I hope that we will look at it at stage 2.

Many members will have received an interesting paper from the Royal College of Nursing and others yesterday about this important aspect of the bill. I was struck by the RCN’s wish to see two principles, among many others, in the bill. One was about protecting and enhancing the safety and welfare of service users, which is pretty crucial, and the other was about enabling service users to participate in decisions about their need for services and the provision of those services to them. That is also important and it connects with the recent debate that we had on person-centred care. My conclusion from the evidence of Alison Petch and others is that we need the bill, or some amended version of it, and that it is a necessary but not sufficient condition for the delivery of more integrated care.

That said, we have to make sure that the bill will help, that it is clear and that it does not get in the way. Clarity is an issue because, at several points in the committee’s report, we say that we want more information. One particular aspect that I want to mention is the surprise that I felt when we received some very late evidence from the Government—it came in after all the evidence sessions, including the Government’s—about the extent of health board budgets that were to be
Third sector. I would like to see a bit more in the bill bodies, as are, of course, service users and the happen. The role of GPs is crucial to the new engaged with each other but often that did not where primary and secondary care clinicians were involved. CHPs were meant to be fairly autonomous. All that wording needs to be looked at and if the Government intends something else, it or we will have to amend the bill stage 2. That uncertainty is connected to other uncertainty about the relationship of the integration body to the parent bodies. Peter Gabbitas of the City of Edinburgh Council and the health board—he already has a joint appointment—gave powerful evidence to the committee about that. At stage 2 we need to look in detail at the wording of the bill in that respect. For example, section 21 says that the chief officer “is in all respects as if the person who delegated the function”, which gives the impression that the chief officer is fairly autonomous. All that wording needs to be looked at and if the Government intends something else, it or we will have to amend the bill at stage 2.

The locality arrangements and clinical involvement are crucial. CHPs were meant to be local but often turned out to be otherwise, to my disappointment. They were meant to be the places where primary and secondary care clinicians engaged with each other but often that did not happen. The role of GPs is crucial to the new bodies, as are, of course, service users and the third sector. I would like to see a bit more in the bill on all that and I would like it to be included in negotiations on the GP contract.

I have 10 seconds left. Let us look at good practice, wherever it is to be found. I apologise to the cabinet secretary, as this is the second debate in a row in which I am referring him to a good example in England. “Integrating health and social care in Torbay: Improving care for Mrs Smith” is an excellent publication by the King’s Fund about how integration has worked successfully in Torbay in Devon and realised the objectives that we want: fewer emergency admissions and more care in the community.

16:01

Aileen McLeod (South Scotland) (SNP): I am delighted to be speaking in a debate on the general principles of a bill that will introduce a substantial and wide-ranging reform of the way in which we deliver adult health and social care. The cabinet secretary reminded us in his opening speech why the bill is so necessary. As a nation, we have larger numbers of people who are living longer than ever before. That is good news, but it means that we need to re-examine how we deliver and manage care in Scotland for our older people.

The integration of health and social care services is needed to improve outcomes for individuals, particularly adults with multiple long-term conditions and complex support needs, and to improve the experiences of both those who use such services and those who provide them. As we know, key to delivering that vision is the principle of person-centred healthcare, whereby services are integrated around the needs of the individual.

I want to highlight the representations that the committee received on the need to ensure that the housing sector’s contribution to improved health and social care outcomes is recognised in the bill, and that the new integration authorities involve their strategic housing partners in joint commissioning to achieve person-centred quality care at home.

Ultimately, our aim should be that everyone, no matter the complexity of their requirements, has an equal chance of a good life. We know that homes that are responsive to a patient’s needs—particularly if the patient has dementia, a learning difficulty or autism—are needed to achieve that aim, as they make a significant difference to how care and support are delivered and the outcomes that they have.

Another key issue that was raised with the committee was the need for the full involvement of the third sector. Issues were also raised at both the strategic partnership and local levels surrounding the involvement of a range of other key stakeholders, including our allied health
professionals, service users, carers and disabled people and their representative organisations, all of whom have a wealth of collective experience, expertise and professionalism. They are huge assets in helping to achieve a person-centred and needs-led approach to the delivery of locally based quality health and social care services.

Another key voice is that of our GPs. The evidence that the British Medical Association and the Royal College of General Practitioners submitted to the committee was helpful, as it allowed us to examine possible barriers to fully and successfully engaging GPs in the planning of local services. An excellent example of integration that is already working—and being driven by GPs—is Kirkcudbright community hospital and its adjoining GP practice, which has developed strong working relationships with local social services staff.

That is only one example. At the other end of the spectrum, the GPs at the deep end group’s case in favour of having GP surgeries in our most deprived areas functioning as natural hubs for integrated care to tackle deep-seated health inequalities requires us to recognise that, in many of those communities, services may be the least integrated.

That great variation in local experience reinforces the case for the bill and highlights how important integration at the locality level will be, how important the widest involvement of key stakeholders—including GPs and our local professionals—and partners at that level will be, and how important it is to scale up the capacity of the third sector to ensure that those who work closest to individuals and communities can participate and engage fully in service design and service delivery. Fully involving our GPs, the third sector, local professionals, carers groups and disabled people at the locality level will make a positive difference to the delivery of integration. The localities will be where many of the key decisions concerning service users will be made.

In Dumfries and Galloway, the local authority and the NHS board are already clear that the way to implement integration is to focus on building up the service model at locality level first. Our region has a natural advantage, in that it has four well-established areas corresponding to the old district councils—a natural pre-existing delivery model. The NHS and the council have capitalised on that by commencing integration from the point closest to the service user through planning local integration in those four areas, rather than starting at the furthest away point with the top-level governance model. Of course, both those structures need to be right, but in considering the top-level arrangements we must not lose sight of the fundamental importance of integration in the localities, where the services will actually be delivered and the real difference made.

I will close by saying that I fully support the general principles of the bill. I look forward to considering the amendments during stage 2, when I hope that we can work together to produce an act that will be regarded as a fundamental reform of the way in which we care for Scotland’s people.

16:06

Ken Macintosh (Eastwood) (Lab): I believe that all members in the chamber today will offer broad support for the general principles of the bill, and I certainly want to express my enthusiasm for its direction of travel towards greater integration between health and social care. However, like others, I must admit to feeling slightly worried about the bill’s ability to deliver on that agenda and to feeling downright anxious about whether some aspects of the legislation will work at all.

I recognise and acknowledge the good intentions behind the Public Bodies (Joint Working) (Scotland) Bill. In fact, some of the language in the proposals looked rather familiar to me from previous parliamentary sessions. I remember speaking about what was then called the joint futures agenda not long after being elected in 1999. For those who may not remember that, the joint futures group was set up by the first Scottish Executive—more than 14 years ago now—with the specific aim of trying to improve joint working between social care and healthcare and to secure better outcomes for patients and service users.

The various recommendations of that group read like the bill’s policy memorandum. They focused on joint working, the rebalancing of care between community care and acute care, how to improve the financial and management frameworks of the different agencies involved and how to establish best practice. They also examined some of the difficulties around charging. Here we are, more than 10 years on, still wrestling with precisely the same thorny issues.

The reason that I mention joint futures is not to sound jaundiced or cynical or to suggest that integrated working cannot be achieved, but quite the reverse. If this was important in 1999, it is even more important in 2013, with the rapid pace of demographic change, the ever-increasing pressures on our budgets and the need to move to a preventative care agenda. I mention the work that has gone on before simply to highlight what a difficult agenda this is to achieve.

As the Health and Sport Committee reveals in its report, the legislation itself is perhaps less important than achieving cultural change—getting health professionals, social workers, the voluntary
sector and the myriad of people who are involved in care to work in partnership, rather than just within their own professional disciplines, funding structures or special areas of interest.

There are practical difficulties with the bill, too. I was drawn almost immediately to the issue of governance. Having just read the Auditor General’s report on police reform, I suspect that no member can be unaware of how legislative confusion over roles and responsibilities can hamper the creation of a new organisation. It is strikingly obvious that, if there is not clarity about the relationship between the new joint boards proposed in the bill and their parent bodies—the relevant NHS board and local authorities—that is a recipe for conflict.

As for budgets, all of us will be familiar from casework, if not from our own experience, that services tend to follow the money. One difficulty here is that there are so many competing budgetary agendas. There is an expectation that the bill will save money or at least deliver efficiencies to meet rising demand. Alongside meeting rising demand, there is a clear drive to focus on community and social care rather than on acute care, but there is a rather less specific commitment to reallocate those acute budgets. In theory, yes, reducing unplanned admissions will free up resources, but we also know that in practice the demand on our hospitals is such that those resources will immediately become reallocated—any beds that become free are immediately filled by other patients. That is before we even get into the fact that, in social work, the health service, local authorities, NHS boards, housing or the voluntary sector, there will be competing budgetary needs and not simply collaborative or consensual agreement on spending priorities. I am afraid that there is no shortage of people or organisations that think that they can spend someone else’s budget better.

Most important of all, it is vital that the bill succeeds not because of organisational simplicity or budgetary accountability, but simply to make life better for patients. The committee’s report contains a particularly informative section about the difficulty of integrating the free healthcare that is available in the NHS with social care that is subject to charges and various eligibility criteria. We know from the on-going legal cases on NHS continuing care what a minefield that can be and how much anxiety it produces. Those with chronic neurological conditions such as Parkinson’s are particularly anxious about where we will head in the area. Before the bill has even cleared stage 1, we know that people the length and breadth of the country are struggling with 15-minute care visits. Our health and care services are under huge pressure to maintain quality and standards and they sometimes buckle under it.

As the RCN and others have made clear, quality and safety of care are unfortunately not at the heart of the bill—or not yet. The briefing for the debate from Macmillan Cancer Support contained an excellent line, which states:

“We believe that this debate must focus on how services will work for the cancer patient, not on how it will work for the service provider.”

That applies to patients in general and I entirely agree with it. The bill is well intentioned and I hope that it can deliver.

16:11

Gil Paterson (Clydebank and Milngavie) (SNP): I am pleased to speak in the debate as a member of the Health and Sport Committee. Scotland’s people are living longer and healthier lives, and all the evidence that has been gathered has brought about the realisation that it is better for people of all ages to recover and be treated in their home where appropriate. It is therefore imperative that all the relevant agencies are involved in the good work of ensuring that the recovery process works to a high degree and maintaining a high standard of health and social care for the individual. Those agencies should be not so much connected but intertwined to effect the best results.

Although we can point to some good examples of integration working and working well, for the best part, I do not think that it is an exaggeration to say that the norm in past attempts has been failure. In the evidence that was presented to the committee, we did not find a single authoritative voice suggesting that integration between the sectors would be a bad thing. On the contrary, the opposite is the case—all the evidence said that joint working would be to the benefit of everybody, both provider and receiver. It is hard to disagree that, as we have a universal goal with a high score value at the end, legislation needs to be introduced to bring about that goal.

Most of those who have questions on the lack of success so far have put that down to leadership. I must confess to a little scepticism about that view. To me, from the outside looking in, the issue is more about budget protection in each sector than anything else. If I am wrong, and the commentators who think that the lack of good leadership is the main reason are right, legislation clearly will not solve that, as it does not provide or manufacture such leadership. Having said that, I am confident that legislation will be the stimulus that will make the difference. I am more than confident that those who work in the health and social care professions and in the third sector
have the required leadership—that is apparent day in, day out—and are more than capable of making the bill a success.

In many debates in the Parliament, it has been acknowledged that the wellbeing of the patient is paramount and that the patient and their family are the first and most crucial aspect. From when someone is admitted to hospital with an illness to when they are released to recover fully at home, the patient's needs are our top priority. We know that most people desire to stay in their home, albeit with vital care support and assistance when they have conditions or are infirm. It is also crucial that we provide an integrated service that gets it right first time for the individual and that recovery takes place with fewer relapses. Relapses are costly in terms of money and the impact on someone’s already fragile health. They may also add to the cost of care.

Getting it right will allow the savings that are made to be deployed back into health and social care services to make the joint sectors even more beneficial, and so the progress will go on, moving forward at all times.

I must offer some caution to temper my optimism. With the UK Government’s cuts agenda continuing to have an acute impact on Scotland’s finances, we might be expected to do the same—or even more—with less money. I hope that I am wrong in that regard and that the hard work that is being carried out by all sides will be rewarded and recognised by any savings being reinvested back into the sector to ensure that our people are kept healthy.

Scotland has an ageing population, and the future challenges that we face will be huge and complex. I hope that the bill will go some way towards ensuring that we are ready to face those challenges and rise to meet them.

I am pleased to commend the bill to the Parliament and support its progression from stage 1.

16:16

Jim Hume (South Scotland) (LD): The bill has been a long time in the making. The integration of health and social care is overdue and it is an idea whose time has certainly come. It was a key component of the Scottish Liberal Democrat manifesto for the last election, and we have long called for the delivery of common sense by having health boards, local authorities and the third sector work more closely together to provide more joined-up care and better outcomes for patients.

The pressures and challenges that the NHS faces have undoubtedly made the proposals necessary. For example, the incidence of emergency admissions has increased significantly in the past few years alone, with the largest increase among the over-75 age group.

Although I am supportive of the integration of health and social care and support the bill in principle, I share some of the reservations of many people in the public and third sectors—I will touch on those shortly—and expect further engagement from the Government to enhance the bill as it progresses.

One of my concerns, which was well articulated by Glasgow City Council and others in their evidence to the committee, is about disconnects in care provision. The failure in patient outcomes occurs not only because health and social care are not integrated, but because of the disconnect between acute and primary care. Although that is noted in the bill’s policy memorandum, some people believe that the proposals will address only one of the disconnects and will leave the other unchecked. The submission from Glasgow City Council highlighted the point that “integration works best when GPs and other stakeholders are engaged effectively.”

The cabinet secretary was right to say in his response to the committee’s report that structural change will not in itself lead to greater partnership working, but that a cultural change is also required. I welcome his commitment that GP engagement will form part of the contract discussions, but he will have to provide more detail on the Government’s plans, irrespective of continuing negotiations.

The Scottish Government must be realistic. Demands on GPs may be about to increase significantly at a time when the proportion of the NHS budget that is given to general practice has fallen. The cabinet secretary must still explain how he plans to put a square peg in a round hole, regardless of integration joint boards agreeing integrated budgets, because the capacity and resources might simply not be available, although the desire exists.

I note COSLA’s understandable concerns regarding the degree of latitude that the bill appears to offer the cabinet secretary to widen its scope beyond adult social care and to bring any local government function within its parameters. I give him the benefit of the doubt and characterise that as an unintended erosion of local democracy and creep towards centralisation. To his credit, he appears to have realised that there is a real issue with the bill. I welcomed his commitment to the Health and Sport Committee that he would work with COSLA on amendments at stage 2 to rectify that.

That said, the air of centralised power cannot be overlooked. The electorate look to their health
boards to provide their health services, and they elect their local councillors to manage their social care services. They are the people whom the electorate will, rightly, hold accountable. However, the integration plan that is designed by the two bodies cannot simply be agreed between them; it must also be signed off by Scottish ministers. The cabinet secretary will be well aware that many people have described the plans as being too prescriptive and too detailed. I suppose that they have a point.

In addition to integration plans having to be signed off, the joint integration boards have been instructed by the Scottish Government to whom their joint accountable officer will report. The Government will also tell them what their responsibilities will be. Can we not at least trust the joint integration boards to determine what is most appropriate for them locally, because they are best placed to do that? It would be interesting to find out whether the cabinet secretary agrees that it is perhaps not entirely necessary that ministers personally determine the job criteria and the line managers of newly created positions. Perhaps Michael Matheson could reflect on that in his summing-up speech.

It is not a perfect bill—far from it. There are still issues to be ironed out regarding democratic accountability, the extent of the third sector's role and so on. However, the principle is sound, which is why the Liberal Democrats will support the bill at stage 1.

16:21

Richard Lyle (Central Scotland) (SNP): As a member of the Health and Sport Committee, I am pleased to speak in the debate because the committee has spent some time working on the bill and has considered a total of 81 submissions that were received after the call for evidence, and has considered oral evidence that was given by various sources during committee meetings. Further to that, the committee visited projects in Inverness and West Lothian to gain first-hand experience of joint working on the front line.

I was able to take part in the West Lothian visit, and I was impressed with how people there are taking the bill on board, and with what they are doing to implement changes that should improve the service for local users. I hope that others will follow West Lothian's example.

It is welcome news that the people of Scotland are living longer and healthier lives. Life expectancy in Scotland has increased and is expected to increase by two thirds in the next 20 years—I am sure that many of us are happy about that. Because of that, we need to change how care is delivered now rather than wait for that to become a problem further down the line. I am therefore happy with the Government's proposals as set out in the bill.

I am pleased to note that the Cabinet Secretary for Health and Wellbeing has welcomed the support of the committee for the principles of integrating health and social care with the aim of improving outcomes for service users, and I know that he is committed to doing that.

The committee notes that there is a need for legislation to provide change and to improve outcomes for people who use health and social care services because not enough progress has been made under the current system.

At the moment, Scotland is experiencing problems that integration could help to address. Those include unscheduled emergency admissions to acute care, delayed discharges from acute care to community settings, delays in accessing required support, and lack of communication between services. There are too many occasions in which the hospital and the local social work department are not on the same page; when I was a councillor in North Lanarkshire I had to intervene on a number of occasions to resolve situations in which a patient was ready to come out of hospital but could not go home because support had not yet been supplied. On those occasions, I had to contact the social work department and the hospital in order to ensure that the patient's needs were being met. If such problems could be solved, it would be good news for all patients, especially those who are in the last months of their lives, because delays in those patients' being discharged often results in their becoming too sick to move back to their homes and communities, where they would rather be.

Under the bill, health boards and local authorities will be required to create integrated plans for their areas. As has been said, two models will be available: the body corporate model, in which a health board and a local authority will delegate functions to a joint board that is headed by a chief officer; and the lead agency model, in which local authorities and health boards will delegate functions to each other under the oversight of a joint monitoring committee. Allowing each area to choose which of the two options best suits it would ensure that people in those areas' communities receive the best care, tailored to their needs. I suggest that all partners, plus GPs and local authorities, must work together to make local arrangements.

The point has been made that the Health and Sport Committee had representations from many organisations. However, as I have said, given the number of organisations, how many people will need to get round the table and will the table be big enough?
The bill will allow ministers to set out national health outcomes, and health boards and local authorities will be held accountable by the Scottish ministers and the public for delivering the targets. Councils and health boards should see that the bill is meant to solve and resolve the problems that are not being dealt with under present arrangements.

It has been said that the bill will not guarantee a successful outcome, but I fully support the bill’s intentions and its aim of providing better outcomes for patients and service users while delivering better value, in order to meet the challenges of the ageing population. I will support the bill.

16:26

Hanzala Malik (Glasgow) (Lab): I welcome the opportunity to speak about the bill. We can all agree that the bill’s aim is to create a system of high-quality care that is seamless and effective.

In my many years as a Labour Party councillor on Glasgow City Council, and now as a member of the Scottish Parliament, constituents have regularly come to me as they have slipped through the cracks in the system. Such cracks are caused by a lack of joined-up thinking and practice from social care providers and health boards up and down the country. That situation must end.

The bill does not go far enough to provide integrated health and social care. Many council departments up and down Scotland have merged and renamed themselves as health and social care, but apart from rebranding, little has been done to integrate the different cultures and decision-making structures.

A person who was cared for by a mental health team came to me for support when his case was closed by a doctor who said that his personality disorder was untreatable. That diagnosis completely ignored the possibilities that social workers in that person’s team could offer him. That complete lack of joined-up thinking led to a vulnerable person feeling as if he had been abandoned by the system.

Bob Doris: Mr Malik is making excellent points about cultural challenges. In Glasgow, our health and care partnerships did not work. Section 12(1) of the bill will give ministers the power to intervene to compel integration. Does he agree with my hope that that power will never have to be used, because local authorities and health boards will finally get on with it and do integration properly?

Hanzala Malik: My friend makes a fine point, which I will go on to address. I described a complete lack of joined-up thinking, which leads to vulnerable people feeling abandoned.

The bill does not properly deal with the major differences in eligibility between the health system and the social care system. Healthcare provision is a universal service that is free at the point of delivery, whereas social care provision is subject to eligibility criteria and charging. We need to ensure that the bill sets out clear and transparent decision-making criteria for eligibility in which service users and their carers are involved, so that services are provided effectively.

On joined-up thinking and working, Glasgow City Council had a structure; it had a committee, with area or regional committees that dealt with doctors, healthcare workers and others to provide services, but it was done away with. I am not sure whether the bill will redress that.

Quite frankly, I say that our doctors need all the support they can get, because they are working under a lot of pressure. I have gathered over the past two years that our doctors seem to be doing more and more in terms of service provision. They are also doing a lot of work in communities, which is welcome.

Clarity about services is the most important element of the bill. If people continually fall through the cracks, we are missing the point. There are far too many agencies trying to grapple with providing services to individuals. If one of those agencies lets down the client, patient or individual, the whole structure fails. We must try to ensure that that does not happen.

I call on the cabinet secretary to lodge an amendment to the bill that will secure the fundamental right to services, so that we force all the partners to work together to ensure that service provision is appropriate.

16:31

Roderick Campbell (North East Fife) (SNP): I welcome the opportunity to speak in this important debate, and I welcome the committee’s stage 1 report.

At roughly £4.5 billion per annum according to the 2010-11 figures, health and social care spending on people aged 65 and over constitutes nearly a third of the health and wellbeing portfolio budget. Investment in those areas is not only significant but absolutely essential. It is important to ensure that we fund and design an integrated service that will be sustainable.

The consensus surrounding the bill is positive. It should come as no surprise, given that the bill reflects the current international trend towards integration of health and social care.

I was delighted to learn that the group that is overseeing Fife’s adult health and social care integration—it is called communicating health and
social care integration in Fife—which comprises staff from NHS Fife and Fife Council, was last week shortlisted to be in the final three, out of 130, in the health and social care integration category of The Herald’s society awards 2013. That accolade was dedicated to the council and its NHS Fife colleagues, partners, service users and patients who have helped to support the group’s work. It demonstrates that successful progress is already being made on the ground.

It is fair to say that we need to fund healthcare and social care as efficiently as possible owing to the current pressure on public finances, but we need also to work towards having a care sector that offers a career option and which has motivated staff who are working towards providing a first-rate service. We need to strive to improve the standard of care that some patients are receiving as we plan for the inevitable demographic changes of the future.

Scotland is not alone in moving towards a joined-up approach to delivering those areas of care. For the past 40 years there has been a movement in that direction all around the world. There are no direct parallels with Scotland, but we can and should always learn from international examples.

Nearer to home, England has introduced the Health and Social Care Act 2012. Although the principle is the same, I understand that integration is proving to be difficult to implement, according to some professionals who cite the fragmenting effect of introducing private enterprise into the NHS as an obstacle to success.

In Wales in 2007, a primary, secondary and social care strategy, called chronic conditions management demonstrators, was introduced for people with multiple chronic illnesses, which has resulted in considerable reductions in bed days resulting from emergencies. Indeed, there were falls of 27 per cent, 26 per cent and 16.5 per cent in successive years.

To see the advantages of a local approach, which the bill provides for, we need look no further than Sweden.

In the committee report is a recommendation in paragraphs 43 to 45 regarding the justification for the bill. Some witnesses who gave evidence to the committee suggested that steps could have been taken towards more joined-up care service delivery using existing legislation and guidelines. Some pointed out—rightly, in my view—that legislation alone will not bring about the changes that we want to see. I listened to what Malcolm Chisholm said on that point earlier and agree with it.

I have spoken before about the transformational effect of legislation and said that the introduction of legislation can lead to attitudinal changes across the country. Individuals and organisations not only become obliged to observe a set of guidelines; many do so proactively before they are required to do so in order to remain ahead of the curve. I therefore believe that the committee was right to describe the bill as “the momentum needed to make the widely desired progress a reality”.

I note that, with regard to the provisions in the bill that relate to the two possible options for delivery of integrated services—the body corporate model and the lead agency model—the cabinet secretary has undertaken to provide more information on the roles and duties that will be involved in those arrangements. I welcome that, and the consensus among relevant organisations and the Government on the basic model behind the proposals, which is that local government and health boards should be jointly accountable. That is also very positive, but it is absolutely clear that we cannot have a system in which health boards and local government are locked in budgetary disputes with each other. Such disputes serve no one in the long term, and ultimately the biggest losers are the patients, who are liable to experience delays and confusing information about their care, as experience has shown.

The case for co-operation has been strongly made, and the bill’s provisions that allow a high degree of freedom in choosing the model that is best suited to an area will, I hope, mean that more health boards and local authorities will be able to take forward adapted plans of their own to meet national standards with tailored means to a unified end.

To conclude, I commend the committee on its thorough report and look forward to monitoring the bill’s progress as it passes through Parliament.

The Deputy Presiding Officer (Elaine Smith): We now turn to the closing speeches. I remind all members who have participated in the debate that they should be in the chamber for the closing speeches.

16:36

Mary Scanlon (Highlands and Islands) (Con): I, too, commend the Health and Sport Committee for its excellent work in scrutinising the bill and bringing forward its stage 1 report.

I am very pleased to be back to speak in this debate on health and the Public Bodies (Joint Working) (Scotland) Bill. I am even more pleased that I will speak in such a positive way. After hearing about all the problems, I can honestly talk about what is happening in Highland, which is an undoubted success, although I appreciate that there are still challenges.
In last week’s debate on the Children and Young People (Scotland) Bill, Highland Council was commended throughout the chamber for its work on getting it right for every child. I agree that that model is working in Highland and commend Highland Council for its plan to recruit five more health visitors.

There was a time not so long ago when health visiting seemed to be withering on the vine. Some health visitors expressed the view that they did not want to become social workers. The lead agency model in Highland allows Highland Council to focus on the needs of and priorities for children and young people, and to adopt not only an integrated model of delivery but, more important, an integrated model of care and support that covers all aspects of a child’s needs.

There is still a way to go—I would like to see more holistic support for troubled families—but I acknowledge that the care model that Highland Council has adopted is good and that tremendous progress has been made from what happened in the past, which in my opinion was a recipe for passing the buck.

The lead agency for adult care—NHS Highland—has also brought about significant improvements. Again, I accept that there are challenges ahead, but I acknowledge the many submissions on the bill that state that cultural change is difficult.

In the past, when local constituents came to my surgeries to ask whether I could help to get their elderly parent out of Raigmore hospital to be cared for at home or in a care home, I had to phone social workers. On many occasions, the social work ring-fenced budget had run out, and people had to wait until the end of the financial year, which could have been several months. As far as the council was concerned, the person was being cared for, albeit at a higher price to the public purse, in hospital. That led to high figures for delayed discharges—otherwise known as bedblocking—which of course impacted on hospital admissions.

Now I can email the chairman of NHS Highland—I did so twice last week—who can arrange for the appropriate care package to be delivered at home or in a care home, in a seamless manner. It is in NHS Highland’s interests to free up beds and ensure that every patient receives appropriate care.

In the past, Highland Council paid up to 80 per cent more per person per week if someone was cared for in a council-run residential care home rather than a home in the independent or voluntary sector. Now that NHS Highland is in charge of the budget, questions need to be asked about why council care homes receive so much more funding, given that all care homes must achieve the same quality standards, which are set out by the Care Inspectorate. I accept that there is a challenge in that regard.

Earlier this year, care-at-home services in Highland received a very poor inspection report—I was thinking about that when Neil Findlay was speaking. The report was not a disaster but presented an opportunity for NHS Highland to bring in more support and training for care workers, to enable them to provide the level and quality of care that we expect them to provide. The lead agency model brings carers into the whole healthcare system, where they can get the maximum support.

I spent many years as a member of the Parliament’s health committees. In particular, I was a member of the Health and Community Care Committee when it scrutinised the bill that became the Community Care and Health (Scotland) Act 2002. I can confirm that, even then, all but one witness said that a single agency should deliver care of the elderly, although there was no consensus about who should do that. We talked about the NHS, social work and GPs, and there was talk of pooled budgets and aligned budgets. At the time, the cultural differences between the NHS and social work were even more significant than they are now. I think that the situation has improved considerably in recent years.

I appreciate that there is no single definition of integrated care. However, I have talked about Highland because good practice should not be ignored. I agree with the Multiple Sclerosis Society, which said in its written submission to the Health and Sport Committee that the bill should not focus “too heavily on structural change ... at the expense of the primary focus on improving outcomes for people.”

That is my point. The Highland model focuses on the person and not on where they are, what the budget is or constant arguments between NHS Highland and the Highland Council. Highland’s focus is on the person, as is my focus and, I am sure, that of the Health and Sport Committee.

What has happened in Highland has not required legislation, but it is disappointing that progress has been so slow in other parts of Scotland. I welcome the bill; we will support it at stage 1.
not sure that the bill alone will achieve that—it needs to go further. Moreover, I am not convinced that it is possible to legislate for the type of leadership and cultural change that Duncan McNeil and Malcolm Chisholm talked about, which is crucial to making the step change on how we deliver care.

Mary Scanlon talked about Highland, which has adopted the lead agency model. No other area appears to be taking that model forward. It is clear that the model’s success—or partial success, because Highland admits that it is a work in progress, which has a long way to go—and indeed the fact that integration has happened at all, has been the result of strong leadership at NHS and council levels. People have been committed to change, and there has been cultural change in the staffing structure. Most of all, there has been trust. The people involved have said that it will be difficult to replicate the lead agency approach elsewhere unless there is trust.

It is not possible to legislate for trust and cultural change. The bill addresses the mechanisms and bureaucracy, but we must be clear that that alone will not work. We will need to consider how we nurture the culture and leadership in organisations.

**The Deputy Presiding Officer:** I ask that Ms Grant moves her microphone a wee bit closer because I can hear the private conversation taking place in front of me somewhat better than I can hear her.

**Rhoda Grant:** I hope this is better, Presiding Officer.

The bill deals mainly with the bureaucracy, but even that does not seem to be done very well. The legislation will allow a board to be set up with an accountable officer, but staffing and resources appear to remain with the parent bodies. What budget will be required by the new body if it does not have responsibility for paying staff or if capital resources remain in the ownership of the parent authority? How can that new body direct their use? That is not at all clear.

The cabinet secretary said in his opening speech that integrated budgets are essential to success, but in committee he said that—as the Government has said in previous budgets—healthcare money would remain ring fenced and protected and that local government money would remain part of the local government settlement. It is therefore difficult to see how the budgets can be integrated if organisations must account separately for the money and show that it is spent in their own organisation and under their existing responsibilities. We must look at how that will work.

Malcolm Chisholm mentioned health board budgets. Half of their budgets will go into the new body. That might work in some instances, but what about acute centres of excellence? They may take patients from all over the country, but what part of their budget is ring fenced for that national service and what part will go to local service delivery? Those matters are not at all clear.

Neither is it clear what thought has gone into the impact of people working together with different terms and conditions on salaries, pay bands, pensions and policies, including disciplinary and grievance policies. How will those work when people work together? Who would take out a grievance? What policy will they use if they are working with somebody employed by a different agency? That issue needs to be considered, including by the governing bodies and the trade unions.

We need to make progress on those issues because, as Ken Macintosh mentioned, if the budgets, the powers and governance are not sorted out, we will end up in lengthy wrangling. I can see that happening if the cabinet secretary does not consider those important issues.

Let me be clear that service users and their carers need to be at the centre of the legislation. They are concerned about where they fit in, how they will be involved, whether co-production is at the heart of the bill, whether services are provided for them rather than their being allowed to design their own services, and how they will be represented.

The point was made that the voluntary sector interface also represents service providers and that quite often service users feel drowned out by the providers’ voices. We need to make the distinction between service users and providers, and we must ensure that the individual is very much at the centre of what we provide in order to help them to live their lives and to enable them to live how we would wish to live.

For example, should an individual wish to move, their care package should be portable and move with them. They should also know what that care package would cost in other areas. That is important and as Ken Macintosh said—Macmillan Cancer Support research made the same point—the service user must be at the centre.

Putting the service user at the centre also means that we must look at quality and safety. The RCN, among many other organisations, asked for that issue to be covered in the bill. We need minimum standards of care—people need to access the same level of care, regardless of where they live, and they need to know what to expect.
It is not possible to have quality without reasonable conditions for staff. Neil Findlay mentioned working conditions. Many people who deliver front-line care do not even get the minimum wage, training or time to do their job. They are frustrated and distressed by the stress that the job causes if they cannot do it properly. We therefore need to ensure that quality is covered in the bill.

Furthermore, some of the principles on integration need to be moved up the bill and emphasised, so that everyone is clear about the culture change that is needed as well as the different structures that are to be put in place.

There are many more issues that we need to consider. For instance, we need joint inspection that is independent, rigorous and available to workers, staff and service users. Whistleblowers also need to be protected in those conditions.

I have come to the end of my time, but I very much hope that the Government will listen and will strengthen the bill. It could be a good bill if those concerns are listened to and taken into consideration.

16:50

The Minister for Public Health (Michael Matheson): This has been a good debate on the stage 1 report, with a number of important speeches.

What has struck me most in the debate is that the change that the bill will introduce through the integration of health and social care will be one of the largest changes to take place in the health and social care system in almost a generation. It is unusual that a piece of legislation that will result in such a significant change has such cross-party support. That is a reflection of the fact that, as the committee’s report recognises, there is a broad consensus around the issue and the need for it to be addressed.

In his opening speech, the cabinet secretary set out some of the key drivers behind the need to take integration forward, such as the demographic challenge that we face. In themselves, however, those are not the only reasons for integration.

Ken Macintosh highlighted the history of the debate. He talked about the joint futures agenda back in 1999 and the fact that the document for taking forward joint futures echoed many of the opportunities that the bill creates for partnership working, joint budgets and joint commissioning of services. However, the policy predates joint futures. The whole integration agenda started in the 1980s and continued into the 1990s. The debate has been around for some time and has presented some real challenges.

I have no doubt that, when Malcolm Chisholm was a health minister, he tried to pursue the agenda and was successful in some areas and unsuccessful in others. That demonstrates the challenge in ensuring that integration takes place on a systematic and consistent basis across the country, which is why the bill is extremely important.

The bill will not resolve all the difficult issues that we face in our health and social care system at present, but it will ensure that we focus on some of the challenges much more effectively so that, in health and social work, our local authorities and health boards will work much more closely in partnership.

Neil Findlay referred to the route that West Lothian Council pursued in 2003. That is an interesting illustration, as the joint futures agenda goes back to 1999. There was a four-year period before West Lothian Council was able to take forward the agenda, but it is now the most advanced area in the country in this matter, which we should recognise. When colleagues in other parts of the country ask me what integration is going to look like, I tell them to look at what is happening in West Lothian and the way in which the council has been able to lead the agenda.

Neil Findlay: Will the minister give way?

Michael Matheson: I will just finish this point.

The experience of the 1990s, joint futures and what has happened in West Lothian teaches us that, if we do not provide the legislative framework to drive integration forward, it will not happen on a consistent basis. The bill builds on the good practice in areas where joint working is taking place, ensuring that it happens consistently and right across the country.

Neil Findlay: I welcome the minister’s acknowledgement of the excellent work that is being done by that Labour council. I am sure that it will be a shining example for other councils to follow.

Michael Matheson: Sure, and I know that my SNP colleagues did exactly the same in driving forward that agenda when they were in charge of West Lothian Council. I could, of course, identify other councils that are not doing as well, but I will not get into that, because I think that it is a question of ensuring that we create the right legislative framework to drive forward the agenda in a much more effective way.

Bob Doris pointed out that the integration of health and social care has been an aspiration for several decades, and the bill will make that happen in a way that has never previously been done. In doing so, it will enable us to integrate the
services that people receive much more effectively.

What Mary Scanlon said about the experience in Highland was a good illustration of the benefits that come from the greater integration of services. Taking forward that agenda has put an end to the lack of planning and the cost shunting that can go on between different agencies. The experience of the approach that has been taken in Highland bodes well for the benefits that can be achieved through integration.

Some members raised concerns about the potential for services that have been provided by health moving into social care and being charged for. When we consider such issues, we should be careful to remember that the moving of more services into the community is not a new development. The late 1980s and the 1990s saw the closure of long-stay hospital beds for people with a mental illness and for those with learning disabilities. Most of those patients moved into the community and received social care packages to support them there. Many of them continue to live in the community with the help of such support. Therefore, the process that we are talking about is not new—it has taken place previously.

It is also worth bearing in mind that the bill is not about taking a service that is provided in hospital, such as physiotherapy, and giving responsibility for it to a social care partnership, which must then decide whether to charge for it. Instead, the bill is about ensuring that there is joint commissioning of health and social care services, that those services are jointly planned and integrated, and that people work together collectively to look at the best way of doing that.

We need to consider how we can best configure social care services at a local level to meet the demand on the healthcare system, and how we can better configure them to reduce the demand that exists in some areas. Rather than taking something that health does and putting it into the social care setting, we must ensure that services are configured and planned much more effectively.

A number of members, including Duncan McNeil and Hanzala Malik, highlighted the importance of general practitioners in taking forward the integration agenda. Primary care is key to the success of greater provision of healthcare in a community setting and to ensuring that social care provision is properly aligned with that.

The work that we are doing with the British Medical Association on issues such as the GP contract gives us an opportunity to do some of those things in a way that has never been done. Although those negotiations are confidential, I am strongly of the view that we are all singing from the same hymn sheet—GPs, social work, the Government, the independent sector and the third sector all want to see more effective integration. We need to find a way that allows us to deliver that for patients on a daily basis. We are taking forward our work with the BMA to assist us in achieving that.

Neil Findlay highlighted concerns about the quality of the inspection process for those people who receive care at home. I recognise some of the challenges of conducting inspection in a home setting. That is why the cabinet secretary has already commissioned the Care Inspectorate to do work on how we can improve the inspection process and ensure that it is much more rigorous when it comes to the quality of care that is provided at home.

I point out that inspections are not a bad thing. Inspection is a good part of the system that can help to drive up standards and lead to improvement. As Mary Scanlon said, care-at-home services in Highland did not receive a fantastic report, but that report has created a platform for improving those services. That is what we need to do much more systematically right across the country. The work that the cabinet secretary has asked the Care Inspectorate to undertake is exactly about doing that and ensuring that we have a more robust and clear inspection regime for care at home.

I believe that the bill has not only cross-party support in the Parliament but public support, because people want to see services working in co-ordination and planning their delivery much more effectively in their communities. The bill will help us to make significant changes in how we can deliver in our communities right across Scotland.

I call on members to support the cabinet secretary’s motion at decision time.
Public Bodies (Joint Working) (Scotland) Bill: Financial Resolution: The Cabinet Secretary for Finance, Employment and Sustainable Growth (John Swinney) moved S4M-08027—That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Public Bodies (Joint Working) (Scotland) Bill, agrees to any expenditure of a kind referred to in paragraph 3(b) of Rule 9.12 of the Parliament’s Standing Orders arising in consequence of the Act.

The motion was agreed to (DT).
Public Bodies (Joint Working) (Scotland) Bill

1st Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

Sections 1 to 53                  Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 1

Alex Neil

1 In section 1, page 1, line 11, leave out <plan> and insert <scheme>

Alex Neil

2 In section 1, page 1, line 13, leave out <plan is a plan> and insert <scheme is a scheme>

Alex Neil

3 In section 1, page 1, line 19, at end insert—

<(ca) where subsection (5A) applies, a method of determining amounts to be made available by the Health Board in respect of functions that are to be delegated by the Health Board,>

Alex Neil

4 In section 1, page 1, line 20, leave out <a method of calculating> and insert <where subsection (5A) does not apply (or where it applies but the Health Board deems it not to apply), a method of determining>

Rhoda Grant

202 In section 1, page 1, line 22, at end insert—

<(da) arrangements for monitoring the use of resources in respect of delegated functions, including payments made in accordance with paragraph (d),

(db) arrangements for monitoring and improving the quality, safety and standards of services provided in pursuance of functions delegated under paragraph (b) or (c),

(dc) arrangements for the participation in the planning and delivery of services provided in pursuance of functions delegated under paragraph (b) or (c) of—

(i) service-users,

(ii) unpaid carers,

(iii) non-commercial organisations who appear to the local authority and the Health Board to represent the interests of service-users and unpaid carers,

(iv) relevant staff of the local authority,
(v) relevant staff of the Health Board,
(vi) such other persons as the local authority and the Health Board think fit,

(dd) arrangements for the development of a strategy to support and develop the ability of the persons mentioned at paragraph (de)(i) to (iii) to participate in such planning and delivery of services.

Nanette Milne

203 In section 1, page 1, line 22, at end insert—

<(  ) arrangements for a single point of entry to complaints systems for all services provided in pursuance of functions delegated under paragraph (b) or (c).>

Alex Neil

5 In section 1, page 2, line 3, at end insert—

<(4A) A local authority may delegate a function under an integration scheme only if the function is conferred by an enactment listed in schedule (Enactments conferring on local authorities functions which may be delegated).

(4B) A Health Board may delegate a function under an integration scheme only if the function is prescribed.

(4C) The Scottish Ministers may by regulations prescribe which of the functions conferred by enactments listed in schedule (Enactments conferring on local authorities functions which may be delegated) local authorities must delegate under an integration scheme so far as the functions are exercisable in relation to persons of at least 18 years of age where the integration model mentioned in subsection (4)(a) or (b) is to apply under the scheme.

(4D) The Scottish Ministers may by regulations prescribe functions of Health Boards which Health Boards must delegate under an integration scheme so far as the functions are exercisable in relation to persons of at least 18 years of age where the integration model mentioned in subsection (4)(a) or (c) is to apply under the scheme.

(4E) If the integration model mentioned in subsection (4)(d) is to apply under an integration scheme either—

(a) the local authority must delegate the functions prescribed under subsection (4C) so far as the functions are exercisable in relation to persons of at least 18 years of age, or

(b) the Health Board must delegate the functions prescribed under subsection (4D) so far as the functions are exercisable in relation to persons of at least 18 years of age.

(4F) The Scottish Ministers may by regulations prescribe functions of Health Boards that a Health Board—

(a) must delegate under an integration scheme other than in prescribed circumstances,

(b) may not delegate under an integration scheme in prescribed circumstances.

(4G) The Scottish Ministers may by regulations prescribe which of the functions conferred by enactments listed in schedule (Enactments conferring on local authorities functions which may be delegated) local authorities may not delegate in prescribed circumstances.

(4H) The Scottish Ministers may by regulations remove an enactment from schedule (Enactments conferring on local authorities functions which may be delegated).>
In section 1, page 2, line 4, leave out from <by> to <(b)> in line 5

In section 1, page 2, line 6, leave out <plan> and insert <scheme>

In section 1, page 2, line 6, at end insert—

<(5A) This subsection applies where functions that a Health Board proposes to delegate under an integration scheme—
(a) are carried out in a hospital in the area of the Health Board, and
(b) are provided for the areas of two or more local authorities.>

In section 1, page 2, line 7, leave out subsection (6)

In section 1, page 2, line 8, leave out <, may or may not>

In section 1, page 2, line 10, leave out <, may or may not>

In section 1, page 2, leave out lines 12 to 21

Schedule

After section 53, insert—

<SCHEDULE
(introduced by section 1(4A))

ENACTMENTS CONFERRING ON LOCAL AUTHORITIES FUNCTIONS WHICH MAY BE DELEGATED

Sections 22, 26, 45 and 48 of the National Assistance Act 1948.
Sections 1, 4, 5, 6B, 8, 10, 12, 12A, 12AZA, 12AA, 12AB, 13 to 14, 27, 27ZA, 28, 29, 59, 78A, 80, 81, 83, 86 and 87 of the Social Work (Scotland) Act 1968.
Sections 34, 39, 40 and 50 of the Children Act 1975.
Section 24 of the Local Government and Planning (Scotland) Act 1982.
Sections 21, 22 and 23 of the Health and Social Services and Social Security Adjudications Act 1983.
Sections 3, 5, 6, 8, 9 and 10 of the Foster Children (Scotland) Act 1984.
Sections 2, 3, 7 and 8 of the Disabled Persons (Services, Consultation and Representation) Act 1986.
Sections 4, 5 and 5A and Part II of the Housing (Scotland) Act 1987.
Sections 17, 19 to 27, 29 to 32, 36 and 38 of the Children (Scotland) Act 1995.
Sections 10, 12, 37 and 39 to 45 of the Adults with Incapacity (Scotland) Act 2000.
Sections 1, 2, 5, 6, 8 and 92 of the Housing (Scotland) Act 2001.
Sections 5, 6 and 14 of the Community Care and Health (Scotland) Act 2002.
Sections 17, 25 to 27, 33, 34, 228 and 259 of the Mental Health (Care and Treatment) (Scotland) Act 2003.
Sections 10 and 11 of the Management of Offenders etc. (Scotland) Act 2005.
Section 71 of the Housing (Scotland) Act 2006.
Sections 1, 4, 5, 6, 9, 10, 11, 12, 19, 26, 45, 47, 48, 49, 51, 80, 90, 99 and 105 of the Adoption and Children (Scotland) Act 2007.
Sections 4 to 11, 14, 16, 18, 22, 40, 42 and 43 of the Adult Support and Protection (Scotland) Act 2007.
Sections 35, 37, 42, 44, 48, 49, 60, 131, 145, 166 and 167 of the Children’s Hearings (Scotland) Act 2011.
Sections 3, 5 to 13, 16 and 19 of the Social Care (Self-directed Support) (Scotland) Act 2013.

Section 2

Alex Neil
11 In section 2, page 2, line 27, leave out <as respects each local authority area>

Alex Neil
12 In section 2, page 2, line 29, leave out <plan> and insert <scheme>

Alex Neil
13 In section 2, page 2, line 32, leave out <plan> and insert <scheme>

Alex Neil
14 In section 2, page 2, line 32, at end insert—

<( ) For the purposes of subsection (4), if the local authorities and the Health Board decide that the integration model mentioned in paragraph (c) or (d) of section 1(4) is to apply—

(a) functions are to be delegated under those models to only one of the local authorities,
(b) the authorities and the Health Board must set out in the integration scheme which local authority the functions are to be delegated to (the “lead authority”),

(c) paragraph (c) of section 1(4) applies as if for the words “to the local authority” there were substituted the words “and the local authority or authorities to the lead authority”, and

(d) paragraph (d) of section 1(4) applies as if for the words from “to”, where it first occurs, to “local” there were substituted “or authorities to the Health Board and delegation of functions by the Health Board and the local authority or authorities to the lead”.

Alex Neil
15 In section 2, page 2, line 33, leave out <plan> and insert <scheme>

Alex Neil
16 In section 2, page 2, line 35, leave out <plan> and insert <scheme>

Alex Neil
17 In section 2, page 2, line 37, leave out <plans> and insert <schemes>

Section 3

Alex Neil
18 In section 3, page 3, line 3, leave out <plan> and insert <scheme>

Rhoda Grant
204 In section 3, page 3, line 6, at end insert—

<( ) outcomes agreed for the area of the local authority through community planning.>

( ) In this section “community planning” means planning to which the provisions of section 15(1) of the Local Government in Scotland Act 2003 (community planning) apply.

Section 4

Alex Neil
19 In section 4, page 3, line 9, leave out from <must> to end of line 11 and insert <are provided in pursuance of functions which are delegated under an integration scheme is to improve the wellbeing of service-users>

Malcolm Chisholm
19A As an amendment to amendment 19, line 3, after <wellbeing> insert <and independent living>

Alex Neil
20 In section 4, page 3, line 13, leave out <the> and insert <a>

Alex Neil
21 In section 4, page 3, line 14, leave out <recipients> and insert <service-users>
Malcolm Chisholm

205 In section 4, page 3, line 15, after <the> insert <rights and>

Nanette Milne

206 In section 4, page 3, line 15, after <needs> insert <aspirations, abilities, characteristics and circumstances>

Alex Neil

22 In section 4, page 3, line 15, leave out <recipients> and insert <service-users>

Malcolm Chisholm

207 In section 4, page 3, line 16, after first <the> insert <rights and>

Alex Neil

23 In section 4, page 3, line 16, leave out <recipients> and insert <service-users>

Alex Neil

24 In section 4, page 3, line 17, at end insert—

< ( ) takes account of the dignity of service-users,
( ) takes account of the participation by service-users in the community in which service-users live,>

Aileen McLeod

143 In section 4, page 3, line 17, at end insert—

< ( ) protects and improves the safety of service-users,
( ) improves the quality of the service,>

Malcolm Chisholm

208 In section 4, page 3, line 17, at end insert—

< ( ) is based on recognised guidance and adherence to established quality standards and promotes continuous improvement in the standard and quality of care,>

Malcolm Chisholm

Supported by: Nanette Milne

209 In section 4, page 3, line 17, at end insert—

< ( ) enables service-users to exercise choice and control and to participate in decisions regarding their need for services and the provision of those services to them,>

Alex Neil

25 In section 4, page 3, line 19, leave out <and local professionals> and insert <(including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)>

6
Alex Neil
26 In section 4, page 3, line 22, leave out <“recipients”> and insert <“service-users”>

Section 5

Bob Doris
210 In section 5, page 3, line 35, at end insert—

<(  ) persons working as a member of a relevant profession,>

Rhoda Grant
Supported by: Nanette Milne
211 In section 5, page 4, line 7, at end insert—

<(  ) other organisations contributing to the health and wellbeing of service-users.>

Section 6

Alex Neil
27 In section 6, page 4, line 10, leave out <plan> and insert <scheme>

Alex Neil
28 In section 6, page 4, line 11, leave out <plan> and insert <scheme>

Rhoda Grant
Supported by: Nanette Milne
212 In section 6, page 4, line 12, leave out from <consult> to <such> in line 13 and insert <secure the involvement in the planning process of—

(za) service-users,
(zb) unpaid carers,
(zc) non-commercial organisations who appear to the local authority and the Health Board to represent the interests of service-users and unpaid carers,
(a) such other>

Bob Doris
213 In section 6, page 4, line 14, at end insert—

<(  ) persons working as a member of a relevant profession, and>

Alex Neil
29 In section 6, page 4, line 16, leave out <plan> and insert <scheme>

Section 7

Alex Neil
30 In section 7, page 4, line 20, leave out <plan> and insert <scheme>
Alex Neil
31 In section 7, page 4, line 22, leave out <plan> and insert <scheme>

Alex Neil
32 In section 7, page 4, line 24, leave out <plan> and insert <scheme>

Alex Neil
33 In section 7, page 4, line 26, leave out <plan> and insert <scheme>

Alex Neil
34 In section 7, page 4, line 28, leave out <plan> and insert <scheme>

Alex Neil
144 In section 7, page 4, line 28, after <plan> insert <they must—

(a) give the local authority and the Health Board reasons for the refusal (including identifying which particular parts of the scheme caused them to decide to refuse approval),

(b) explain how the scheme should be modified, and

(c) specify a day by which>

Alex Neil
35 In section 7, page 4, line 29, leave out <plan> and insert <scheme>

Alex Neil
145 In section 7, page 4, line 29, leave out <under subsection (1)> and insert—

<( ) Following submission of a modified scheme under subsection (4), the Scottish Ministers may—

(a) approve the modified scheme, or

(b) refuse to approve it.

( ) Where the Scottish Ministers refuse to approve a modified scheme, the local authority and the Health Board are to be treated as if they failed before the prescribed day to submit an integration scheme under this section; and section 39 applies accordingly.>

Section 8

Alex Neil
36 In section 8, page 5, line 2, leave out <plan> and insert <scheme>

Section 9

Alex Neil
37 In section 9, page 5, line 7, leave out <plan> and insert <scheme>
In section 9, page 5, line 10, leave out <The functions are to be delegated before> and insert <If the functions are not delegated on the day specified by virtue of section 23(3A), they are delegated on>.

In section 10, page 5, line 23, leave out <the constituent authorities> and insert <each constituent authority>.

In section 10, page 5, line 27, leave out subsection (8).

In section 11, page 6, line 3, after <may> insert—

<(  ) make provision in relation to only one integration joint board, or some integration joint boards,>

In section 11, page 6, line 4, at end insert—

<(  ) Before making an order under this section, the Scottish Ministers must consult—>

(a) if the order relates to integration joint boards generally, each—

(i) local authority,

(ii) Health Board, and

(iii) integration joint board then established,

(b) if the order relates to one integration joint board, or some integration joint boards—

(i) the constituent authorities in relation to that or those boards, and

(ii) that or those boards, to the extent then established.>

In section 12, page 6, line 11, leave out <their functions> and insert <functions conferred on them by or by virtue of this Act>.

In section 12, page 6, line 12, leave out <local authority or Health Board> and insert <constituent authority>.
Alex Neil
45 In section 12, page 6, line 13, at end insert—

<( ) enabling integration joint boards to establish committees for any purpose,
( ) about such other matters relating to any such committee as the Scottish Ministers think fit,
( ) enabling an integration joint board to delegate to its chief officer, any other member of its staff or any such committee functions delegated to the integration joint board in pursuance of an integration scheme.>

Rhoda Grant
214 In section 12, page 6, line 15, at end insert—

<( ) An order making provision under subsection (1)(a) must include provision for the membership of integration joint boards to include representatives of—
(a) service-users,
(b) unpaid carers, and
(c) non-commercial organisations who appear to the local authority and the Health Board to represent the interests of service-users and unpaid carers.>

Bob Doris
215 In section 12, page 6, line 15, at end insert—

<( ) An order making provision under subsection (1)(a) must include provision for the membership of integration joint boards to include—
(a) at least one person working as a member of a relevant profession,
(b) such other persons as the Scottish Ministers think fit.>

Alex Neil
46 In section 12, page 6, line 16, leave out <this section> and insert <subsection (1) (other than an order containing provision of the type mentioned in paragraph (a) or (b) of that subsection)>.

Alex Neil
47 In section 12, page 6, line 16, after <may> insert—

<( ) make provision in relation to only one integration joint board, or some integration joint boards,
( )>

Alex Neil
48 In section 12, page 6, line 17, at end insert—

<( ) Before making an order under this section, the Scottish Ministers must consult—
(a) if the order relates to integration joint boards generally, each—
(i) local authority,
(ii) Health Board, and
(iii) integration joint board then established,
(b) if the order relates to one integration joint board, or some integration joint boards—

(i) the constituent authorities in relation to that or those boards, and

(ii) that or those boards, to the extent then established.

Alex Neil

49 In section 12, page 6, line 19, leave out <a local authority or a Health Board> and insert <their constituent authorities>

Alex Neil

50 In section 12, page 6, line 20, at end insert—

<(  ) Before making a scheme under subsection (3), the Scottish Ministers must consult—

(a) the integration joint board to which the scheme relates, and

(b) the constituent authorities in relation to that board.>

Rhoda Grant

216 In section 12, page 6, line 20, at end insert—

<(4) Before making a scheme under subsection (3) in relation to staff, the Scottish Ministers must consult in respect of each group mentioned in subsection (5), such persons appearing to be representative of the group as the Scottish Ministers think fit.

(5) The groups mentioned in subsection (4) are—

(a) health professionals,

(b) social care professionals,

(c) such other groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.>

After section 12

Alex Neil

51 After section 12, insert—

<Integration joint boards: finance and audit>

(1) The chief officer of an integration joint board has responsibility for the administration of the financial affairs of the integration joint board.

(2) In section 106 of the Local Government (Scotland) Act 1973 (application of Part 7 of Act to bodies other than local authorities etc.)—

(a) in subsection (1), after paragraph (ba) insert—

“(bb) an integration joint board established by order under section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014 (but subject to subsection (1A)),”’, and

(b) after that subsection, insert—

“(1A) Despite subsection (1), sections 95, 101A and 105A of this Act do not apply with respect to an integration joint board.”.>
After section 12, insert—

<Integration joint boards: complaints procedure>

1. The Scottish Ministers must establish a procedure by which a person, or someone acting on a person’s behalf, may make complaints (or other representations) in relation to services a person has received in pursuance of functions delegated to an integration joint board.

2. Before establishing a procedure under subsection (1), the Scottish Ministers must consult—
   (a) such persons or groups of persons appearing to them to have an interest as may be prescribed, and
   (b) such other persons as they think fit.

3. The Scottish Ministers must keep the procedure under review and must vary it whenever, after such consultation, they consider it appropriate to do so.

4. The Scottish Ministers must give such publicity to the procedure (including the procedure as varied under subsection (3)) as they consider appropriate and must give a copy of the procedure to any person who requests it.

5. In schedule 2 to the Scottish Public Services Ombudsman Act 2002, after paragraph 17A (relating to Prisons) insert—

   “Integration joint boards

   17B An integration joint board established by order under section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014.”.

Section 13

In section 13, page 6, line 23, leave out <plan> and insert <scheme>

Malcolm Chisholm

In section 13, page 6, line 26, after <payment> insert <or notional payment>

In section 13, page 6, line 27, leave out from <calculated> to <calculation> and insert <determined in accordance with the method>

In section 13, page 6, line 28, at end insert—
Where an integration scheme contains provision of the type mentioned in section 1(3)(ca), the Health Board must set aside for use by the integration joint board an amount determined in accordance with the method set out in the scheme in relation to each function delegated by it.

Alex Neil
57 In section 13, page 6, line 29, at beginning insert "Where an integration scheme contains provision of the type mentioned in section 1(3)(d),"

Alex Neil
58 In section 13, page 6, line 30, leave out from "calculated" to "calculation" and insert "determined in accordance with the method"

Alex Neil
59 In section 13, page 6, line 30, leave out "plan" and insert "scheme"

Section 14

Alex Neil
60 In section 14, page 6, line 34, leave out "plan" and insert "scheme"

Alex Neil
61 In section 14, page 6, line 34, at end insert—

(1A) If the functions are not delegated on the day specified by virtue of section 23(3A), they are delegated on the prescribed day.

Alex Neil
62 In section 14, page 6, line 35, leave out "prescribed day" and insert "functions are delegated,"

Alex Neil
63 In section 14, page 6, leave out line 39

Section 15

Alex Neil
64 In section 15, page 7, line 3, leave out "plan" and insert "scheme"

Rhoda Grant
218 In section 15, page 7, line 4, at end insert—

(1A) Before making a scheme under subsection (1) in relation to staff, the Scottish Ministers must consult in respect of each group mentioned in subsection (1B), such persons appearing to be representative of the group as the Scottish Ministers think fit.

(1B) The groups mentioned in subsection (1A) are—

(a) health professionals,
(b) social care professionals,
(c) such other groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.>

Alex Neil

65 In section 15, page 7, line 5, leave out <plan> and insert <scheme>

Alex Neil

66 In section 15, page 7, line 6, at end insert—

<( ) Before making a scheme under subsection (1), the Scottish Ministers must consult—

(a) the person who is to delegate functions under an integration scheme falling within
subsection (2), and

(b) the person to whom the functions are to be delegated.>

Section 16

Rhoda Grant

219 In section 16, page 7, line 13, at end insert—

<( ) An order making provision under subsection (1)(a) must include provision for the membership of integration joint monitoring committees to include representatives of—

(a) service-users,

(b) unpaid carers, and

(c) non-commercial organisations who appear to the local authority and the Health Board to represent the interests of service-users and unpaid carers.>

Bob Doris

220 In section 16, page 7, line 13, at end insert—

<( ) An order making provision under subsection (1)(b) must include provision for the membership of integration joint monitoring committees to include—

(a) at least one person working as a member of a relevant profession,

(b) such other persons as the Scottish Ministers think fit.>

Section 17

Alex Neil

67 In section 17, page 7, line 18, leave out <plan> and insert <scheme>

Alex Neil

68 In section 17, page 7, line 20, leave out <plan> and insert <scheme>

Alex Neil

69 In section 17, page 7, line 21, leave out from <calculated> to <calculation> in line 22 and insert <determined in accordance with the method>
Alex Neil

70 In section 17, page 7, line 22, leave out <plan> and insert <scheme>

Section 18

Alex Neil

71 In section 18, page 7, line 25, leave out <Subsection (2)> and insert <This section>

Alex Neil

72 In section 18, page 7, line 26, leave out <plan> and insert <scheme>

Alex Neil

73 In section 18, page 7, line 28, leave out <plan> and insert <scheme>

Alex Neil

74 In section 18, page 7, line 28, at end insert—

<(1A) Where an integration scheme contains provision of the type mentioned in section 1(3)(ca), the Health Board must set aside for use by the local authority an amount determined in accordance with the method set out in the scheme in relation to each function delegated to the local authority.>

Alex Neil

75 In section 18, page 7, line 29, at beginning insert <Where an integration scheme contains provision of the type mentioned in section 1(3)(d),>

Alex Neil

76 In section 18, page 7, line 29, leave out from <calculated> to <is> in line 30 and insert <determined in accordance with the method>  

Alex Neil

77 In section 18, page 7, line 30, leave out <plan> and insert <scheme>

Alex Neil

78 In section 18, page 7, line 31, at end insert—

<( ) Each local authority which delegates functions to another local authority (the “lead authority”) under the scheme must make a payment to the lead authority of the amount determined in accordance with the method set out in the scheme in relation to each function delegated by the authority to the lead authority.>

After section 18

Alex Neil

79 After section 18, insert—

<Health funding: further provision

(1) This section applies where under section 13(2A) or 18(1A) a Health Board is required to set aside an amount in respect of certain functions delegated to an integration authority.
(2) The integration authority may by direction require a Health Board—
   (a) to carry out a function delegated to the integration authority by the Health Board
       and in relation to which amounts have been set aside, and
   (b) to use an amount of the set aside amount specified in the direction (the “specified
       amount”) for that purpose.

(3) If the integration authority gives a direction under subsection (2) and, despite the
    direction, the Health Board does not use all of the specified amount, the integration
    authority may require the Health Board to pay to it the unused amount of the specified
    amount.

(4) If the integration authority gives a direction under subsection (2) and, despite the
    direction, the Health Board requires to use more than the specified amount, the Health
    Board may require the integration authority to reimburse it for the additional amount
    used.

(5) The Health Board must give reports to the integration authority about such matters
    relating to the amounts set aside as the integration authority may specify.

(6) Reports under subsection (5) must be given at such times and in relation to such periods
    as the integration authority may specify.

Section 19

Alex Neil

80 In section 19, page 7, line 33, leave out <or 15(1)> and insert <, 15(1) or 36(3)>

Alex Neil

81 In section 19, page 8, line 13, at end insert—
   <( ) Nothing in subsection (3)—
   (a) imposes on the new employer any liability for a share in any deficit in a pension
       scheme of the original employer that—
       (i) is attributable to the person’s membership of the scheme, and
       (ii) accrued before the day of the transfer, or
   (b) confers any right on the new employer in respect of a share in any surplus in such
       a pension scheme that is so attributable and that so accrued.>

Section 20

Alex Neil

82 In section 20, page 8, line 23, leave out <plans> and insert <schemes>

Alex Neil

83 In section 20, page 8, line 25, leave out from <buildings> to end of line 26 and insert <their
   resources (including in particular buildings, staff and equipment) in pursuance of the scheme or
   schemes.>
After section 20

Alex Neil

84 After section 20, insert—

<Carrying out of functions conferred on officers of local authorities>

(1) This section applies where a function conferred by an enactment on an officer of a local authority relates to a function delegated to an integration authority under an integration scheme.

(2) Where the integration authority is an integration joint board, the function is deemed to have been conferred also on an officer of the Health Board and any other local authorities that are the constituent authorities of the integration joint board.

(3) Where the integration authority is a local authority or Health Board, the function is deemed to have been conferred also on an officer of the Health Board and any other local authority which prepared the integration scheme.>

Alex Neil

85 After section 20, insert—

<Carrying out of functions conferred on officers of Health Boards>

(1) This section applies where a function conferred by an enactment on an officer of a Health Board relates to a function delegated to an integration authority under an integration scheme.

(2) Where the integration authority is an integration joint board, the function is deemed to have been conferred also on an officer of the local authority or authorities that are the constituent authorities of the integration joint board.

(3) Where the integration authority is a local authority or Health Board, the function is deemed to have been conferred also on an officer of the local authority or authorities which prepared the integration scheme.>

Section 21

Alex Neil

86 In section 21, page 8, line 32, leave out <plan> and insert <scheme>

Alex Neil

87 In section 21, page 8, line 33, leave out subsections (2) to (5) and insert—

<(2) The integration authority to which the function is delegated is to carry out the function.

(3) The integration authority has all of the powers and duties from time to time applying in connection with the carrying out of the function.

(4) Despite subsection (2), the delegation of the function in pursuance of an integration scheme does not prevent the carrying out of the function by the person by whom the delegation is made.

(5) The Scottish Ministers may by order provide that an integration authority which is an integration joint board must or must not exercise a power of the type mentioned in subsection (3) in connection with the carrying out of a function specified in the order.>
Alex Neil

88 Leave out section 22 and insert—

Directions by integration authority

(1) Where the integration authority is an integration joint board, it must give a direction to a constituent authority to carry out on its behalf each function delegated to the integration authority.

(2) Where the integration authority is a local authority or a Health Board, it may give a direction to the Health Board or local authority which prepared the integration scheme by virtue of which it is the integration authority to carry out on its behalf any function delegated to the integration authority.

(3) A person to whom a direction under this section may be given must provide the integration authority with such information as the integration authority may reasonably require for the purpose of its deciding—

(a) whether to give the direction,

(b) the content of the direction.

(4) A direction under this section may be given to more than one person in relation to the same function.

(5) If a direction such as is mentioned in subsection (4) is given, the direction may—

(a) require the persons to carry out the function jointly or only in so far as is specified in the direction,

(b) require each person to carry out the function in relation to an area specified in the direction,

(c) require each person to do particular things in relation to the function.

After section 22

Alex Neil

89 After section 22, insert—

Section (Directions by integration authority): supplementary

(1) A direction under section (Directions by integration authority)—

(a) must set out, or set out a method of determining, payments that are to be made by the integration authority to the person who is to carry out the function on its behalf,

(b) may—

(i) regulate the manner in which the function is to be carried out,

(ii) make such supplementary, incidental or consequential provision as the integration authority considers appropriate.

(2) The provision referred to in subsection (1)(b)(ii) may include in particular the imposition on the person who is to carry out the function of requirements—

(a) to provide information to the integration authority,
(b) to take action to enable the integration authority to comply with any order of a court made against it in connection with the carrying out of the function,

(b) to reimburse the integration authority in relation to any liabilities incurred by the integration authority in connection with the carrying out of the function.

(3) The integration authority must make payments in accordance with the provision included in the direction by virtue of subsection (1)(a).

(4) A person to whom a direction under section (Directions by integration authority) is given must comply with the direction.

(5) A direction under section (Directions by integration authority)—

(a) may vary or revoke an earlier direction under that section given by the same integration authority,

(b) must be in writing.

(6) If the conditions in subsection (7) are met, the Scottish Ministers may by order provide that an integration authority which is an integration joint board—

(a) may decide not to give a direction under section (Directions by integration authority) in relation to the carrying out of a function specified in the order, or

(b) may give a direction under that section, despite the making of the order.

(7) The conditions are—

(a) that the Scottish Ministers receive a written application from the constituent authorities requesting that an order be made in relation to the functions specified in the application, and

(b) that the Scottish Ministers consider that the making of an order in relation to some or all of those functions would improve compliance with the national health and wellbeing outcomes.

(8) If the Scottish Ministers do not consider under subsection (7)(b) that the making of an order under subsection (6) would improve compliance with the national health and wellbeing outcomes in relation to any functions, they need not include those functions in the order.

Section 23

Malcolm Chisholm

147 In section 23, page 10, line 22, at end insert <in accordance with regulations under subsection (3ZA).

(3ZA) The Scottish Ministers must by regulations set out the key principles of locality planning for the purposes of subsection (3).

Alex Neil

90 In section 23, page 10, line 22, at end insert—

<(3A) If the functions of the integration authority are not to be delegated to the authority on the day prescribed under section 9(3) or, as the case may be, section 14(1A), the first strategic plan must specify the day on which functions are to be delegated to the authority.>
Alex Neil
91 In section 23, page 10, line 24, leave out <prescribed> and insert <integration start>

Alex Neil
92 In section 23, page 10, line 24, leave out from <and> to end of line 25

Alex Neil
93 In section 23, page 10, line 26, leave out subsection (5)

Alex Neil
94 In section 23, page 10, line 30, at end insert—
<(  ) In this section, “integration start day” means—
(a) in relation to an integration authority which is an integration joint board, the day
on which functions are delegated to the authority by virtue of subsection (3A) or,
as the case may be, section 9(3),
(b) in relation to any other integration authority, the day on which functions are
delegated by virtue of subsection (3A) or, as the case may be, section 14(2) to, or
to the constituent authorities of, the integration authority.>

Section 24

Alex Neil
95 In section 24, page 10, line 32, leave out from beginning to <local> and insert <This section
applies where an integration authority in relation to the area of a local authority is preparing a
strategic plan.
(  ) The integration>

Rhoda Grant
221 In section 24, page 10, line 35, at end insert—
<(  ) outcomes agreed for the area of the local authority through community planning.
(  ) In this section “community planning” means planning to which the provisions of section
15(1) of the Local Government in Scotland Act 2003 (community planning) apply.>

Alex Neil
96 In section 24, page 10, line 35, at end insert—
<(3) The integration authority must have regard to the effect which any arrangements which
it is considering setting out in the strategic plan in pursuance of section 23(2)(a) may
have on services, facilities or resources—
(a) utilised by arrangements set out in pursuance of that section in a strategic plan
prepared by another integration authority,
(b) which would be utilised by arrangements which another integration authority is
considering setting out in pursuance of that section in a strategic plan which it is
preparing.
The references in subsections (3)(a) and (b) to a strategic plan are to a strategic plan relating to the same period as, or relating to part of the same period as, the strategic plan which is being prepared by the integration authority.

**After section 24**

**Malcolm Chisholm**

222 After section 24, insert—

<24A **Duty to seek, record and have due regard to advice**

(1) In preparing a strategic plan, an integration authority for the area of a local authority must, where appropriate, seek, record and have due regard to the professional advice of the persons specified in subsection (3) in respect of issues relating to quality and safety.

(2) An integration authority for the area of a local authority must set out arrangements for how it will, where appropriate, seek, record and have due regard to the professional advice of the persons specified in subsection (3) in respect of issues relating to quality and safety in the carrying out of the integration functions for the area of the local authority.

(3) The persons are—

(a) the chief social work officer of the local authority,
(b) a registered medical practitioner nominated by the relevant Health Board,
(c) a registered nurse nominated by the relevant Health Board,
(d) a registered allied health professional nominated by the relevant Health Board,
(e) any other person prescribed by regulations made by the Scottish Ministers.>

**Section 25**

**Alex Neil**

97 In section 25, page 11, line 1, leave out from <must> to end of line 3 and insert <are provided in pursuance of functions which are delegated under an integration scheme is to improve the wellbeing of service-users,>

**Malcolm Chisholm**

97A As an amendment to amendment 97, line 3, after <wellbeing> insert <and independent living>

**Rhoda Grant**

223 In section 25, page 11, line 5, after <provided> insert <or commissioned>

**Alex Neil**

98 In section 25, page 11, line 5, leave out <the> and insert <a>

**Alex Neil**

99 In section 25, page 11, line 6, leave out <recipients> and insert <service-users>

**Malcolm Chisholm**

224 In section 25, page 11, line 7, after <the> insert <rights and>
Nanette Milne

225 In section 25, page 11, line 7, after <needs> insert <, aspirations, abilities, characteristics and circumstances>.

Alex Neil

100 In section 25, page 11, line 7, leave out <recipients> and insert <service-users>.

Malcolm Chisholm

226 In section 25, page 11, line 8, after first <the> insert <rights and>.

Alex Neil

101 In section 25, page 11, line 8, leave out <recipients> and insert <service-users>.

Alex Neil

102 In section 25, page 11, line 9, at end insert—

<(  ) takes account of the dignity of service-users,
(  ) takes account of the participation by service-users in the community in which service-users live,
(  ) protects and improves the safety of service-users,
(  ) improves the quality of the service,>.

Rhoda Grant

227 In section 25, page 11, line 9, at end insert—

<(  ) takes account of the particular needs of service-users moving into the area of the local authority from the area of another local authority,>.

Rhoda Grant

228 In section 25, page 11, line 9, at end insert—

<(  ) improves the quality of the service to service-users in the community, particularly in relation to the amount of time afforded to those service-users,>.

Malcolm Chisholm

229 In section 25, page 11, line 9, at end insert—

<(  ) is based on recognised guidance and adherence to established quality standards and promotes continuous improvement in the standard and quality of care,>.

Malcolm Chisholm

Supported by: Nanette Milne

230 In section 25, page 11, line 9, at end insert—

<(  ) enables service-users to exercise choice and control and to participate in decisions regarding their need for services and the provision of those services to them,>.
Alex Neil

In section 25, page 11, line 11, leave out <and local professionals> and insert <(including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)>.

Rhoda Grant

In section 25, page 11, line 12, at end insert—

<( ) supports and rewards people who deliver those services in the provision of high quality care to service-users, and>.

Alex Neil

In section 25, page 11, line 14, leave out <“recipients”> and insert <“service-users”>.

Section 26

Alex Neil

In section 26, page 11, line 17, leave out <For the purpose of preparing a> and insert <Before preparing its first>

Alex Neil

In section 26, page 11, line 18, after <group> insert <(its “strategic planning group”)>.

Alex Neil

In section 26, page 11, line 19, leave out from <one> to end of line 21 and insert—

<(i) at least one person nominated by the Health Board which is a constituent authority in relation to the integration joint board,

(ii) where one local authority is a constituent authority in relation to the integration joint board, at least one person nominated by it,

(iii) where two or more local authorities are constituent authorities in relation to the integration joint board, at least one person nominated by the authorities,>.

Alex Neil

In section 26, page 11, line 22, leave out <one person nominated by the local authority> and insert <at least one person nominated by the local authority or authorities>.

Alex Neil

In section 26, page 11, line 23, leave out <plan> and insert <scheme>.

Alex Neil

In section 26, page 11, line 25, after <authority> insert <at least>.

Alex Neil

In section 26, page 11, line 26, leave out <plan> and insert <scheme>.
Bob Doris

232 In section 26, page 11, line 32, after <are> insert—

{(  ) persons working as a member of a relevant profession,
(  )>

Rhoda Grant

233 In section 26, page 11, line 33, at end insert <and must include—

(a) service-users,
(b) unpaid carers, and
(c) non-commercial organisations who represent the interests of service-users and unpaid carers.>

Alex Neil

112 In section 26, page 11, line 33, at end insert—

<(2A) The integration authority is to determine—
(a) the number of members of its strategic planning group,
(b) so far as not set out in this section, the processes for appointment, removal and replacement of members.

(2B) The integration authority may—
(a) appoint members of its strategic planning group from persons nominated under subsection (1),
(b) in such circumstances as the authority considers appropriate, remove persons appointed under paragraph (a) from membership of the group,
(c) appoint members in place of members who resign or are removed from membership of the group.

(2C) A constituent authority may—
(a) remove from its strategic planning group a member appointed to represent it,
(b) nominate under subsection (1) another person in place of a member of the group appointed to represent it.

(2D) A member of a strategic planning group may resign at any time.

(2E) During the period to which any strategic plan of an integration authority relates, its strategic planning group is also to comprise a person to represent the interests of each locality set out in the plan in pursuance of section 23(3)(a).

(2F) It is for the integration authority to—
(a) decide which persons are suitable to represent the interests of a locality, and
(b) select the representative.

(2G) An integration authority may under subsection (2F)(b) select a single person in respect of two or more localities.

(2H) The validity of anything done by an integration authority’s strategic planning group is not affected by any vacancy in its membership.>
In section 26, page 11, line 34, leave out second <the> and insert <an integration authority’s strategic planning>.

In section 26, page 11, line 35, leave out first <The> and insert <An>.

In section 26, page 11, line 35, leave out second <the> and insert <its strategic planning>.

In section 26, page 11, line 36, at end insert—

<(5) The integration authority must make such arrangements as it considers necessary to secure the effective involvement of persons representing the groups mentioned in subsection (2)(a), (b) and (c).>

<(6) Arrangements under subsection (5) may, in particular, include arrangements for—

(a) paying such expenses as appear to the authority to be necessary, including the cost of replacement care,

(b) providing information in a timely fashion and in a format that is accessible to members of the group,

(c) ensuring the accessibility of venues for any meetings of the group,

(d) ensuring access to appropriate training for members of the group.>

Section 27

In section 27, page 11, line 38, leave out from beginning to <local> in line 39 and insert <This section applies where an integration authority in relation to the area of a local authority is preparing a strategic plan.>

In section 27, page 12, line 1, leave out second <the> and insert <its strategic planning>.

In section 27, page 12, line 2, leave out <(1)(b)> and insert <(1A)(b)>.

In section 27, page 12, line 5, leave out second <the> and insert <its strategic planning>.

In section 27, page 12, line 15, leave out from second <the> to end of line 17 and insert <each constituent authority,>.
In section 27, page 12, line 19, leave out <plan> and insert <scheme>.

In section 27, page 12, line 22, leave out <plan> and insert <scheme>.

In section 27, page 12, line 26, after <are> insert—

<( ) persons working as a member of a relevant profession, ( )>

After section 27

After section 27, insert—

<Provision of information for purpose of preparing strategic plan>

(1) A constituent authority must provide an integration authority which is an integration joint board with such information as the authority may reasonably require for the purpose of preparing a strategic plan.

(2) The person mentioned in subsection (3) must provide an integration authority which is a Health Board or a local authority with such information as the integration authority may reasonably require for the purpose of preparing a strategic plan.

(3) That person is the local authority or the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions.>

Section 28

In section 28, page 12, line 41, at end insert—

<( ) groups appearing to the integration authority to be representative of non-commercial organisations contributing to the health and wellbeing of service-users in the area covered by the strategic plan.>

Leave out section 28

Section 29

In section 29, page 13, line 4, leave out <occurrence of the event mentioned in subsection (2)> and insert <finalisation of the plan under section 27>

In section 29, page 13, line 6, leave out subsection (2)
Section 30

Alex Neil

127 In section 30, page 13, line 19, leave out <in its next strategic plan> and insert <by virtue of revising its strategic plan under section (Review of strategic plan)>.

Alex Neil

128 In section 30, page 13, line 23, after <must> insert—

<(  ) seek and have regard to the views of its strategic planning group, and>

Rhoda Grant

237 In section 30, page 13, line 25, at end insert—

<(  ) non-commercial providers of health care or social care, and
(  ) other relevant bodies who may be affected by the decision.>

After section 30

Alex Neil

129 After section 30, insert—

<Review of strategic plan
(1) An integration authority—
(a) must before the expiry of the relevant period review the effectiveness of its strategic plan,
(b) may from time to time carry out such a review.
(2) In carrying out a review under subsection (1), the integration authority must—
(a) have regard to—
(i) the integration delivery principles, and
(ii) the national health and wellbeing outcomes, and
(b) seek and have regard to the views of its strategic planning group on—
(i) the effectiveness of the arrangements for the carrying out of the integration functions in the area of the local authority, and
(ii) whether the integration authority should prepare a replacement strategic plan.
(3) Following a review under subsection (1), an integration authority may prepare a replacement strategic plan.
(4) Subject to subsection (2), the process of such a review is to be such as the integration authority determines.
(5) A constituent authority must provide an integration authority which is an integration joint board with such information as the integration authority may reasonably require for the purpose of carrying out a review under subsection (1).>
(6) The person mentioned in subsection (7) must provide an integration authority which is a Health Board or a local authority with such information as the integration authority may reasonably require for the purpose of carrying out a review under subsection (1).

(7) That person is the local authority or the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions.

(8) A strategic plan prepared in pursuance of this section must specify a day on which the period of the plan is to begin.

(9) In subsection (1), “relevant period”, in relation to an integration authority, means—
   (a) the period of 3 years beginning with the integration start day (as defined in section 23(4)), and
   (b) each subsequent period of 3 years beginning with—
      (i) where a replacement strategic plan is prepared following a review under subsection (1), the day specified under subsection (8),
      (ii) where no replacement strategic plan is prepared following such a review, the day on which the integration authority decides not to prepare a revised strategic plan.>

Alex Neil

130 After section 30, insert—

<Requirement to prepare replacement strategic plan

(1) This section applies where the integration authority in relation to the area of a local authority is an integration joint board.

(2) If it appears to a constituent authority that the strategic plan is preventing, or is likely to prevent, the constituent authority from carrying out any of its functions appropriately or in a way which is consistent with the integration delivery principles and the national health and wellbeing outcomes, the constituent authorities acting jointly may direct the integration authority to prepare a replacement strategic plan.

(3) A direction under subsection (2) must—
   (a) be in writing,
   (b) include a statement summarising the reasons for giving it.

(4) A direction under subsection (2) must specify—
   (a) a day by which the replacement strategic plan must be prepared, and
   (b) a day on which the period of the plan is to begin.

(5) The constituent authorities acting jointly may by direction substitute a different day for a day specified under subsection (4).

(6) An integration authority must comply with a direction given to it under subsection (2).>

Alex Neil

131 After section 30, insert—

<Strategic plan: annual financial statement

(1) Each integration authority must publish an annual financial statement—
(a) when it publishes its first strategic plan, and
(b) each year after that.

(2) An annual financial statement must set out in relation to the strategic plan to which it relates the amount that the integration authority intends to spend in implementation of the plan.

Section 32

Alex Neil

132 In section 32, page 13, line 33, after <where> insert—

<(  ) an integration authority carrying out an integration function for the area of a local authority proposes to take a decision which the authority considers might significantly affect the provision in a locality of the area of a service provided in pursuance of the function, or

(  )>

Alex Neil

133 In section 32, page 14, line 1, leave out <person must take such action as the> and insert <integration authority or, as the case may be, person must take such action as the authority or>

Alex Neil

134 In section 32, page 14, line 4, at end insert—

<(  ) The integration authority may pay to members of groups consulted under subsection (3) such expenses and allowances as the authority determines.>

Section 33

Alex Neil

135 In section 33, page 14, line 6, leave out <and publish>

Alex Neil

136 In section 33, page 14, line 9, after <year> insert <to which it relates>

Alex Neil

137 In section 33, page 14, leave out line 12 and insert—

<(3A) An integration authority must—

(a) publish each performance report before the expiry of the period of 4 months beginning with the end of the reporting year, and

(b) provide a copy of it to the persons mentioned in subsection (3B).

(3B) Those persons are—

(a) where the integration authority is an integration joint board, each constituent authority,

(b) where the integration authority is a local authority and a Health Board acting jointly, the integration joint monitoring committee,
(c) where the integration authority is a Health Board or a local authority—
   (i) the integration joint monitoring committee, and
   (ii) the other authority.

(3C) A constituent authority must provide an integration authority which is an integration joint board with such information as the authority may reasonably require for the purpose of preparing a performance report.

(3D) The other authority must provide an integration authority which is a Health Board or a local authority with such information as the integration authority may reasonably require for the purpose of preparing a performance report.

Alex Neil

138 In section 33, page 14, line 13, after <section> insert—

   <“other authority” means the local authority or the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions,>
Alex Neil
156 In section 34, page 14, line 33, at end insert—

<(  ) change the method of determining amounts to be made available as mentioned in section 1(3)(ca),>

Alex Neil
157 In section 34, page 14, line 34, leave out <calculating> and insert <determining>

Alex Neil
158 In section 34, page 14, line 35, leave out <plan> and insert <scheme>

Alex Neil
159 In section 34, page 14, line 37, leave out <plan> and insert <scheme>

Section 35

Alex Neil
160 In section 35, page 15, line 2, leave out <plan> and insert <scheme>

Alex Neil
161 In section 35, page 15, line 5, leave out <plan> and insert <scheme>

Alex Neil
162 In section 35, page 15, line 7, leave out <plan> and insert <scheme>

Section 36

Alex Neil
163 In section 36, page 15, line 10, leave out <plan> and insert <scheme>

Alex Neil
164 In section 36, page 15, line 12, leave out <plan by a new integration plan> and insert <scheme by a new integration scheme>

Alex Neil
165 In section 36, page 15, line 15, leave out <plan by a new integration plan> and insert <scheme by a new integration scheme>

Section 37

Alex Neil
166 In section 37, page 15, line 21, leave out <plan> and insert <scheme>

Alex Neil
167 In section 37, page 15, line 23, leave out <plan> and insert <scheme>
Alex Neil
168 In section 37, page 15, line 25, leave out <plan> and insert <scheme>

Alex Neil
169 In section 37, page 15, line 26, leave out <plan> and insert <scheme>

Alex Neil
170 In section 37, page 15, line 35, leave out <plan> and insert <scheme>

Section 39

Alex Neil
171 In section 39, page 16, line 10, leave out <plan> and insert <scheme>

Section 40

Alex Neil
172 In section 40, page 16, line 27, leave out <plan> and insert <scheme>

Alex Neil
173 In section 40, page 16, line 28, leave out <plan> and insert <scheme>

Alex Neil
174 In section 40, page 16, line 33, leave out <plan> and insert <scheme>

Alex Neil
175 In section 40, page 16, line 34, leave out <plan> and insert <scheme>

Alex Neil
176 In section 40, page 16, line 39, leave out <plan> and insert <scheme>

Section 42

Alex Neil
177 In section 42, page 17, line 13, leave out <plan> and insert <scheme>

Alex Neil
178 In section 42, page 17, line 15, leave out <plan> and insert <scheme>

Alex Neil
179 In section 42, page 17, line 16, leave out <plan> and insert <scheme>

Alex Neil
180 In section 42, page 17, line 19, leave out <plan> and insert <scheme>
In section 42, page 17, line 22, leave out <plan> and insert <scheme>

Section 43

In section 43, page 17, line 29, leave out <plan> and insert <scheme>

In section 43, page 17, line 31, leave out <plan> and insert <scheme>

In section 43, page 17, line 32, leave out <plan> and insert <scheme>

In section 43, page 17, line 34, leave out <plan> and insert <scheme>

In section 43, page 17, line 36, leave out <plan> and insert <scheme>

In section 43, page 17, line 38, leave out <plan> and insert <scheme>

In section 43, page 18, line 1, leave out <plan> and insert <scheme>

In section 43, page 18, line 4, leave out <plan> and insert <scheme>

In section 43, page 18, line 7, leave out <plan> and insert <scheme>

After section 43

After section 43, insert—

<Meaning of “constituent authority”>
For the purposes of this Part, each local authority and the Health Board which prepared the integration scheme in pursuance of which an integration joint board was, or is to be, established is a “constituent authority” in relation to that board.>

Section 45

In section 45, page 19, line 22, leave out <plan> and insert <scheme>
Alex Neil
193 In section 45, page 19, line 25, leave out <plan> and insert <scheme>

Section 48

Alex Neil
194 In section 48, page 20, line 23, leave out <plan> and insert <scheme>

Bob Doris
238 In section 48, page 20, line 24, at end insert—

<“relevant profession” has the same meaning as in the Health Professions Order 2001,>

Alex Neil
195 In section 48, page 20, line 35, leave out <and 37(1)> and insert <, 37(1) and (Meaning of “constituent authority”)>  

Alex Neil
196 In section 48, page 20, line 36, leave out <plan> and insert <scheme>

Alex Neil
197 In section 48, page 20, line 38, leave out <plan> and insert <scheme>

Alex Neil
198 In section 48, page 21, line 1, leave out <plan> and insert <scheme>

Alex Neil
199 In section 48, page 21, line 3, leave out <plan> and insert <scheme>

Section 49

Alex Neil
200 In section 49, page 21, line 11, leave out <section> and insert <sections 1(4H) and>

Malcolm Chisholm
201 In section 49, page 21, line 11, after <5(1)> insert <and 23(3ZA)>

Malcolm Chisholm
239 In section 49, page 21, line 11, after <5(1)> insert <and 24A(3)(e)>
1st Groupings of Amendments for Stage 2

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted;
- the text of amendments to be debated on the first day of Stage 2 consideration, set out in the order in which they will be debated. THIS LIST DOES NOT REPLACE THE MARSHALLED LIST, WHICH SETS OUT THE AMENDMENTS IN THE ORDER IN WHICH THEY WILL BE DISPOSED OF.

Groupings of amendments

“Integration plan” to “integration scheme”
1, 2, 7, 12, 13, 15, 16, 17, 18, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 52, 53, 55, 59, 60, 64, 65, 67, 68, 70, 72, 73, 77, 82, 86, 109, 111, 121, 122, 148, 149, 150, 151, 152, 153, 154, 155, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 192, 193, 194, 196, 197, 198, 199

Budget for delegated functions
3, 4, 8, 146, 54, 56, 57, 58, 69, 71, 74, 75, 76, 78, 79, 156, 157

Integration plan: arrangements to be incorporated
202, 203

Functions which may, must, or may not be delegated
5, 6, 9, 140, 141, 142, 10, 200

Notes on amendments in this group
Amendment 9 pre-empts amendments 140, 141 and 142

Minor and technical
11, 39, 40, 44, 49, 83, 120, 191, 195

Integration scheme: two or more authorities
14

Considerations in preparing integration plan: community planning outcomes
204
Principles

Consultation and involvement of persons working as members of a “relevant profession”
210, 213, 215, 220, 232, 235, 238

National health and wellbeing outcomes: consultation
211

Integration plan: consultation
212

Integration plan: modified scheme
144, 145

Timing of delegation of functions
38, 61, 62, 63

Integration joint boards: operation
41, 42, 43, 45, 214, 46, 47, 48, 51, 217

Transfer of staff etc.
50, 216, 218, 66, 80, 81

Integration joint monitoring committees: membership
219

Carrying out of functions
84, 85, 87, 88, 89

Strategic plan: process
147, 90, 91, 92, 93, 94, 116, 118, 123, 236, 124, 125, 126, 131, 201

Strategic plan: preparation considerations
95, 221, 96, 222, 239

Strategic planning group

Strategic plan: review and replacement
127, 128, 237, 129, 130

Consultation regarding proposed decision which may significantly affect service provision
132, 133, 134

Integration authority: performance report
135, 136, 137, 138, 139
HEALTH AND SPORT COMMITTEE

EXTRACT FROM THE MINUTES

2nd Meeting, 2014 (Session 4)

Tuesday 21 January 2014

Present:
Malcolm Chisholm (Committee Substitute)  Bob Doris (Deputy Convener)
Rhoda Grant                        Colin Keir
Richard Lyle                        Aileen McLeod
Duncan McNeil (Convener)        Nanette Milne
Gil Paterson

Also present: Alex Neil (Cabinet Secretary for Health and Well-being)

Apologies were received from Dr Richard Simpson.

Public Bodies (Joint Working) (Scotland) Bill: The Committee considered the Bill at Stage 2 (Day 1).

The following amendments were agreed to (without division): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 143, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 144, 35, 145, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 216, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 218, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93 and 94.

The following amendments were disagreed to (by division)—
   202 (For 4, Against 5, Abstentions 0)
   19A (For 4, Against 5, Abstentions 0)
   205 (For 4, Against 5, Abstentions 0)
   206 (For 4, Against 5, Abstentions 0)
   207 (For 4, Against 5, Abstentions 0)
   209 (For 4, Against 5, Abstentions 0)
   211 (For 4, Against 5, Abstentions 0)
   212 (For 4, Against 5, Abstentions 0).

The following amendments were moved and, no member having objected, withdrawn: 204, 210, 219 and 147

The following amendments were pre-empted: 140, 141 and 142.

The following amendments were not moved: 203, 208, 213, 214, 215, 217, 146 and 220.

Sections 5 and 16 were agreed to without amendment.
The following provisions were agreed to as amended: sections 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22 and 23.

The Committee ended consideration of the Bill for the day, section 23 having been agreed to.
Scottish Parliament

Health and Sport Committee

Tuesday 21 January 2014

[The Convener opened the meeting at 09:45]

Public Bodies (Joint Working) (Scotland) Bill: Stage 2

The Convener (Duncan McNeil): Good morning and welcome to the second meeting in 2014 of the Health and Sport Committee. As usual at this point, I ask everyone in the room to switch off mobile phones and other wireless devices, as they can interfere with the meeting and the sound system. I should point out that some members and officials are using tablet devices instead of hard copies of their papers.

I have apologies from Dr Richard Simpson. Malcolm Chisholm has joined us once again as the Labour substitute.

There is only one item on the agenda. Today is the first day of stage 2 of the Public Bodies (Joint Working) (Scotland) Bill. Members should have a copy of the bill, the marshalled list of amendments and the groupings.

Today, we can go no further than the end of section 33. We have discussed with the committee that, depending on our progress, an appropriate time to end would be around 12.30—that would be a drop-dead time. We have some time next week to complete our business.

I welcome back to the committee the Cabinet Secretary for Health and Wellbeing, Alex Neil, and his officials.

Section 1—Integration plans: same local authority and Health Board area

The Convener: Amendment 1, in the name of the cabinet secretary, is grouped with amendments 2, 7, 12, 13, 15 to 18, 27 to 37, 52, 53, 55, 59, 60, 64 to 68, 70, 72, 73, 77, 82, 86, 109, 111, 121, 122, 148 to 155, 158 to 190, 192 to 194 and 196 to 199.

I call the cabinet secretary to move amendment 1 and to speak to all the amendments in the group.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): The amendments in the group in my name make a drafting change to the term “integration plan”: they amend it to “integration scheme”. The change is presentational. The term “integration scheme” reflects the purpose of the document setting out the integration arrangements that must be prepared under section 1 or section 2 by the health board and local authority.

Furthermore, stakeholders raised concerns about the potential for confusion about which duty applied to whom and for what purpose in relation to the integration plan and the strategic plan. I am happy to respond to stakeholder concerns and make that presentational change.

I move amendment 1.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I can see why the cabinet secretary wants to make the change. Obviously, because of the bill’s structure, we start with the plans and go on to the delivery.

I do not know whether one of the Government amendments incorporates this point—I am sorry, but I have not checked every single one. The amendments refer to the “scheme”, but the title of section 4 is “Integration planning principles” and I did not notice an amendment that relates to it. It seems a bit awkward that we will change “plan” to “scheme” but that the bill will still refer to “planning principles”. Furthermore, when it comes to the strategic plan at section 24, there are “delivery principles”.

There is a certain awkwardness in that. I therefore wonder whether, if there is not such an amendment, you need to lodge a further amendment to align the references, so that all the references to “plan”, rather than “scheme”, are in the later part of the bill.

The Convener: As no other member wishes to speak, I call the cabinet secretary to respond and sum up.

Alex Neil: Mr Chisholm makes a very fair point, which we will look at, and we will consider whether we need to lodge an additional amendment at stage 3.

Amendment 1 agreed to.

Amendment 2 moved—[Alex Neil]—and agreed to.

The Convener: Amendment 3, in the name of the cabinet secretary, is grouped with amendments 4, 8, 146, 54, 56 to 58, 69, 71, 74 to 79, 156 and 157.

I call the cabinet secretary to move amendment 1 and to speak to all the amendments in the group.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): The amendments in the group in my name make a drafting change to the term “integration plan”: they amend it to “integration scheme”. The change is presentational. The term “integration scheme” reflects the purpose of the document setting out
large, such as Edinburgh royal infirmary or Glasgow Southern general hospital.

Flexible use of budgets is key to improving outcomes, and the principle of an integrated budget is key to successful integration. It is also of key importance to the policy intention of integration that the appropriate parts of acute hospital budgets and activity are included within integrated strategic planning. Discussions, particularly with national health service stakeholders, have nevertheless indicated that inclusion of some hospital budgets in the physical payments to the integration authority could be problematic.

Hospitals that provide a substantial part of their services to the populations of two or more local authority areas—that is, large hospitals—form an important common resource, and dividing up and paying out their budgets to numerous integration authorities could undermine their operational management. At the same time, in order to preserve the integrity of the policy and the intention of the bill, it is important that strategic planning includes the hospital capacity used by the population of the integration authority. All appropriate aspects of the health and social care resource spent on the integration authority’s population must be included within the scope of the strategic plan so that it can be used to total best effect.

The amendments provide that health boards are not required to physically disaggregate the budgets for large hospitals that serve several communities; instead, the health boards can set aside the appropriate portion of the large hospital budget, and its use is then directed by the integration authority via the strategic plan. Amendment 8 provides a definition for "large hospitals".

Amendment 146, from Malcolm Chisholm, appears to introduce a similar alternative mechanism for local authorities to make notional payments to integration joint boards for delegated functions, although I am advised that other changes to the bill would also be needed to achieve that effect. The amendment’s intended effect appears to be that local authorities could also set aside budgets whose use is to be directed by the integration authority.

I gather that Malcolm Chisholm’s intention was in fact to amend the provision about payments as it applies to health board budgets rather than local authority budgets. The effect of such an amendment would be that the health board could either make a payment to the integration authority for all of its delegated functions, not just large hospital budgets, or it could set aside the notional amount for the direction of the integration authority via the strategic plan.

The key point is that my amendments relate to one portion only of health board budgets: the budgets for large hospitals that provide services to more than two local authority areas. Health board budgets covering, for example, community hospitals will be paid to the integration authority and will not be set aside in the same way. I do not support extending the notional budget principle to other aspects of health board budgets, as Mr Chisholm has proposed, or indeed to local authority budgets. Such a change would send a very unwelcome signal to health boards and local authorities about the integration authority’s duties and responsibilities with regard to strategic planning.

It is vitally important to the success of our policy intention that the authority of the integration authority in relation to the strategic planning process and the funding that underpins it are both absolutely clear. The amendments in my name provide the right balance of requiring actual payment with practical flexibility in relation to managing large hospitals.

Amendments 3 and 4 deal with the content of integration schemes, which must include the method of determining resources to be paid to the integration authority and the method of determining any resources that are set aside by the health board for large hospital budgets.

The amendments will also improve the terminology used in the bill regarding budgets. The phrase “method of calculating” will be replaced by “method of determining”, which better reflects the policy intention for integrated budgets, which is that payments should be determined based on a regular process of local discussion and consideration rather than on a prescriptive formula carried forward from year to year.

That change in terminology is also seen in amendments 54, 58, 69 and 76, which relate to payments to the integration joint board, and in amendments 156 and 157, which cover revision of integration schemes.

Amendments 56 and 74 apply, respectively, to the integration joint board model and the lead agency with the local authority as lead agent model. They have the same effect as each other, providing that health boards must set aside an amount to be determined in accordance with the method set out in the integration scheme for large hospital functions.

Amendments 57 and 75 provide for the requirement on health boards to make payments either to an integration joint board or a local authority acting as the lead agency for delegated functions where no large hospital functions are delegated or, where they are delegated, when the
health board has decided to include them in the payments.

Amendment 79 provides for the integration authority to be able to direct the health board on the use of large hospital budgets in line with the strategic plan. We expect integration to achieve a shift in the balance of investment in institutional and non-institutional care, and strategic plans will set out changes in the use of resources of large hospitals. We expect strategic plans to set out how integration authorities will reduce the use of large hospital services for the population. At the same time, it is possible that in some circumstances strategic plans will set out an intention to use more of some services that are provided in large hospitals.

It is possible that, in either circumstance, a planned reduction or increase in the use of large hospital services will not be realised despite what is set out in the strategic plan. When that happens, an adjustment will be needed to the payments between the health board and the integration authority to reflect the change in resources. If a planned reduction in the use of large hospital services is realised by the integration authority, amendment 79 will enable an integration authority to require a health board to pay to it any savings that are realised by the health board in relation to services delivered in a large hospital so that the integration joint board may reallocate that money to interventions to reduce hospitalisation.

If a planned increase in the use of large hospital services is not realised, amendment 79 will enable an integration authority to require a health board to pay back to it money for services that were not used. Likewise, if the integration authority uses more of the large hospital services than was planned for, amendment 79 will require the integration authority to pay money to the health board as it would normally have to when directing under section 22.

Amendments 71 and 78 are concerned with payments to local authorities in respect of delegated functions. The bill provides for different models of integration including circumstances in which more than one local authority is covered by an integration scheme with one health board. Amendments 71 and 78 provide for a situation in which more than one local authority is covered by the same integration scheme as a health board and a lead agency arrangement is put in place whereby one of the local authorities is the lead agency. In such a circumstance, the amendments provide that the delegating local authority must make a payment to the local authority that is acting as the lead agency in relation to each delegated local authority function.

I am particularly grateful to all the participants in our integrated resources advisory group and our national steering group on joint strategic commissioning for their contribution to this work.

I move amendment 3, and I invite Malcolm Chisholm not to move amendment 146.

Malcolm Chisholm: I always intended amendment 146 to be a probing amendment. As you have indicated, minister, I made a mistake in putting it against line 26 rather than line 29, as my concern was section 13(3). However, as it is only a probing amendment I am sure that it is not a cardinal offence to have put it in the wrong place. I still have points to make in relation to it.

This is an important group of amendments, as it takes us to two of the central issues of the bill that featured prominently during our stage 1 consideration. The first is the funding arrangement and the second is the balance of power, if I can put it that way, between the integration authority and the local authority and health board that form the strategic plan.

10:00

A problem with the bill as formulated is that it could return us to bureaucratic commissioning arrangements. The bill says:

“The Health Board must make a payment to the integration joint board”.

Presumably the integration joint board would then have to make a payment back for services that it commissions. That would be a problem.

The complex amendments lodged by the cabinet secretary try to deal with that. It is a bit unsatisfactory that the funding detail came out only after the stage 1 consideration. We had no chance to question officials about the funding detail at that stage, and we were all very surprised when we received a note that said that, I think, at least half the health board budget and three quarters of the over-75s emergency care budget would be handed over, if that was the language that was used. I am not saying whether that is right or wrong; I am just saying that we were surprised that the extent of financial delegation was that great. That is my little moan out the road.

We now have detailed Government amendments. My colleagues and I would not be minded to oppose them, but we might want to reserve the right to examine them further before stage 3 to see whether they meet all the concerns. They seem to avoid the pitfalls of reintroducing the old-style commissioning arrangements.

The Government amendments refer to the amounts “set aside”, which is very similar language to that used in my proposals on notional payment. My amendment 146 would make the reference to “payment or notional payment”, so I do not accept the cabinet secretary’s criticism that
that implies that the notional payments would be for everything; rather, I meant that notional payment as well as genuine payment would be an option.

The balance of power issue is also illuminated by the amendments, and amendment 79 is significant in that regard. I do not have a particularly strong view on the matter, but I draw the conclusion from amendment 79 that it will very much be the integration authority that calls the shots in directing health boards on what they should do with their acute hospitals. I think that that is the intention, and again I will want to reflect further and perhaps listen to what health boards have to say on the matter.

An issue that came up at stage 1 was exactly how much power is to be invested in the integration authority. Amendment 79 makes it clear that the key decisions will be made by the integration authority and that it will have the power to direct health boards.

My colleagues and I are not minded to vote against the cabinet secretary’s amendments. Since my amendment 146 was always a probing amendment, I am very happy not to move it. However, we reserve the right to scrutinise what is a central part of the bill further at stage 3.

Alex Neil: I thank Malcolm Chisholm for his contribution, which was very helpful. I am happy to meet Malcolm and any other committee member before stage 3 if they require further clarification of our intentions on the detail.

I realise that this is a very complex area and I want to be happy that members are satisfied, before we get to stage 3, that what we are proposing is the right thing to do. I think that is—and I very much welcome Malcolm Chisholm’s offer to not move his amendment. It is not very often that he makes a mistake.

The Convener: Charm will get you everywhere, cabinet secretary. [Laughter.]

Amendment 3 agreed to.

Amendment 4 moved—[Alex Neil]—and agreed to.

The Convener: Amendment 202, in the name of Rhoda Grant, is grouped with amendment 203.

Rhoda Grant (Highlands and Islands) (Lab): I have lodged a number of amendments that seek to embed co-production into the bill. The reason for the bill is to improve services to service users and their carers. Integration means that they should receive a seamless service. However, we should all strive to involve service users in devising the services that they receive in order to enable them to live fulfilling lives.

Amendment 202 seeks to embed co-production into the plan for integration. The integration plan sets out how the authority will work and what actions will flow therefrom. Asking the authority, as part of the plan, to make arrangements for the participation of service users, carers and their representatives would ensure that co-production is required. Those principles will flow forward into front-line service delivery. The amendment would also ensure that any service users will be supported in their involvement.

Proposed new subparagraphs (dc)(iv), (dc)(v) and (dc)(vi) would ensure that staff are embedded to participate, and allow the authority to use expertise from other organisations in the third sector within the community as it sees fit.

Amendment 202 highlights the need for accountability for the use of resources. It would ensure that services are monitored and arrangements made to improve quality, safety and standards of service. That issue runs through other amendments and was sought by a number of consultees to the bill, including the Royal College of Nursing. Those principles need to be made clear as part of the integration plan.

I also speak in support of amendment 203, in the name of Nanette Milne, which seeks to ensure that an integrated plan makes arrangements for a single complaints system. I have also lodged amendment 217, which asks Scottish ministers to set up an integrated complaints system. My amendment would ensure that the integrated authority is subject to the public service ombudsman keeping it in line with its constituent authorities. The amendments together would ensure the provision of Scotland-wide guidelines on how complaints should be handled and ensure that joint boards implement that as part of their integration plan.

I move amendment 202.

Nanette Milne (North East Scotland) (Con): My amendments focus on ensuring that service users and unpaid carers are central to planning and shaping integrated services, that there is a strong voice for the third sector in joint strategic commissioning and locality planning and that there is a focus on personal outcomes for service users.

If integration is to produce seamless services for the people who use them, health and social care partnerships should be obliged to provide a clear, simple route into a complaints process to ensure that the needs and experience of service users are listened to and learned from, which should help to drive improvement.

Complaints processes are a key accountability mechanism, helping people to access their rights in relation to health and social care. Amendment 203 would amend the bill to include reference to
ensuring effective access to a complaints system. I also support amendment 202, in the name of Rhoda Grant.

**Alex Neil:** Amendments 202 and 203 seek to place requirements on health boards and local authorities to include additional items within their integration scheme. I begin with the items that are listed in amendment 202. I draw the committee’s attention to the policy statement that outlines the regulations that I intend to make under the power contained in section 1(3)(e). Within those regulations, I will set out in more detail than is appropriate on the face of the bill the arrangements that must be put in place to ensure, first, that there is effective monitoring of integrated resources and payments and, secondly, how clinical and care governance will assure the quality, safety and standards of the services developed. The regulations will therefore cover the matters that are addressed in proposed new subsections (da) and (db) of amendment 202.

The strategic planning and locality planning processes that integration authorities must put in place will determine how integrated services must be planned and delivered. Scottish ministers have included within sections 26, 27 and 32 of the bill a requirement to consult and take account of the views expressed by a wider range of stakeholders than amendment 202 would require. The bill therefore already makes provision for the consultation of stakeholders that goes beyond that which is proposed in subsection (dc) of amendment 202.

It is not proportionate to require in primary legislation the participation of those listed in amendment 202 over other key parties and stakeholders, and I do not consider that a requirement in the integration scheme to develop a strategy to support stakeholders in the planning and delivery of services is the best approach.

I am also concerned that amendment 202 limits that strategy to a small number of stakeholders. For example, it does not include general practitioners, who equally might need support in developing their skills to strategically plan services across the area of an integration authority. Instead, I intend to set out in statutory guidance that such support should be provided to all participants in the various activities required in the bill. That will ensure that all participants are offered support to fully engage in the planning and delivery of services and that such support can be tailored to each activity instead of simply being provided for in a high-level strategy.

Amendment 203 seeks to require integration schemes to provide a single point of entry for complaints that fall within the scope of integration. I fully recognise that the current system for social work complaints is no longer up to date or fit for purpose and we have been working to produce a new system that will be more accessible, allow complaints to be completed far faster and produce a co-ordinated response for the complainant. In due course we will bring forward under Scottish ministers’ existing powers changes to secondary legislation that I expect will satisfy what Nanette Milne quite rightly intended by lodging amendment 203. However, the Public Bodies (Joint Working) (Scotland) Bill is not the appropriate legislative vehicle for making changes to the complaints system, especially when we have not consulted on them as part of the bill.

I therefore urge Rhoda Grant not to press amendment 202 and Nanette Milne not to move amendment 203.

**Rhoda Grant:** I will press amendment 202 because I truly believe that adopting the principles of co-production means not just consulting people but involving service users in such decisions. If they are involved in the integration scheme, they will be able to influence the various stages of the work of this legislation.

In response to the cabinet secretary’s point about GPs, I should point out that they would be included under proposed subsection (dc)(vi), where local authorities and health boards can involve any other person they think fit. I know that, much to my regret, GPs are not employees of the health board, but they could be involved.

As I have said, I will press amendment 202 because I think that it is important to how the bill works and in involving service users and carers in designing services and their own care.

**The Convener:** The question is, that amendment 202 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeill, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

**Against**
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

**The Convener:** The result of the division is: For 4, Against 5, Abstentions 0.

**Amendment 202 disagreed to.**

**The Convener:** I call Nanette Milne to indicate whether she wishes to move amendment 203, which has been debated with amendment 202.
Nanette Milne: Thank you, convener. I appreciate the cabinet secretary’s understanding of my reasons for lodging these amendments—

The Convener: Nanette, at this point, you can only indicate whether you are moving the amendment.

Nanette Milne: I will not move my amendment, and I will reserve my position for stage 3.

Amendment 203 not moved.

The Convener: Amendment 5, in the name of the cabinet secretary, is grouped with amendments 6, 9, 140 to 142, 10 and 200. Under the pre-emption rule, if amendment 9 is agreed to I cannot call amendments 140 to 142.

Alex Neil: The Scottish Government has made it clear from the outset that the policy of integration applies to health and social care functions. At its introduction, the bill permitted any local authority function to be included in the integrated arrangement with health functions, subject to provision made by regulations restricting the range of local authority functions that could be delegated. This group of amendments changes the approach so that the range of local authority functions that can be delegated will be set out in the bill itself in the proposed new schedule.

10:15

On amendment 5, proposed new subsection (4A) provides for local authorities to delegate functions that are conferred on them by the acts listed in the schedule proposed in amendment 10. In policy terms, those can be considered as, in effect, social care functions. Proposed new subsection (4C) provides for the Scottish ministers to prescribe from that list of functions those that must be delegated by a local authority but only in so far as they relate to adults. The Scottish ministers will be able to require the delegation of adult social care functions only, leaving the delegation of other functions in the schedule to local determination.

Proposed new subsection (4B) provides for health boards to delegate functions prescribed by the Scottish ministers. Proposed new subsection (4D) provides for the Scottish ministers to prescribe the functions of a health board that must be delegated where an integration joint board is established or where the local authority is the lead agency. Again, the Scottish ministers can prescribe functions only in so far as they relate to adults. Therefore, again, the Scottish ministers can require the delegation of adult health care only, leaving the delegation of other health functions to local determination.

Proposed new subsection (4E) sets out the requirements on which an integration model that is provided for in proposed new subsection (4D), in which the health boards and local authorities are both lead agencies, is agreed. The local authority must delegate social care functions in relation to adults or the health board must delegate health functions in relation to adults. That ensures that the integration of adult health and social care functions is achieved.

Proposed new subsections (4F) and (4G) make provisions similar to those that are contained in sections 1(6)(c) and 1(6)(d). The Scottish ministers may set out the functions of health boards and local authorities that must or may not be delegated under certain circumstances. Subsections (4F) and (4G) provide some flexibility for the Scottish ministers to set out functions that go together and those that do not go together.

Proposed new subsection (4H) enables the Scottish ministers to remove enactments from the schedule, should that be considered appropriate in future. The exercise of that power is subject to affirmative procedure.

Amendments 6 and 9 are consequential on amendment 5. Amendment 10 provides for the schedule that creates a list of functions conferred on local authorities that constitute social care under the bill. Amendment 200 sets out that regulations made under proposed new subsection (4H) of section 1 will be subject to the affirmative procedure.

I turn to amendments 140 to 142 from Mr Chisholm, which are pre-empted by amendment 9 in my name. Amendment 9 removes the requirement for the Scottish ministers to prescribe the functions that may not be delegated. However, it is important that the Scottish ministers have the flexibility to prescribe when functions may not be delegated in certain circumstances, not least because I wish to ensure that the bill is future-proof—that is, that it is able to keep pace with changes in technology, practice and service design and redesign.

Providing a certain service in a hospital will be entirely right for some individuals. However, for others, the most appropriate place may be in their own home or a community setting. The bill and amendment 5 provide for that legitimate flexibility, but amendment 142 would remove it. Therefore, I cannot support amendments 140 to 142.

I move amendment 5 and ask Mr Chisholm not to move amendments 140 to 142.

Malcolm Chisholm: I struggle to follow the cabinet secretary’s line of argument, because I would have thought that my amendments would give him the maximum amount of flexibility.

When I read section 1 of the bill, I thought that it was rather overdone and rather complex but,
when I saw the amendments that the cabinet secretary had lodged, I realised that it was simplicity itself compared to them. I cannot see how he can possibly argue in favour of flexibility when he is adding a schedule to the bill that lists in fine detail those parts of local government legislation that may be subject to delegation.

That, in itself, removes all flexibility. I would have thought that the minimum change that the cabinet secretary could make would be to ensure that the content of that schedule was in regulations rather than being on the face of the bill. I have still to be persuaded that all this level of detail is necessary in the first place. I thought that the conclusion that we had derived from our stage 1 discussions was that certain functions had to be delegated and therefore it seems to me that it would be adequate for the bill to say, “These are the functions that must be delegated” and leave it to the good sense and local determination of health boards and local authorities to decide whether they want to add to that list. That would be the principled argument for my position.

There is also a practical argument. Health boards and local authorities are concerned that they might be delayed in their wish to hand over powers to the integration authority while they wait for regulations. All that they need to know is what must be delegated; the rest could surely be left to local determination. If I am missing something to do with the requirements of legislation, and if that is impossible, I will accept the cabinet secretary’s argument, but I cannot say that I am persuaded by any of the arguments that he has made hitherto. I will just have to listen to his winding-up remarks and make a snap decision on whether to move my amendments.

As this is the only time that I will be allowed to speak, I should say that if I decide not to move my amendments, the decision will be subject to the same caveat that I intimated earlier and that, on further consideration, we might wish to revisit the issue at stage 3.

Rhoda Grant: I have some concerns about the amendments. They are hugely technical and quite difficult to scrutinise.

An issue that has been raised with me is the transition between child and adult services. It is a big issue but it was not really covered when we talked about the bill. Will the Government’s amendments prohibit an integrated transition between child and adult services?

In my region, Highland Council and NHS Highland have a different integration model in which children’s services have been transferred to the local authority. Is there anything in the amendments that will prohibit other authorities from taking that same line?

I seek reassurance for those who have issues about the transition between child and adult services. Such transitions are fraught with difficulty at the moment and if the amendments make that worse, that would be a retrograde step.

Alex Neil: I think that Mr Chisholm and I are trying to get to exactly the same place but we are doing it in a slightly different way. I will clarify a number of things.

First, we will state clearly in the bill what must be the responsibility of the integration authority. Also, by agreement with the health board and the local authority, the integration authority can take on any of the relevant additional functions that it might wish to do. In fact, in a number of the partnerships that are already operating, such as that in West Lothian, they are already doing so, and children’s services is a very good example of that.

Secondly, I want to clarify for Rhoda Grant that the bill does not restrict any partnership from taking on the additional responsibility of children’s services. Again, the informal, non-statutory partnerships are up and running and that is already happening in a number of them. There is no restriction on that and my personal view is that it would make sense for partnerships to do so in a number of circumstances.

Malcolm Chisholm: May I come in on that?

The Convener: I am sorry; the cabinet secretary is winding up and there is no opportunity for debate at this stage.

Alex Neil: We had representations from local government that the wording in the bill was too wide and that it did not clarify the definition of social care services and social care functions. Local government was concerned that the definitions were so wide that they could take in any range of responsibilities that go above and beyond what is intended in the bill. I therefore agreed that more definition in the bill was required to allay those concerns.

That is the reasoning behind the amendments. We are trying to get to the same place: a clear definition of what must be done by the integrated authorities and what they may do in addition to that, depending on local decision making. As I said, there is total flexibility there. If the health board and the local authority agree to place any additional non-statutory requirement on integrated bodies to provide such services, they are entirely free to do so.

I have offered to meet Mr Chisholm and anyone else on the committee for further discussions before we get to stage 3. I would be happy to discuss this particular area of policy, because we are absolutely sure that we are doing the right
thing. In addition, we are taking local authority colleagues with us on this, which is extremely important for the success of the entire project.

Amendment 5 agreed to.

Amendments 6 to 8 moved—[Alex Neil]—and agreed to.

The Convener: I remind members that if amendment 9 is agreed to, amendments 140 to 142 will be pre-empted.

Amendment 9 moved—[Alex Neil]—and agreed to.

Section 1, as amended, agreed to.

Schedule

Amendment 10 moved—[Alex Neil]—and agreed to.

Section 2—Integration plans: two or more local authorities in Health Board area

The Convener: Amendment 11, in the name of the cabinet secretary, is grouped with amendments 39, 40, 44, 49, 83, 120, 191 and 195.

Alex Neil: This group contains minor and technical amendments in my name. Section 2 addresses requirements to put in place integration arrangements in health board areas that cover more than one local authority area.

Amendment 11 will remove some text that is now considered to be redundant; the effect of the bill will be unchanged. Amendment 39 is a drafting amendment to ensure that the requirement to consult the constituent authorities on the appointment of the chief officer is specific to the appropriate constituent authorities of the integration joint board.

Amendment 40 will remove the definition of a constituent authority from section 10. A separate definition of that will be inserted by amendment under section 43. Amendments 44, 49 and 120 are drafting amendments to provide consistency in the use of the term “constituent authorities” in relation to an integration joint board. The amendments will achieve more consistent use of terminology in the drafting of the bill.

Amendments 191 and 195 provide a definition for the use of the terms “constituent authority” and “constituent authorities”. The term refers to the local authority or local authorities and health board as parties to an integration scheme in pursuance of which an integration joint board has been established. Amendment 195 provides for where “constituent authority” is to be used.

Amendment 83 seeks to broaden the duty of co-operation in relation to integration schemes. The current drafting of the duty is narrow and refers to what could be interpreted as an exhaustive list of resources. I believe that the duty of co-operation would be clearer and more effective if it was expanded to cover all shared resources. That will better ensure effective and efficient use of all resources and reduce conflicting demand in the delivery of services.

I move amendment 11.

Amendment 11 agreed to.

Amendments 12 and 13 moved—[Alex Neil]—and agreed to.

10:30

The Convener: Amendment 14, in the name of the cabinet secretary, is in a group on its own.

Alex Neil: Section 2 addresses requirements to put in place integration arrangements in health board areas that cover more than one local authority area. Amendment 14 ensures that all adult health and social care functions that are prescribed as being required to be included in an integrated arrangement are held by a single body. Integration must result in service planning and provision that is integrated from the perspective of the service user. We will not achieve that position if adult health and social care functions are planned for and delivered by different bodies. It is therefore vital that the bill ensures that all integrated functions are held by one body.

As originally published, that was not a requirement of the bill. That meant that it would have been possible for a health board and two or more local authorities to split up adult health and social care functions by delegating them to more than one local authority in a multicouncil health board area. Amendment 14 ensures that that course of action, which would have seriously undermined the policy intention of integration, is not possible.

I move amendment 14.

Amendment 14 agreed to.

Amendments 15 to 17 moved—[Alex Neil]—and agreed to.

Section 2, as amended, agreed to.

Section 3—Considerations in preparing integration plan

Amendment 18 moved—[Alex Neil]—and agreed to.

The Convener: Amendment 204, in the name of Rhoda Grant, is in a group on its own.

Rhoda Grant: The purpose of amendment 204 is to ensure that the integrated authority also has regard to the community planning process. If we
genuinely want to integrate services that are responsive to local communities’ needs, we must also integrate them with other local planning processes. Doing so would acknowledge that health and care services operate in the wider sphere of public services and would mean that they must contribute to the fulfilment of single outcome agreements. Although integrating services is about improving service users’ experience and creating efficiencies, those services also need to play their part in meeting their partner authorities’ obligations with regard to existing legislation. Amendment 204 would mean that stronger connections would be made with the community planning agenda, which is important to the integration of all services.

I move amendment 204.

Alex Neil: The bill requires health boards and local authorities to take account of the integration planning principles and the national health and wellbeing outcomes when preparing an integration scheme. Amendment 204 seeks to add community planning outcomes to that list.

The Government is bringing forward a community empowerment bill that will include integration authorities as bodies that must participate in community planning along with health boards, local authorities and others. A requirement to include integration authorities in community planning itself is much the stronger way to ensure the proper place of integrated health and social care in community planning, rather than referring to community planning outcomes that do not at present exist in law.

I invite Rhoda Grant to agree that the Scottish Government’s position in relation to community planning and integration is stronger than her proposal, and to withdraw amendment 204.

Rhoda Grant: I will seek further information from the cabinet secretary, possibly in the interlude between stages 2 and 3, on whether the community empowerment bill will come into force before the Public Bodies (Joint Working) (Scotland) Bill comes into force, because I think there might be an overlap there. I will withdraw amendment 204 and await that clarification.

Amendment 204, by agreement, withdrawn.

Section 3, as amended, agreed to.

Section 4—Integration planning principles

The Convener: Amendment 19, in the name of the cabinet secretary, is grouped with amendments 19A, 20, 21, 205, 206, 22, 207, 23, 24, 143, 208, 209, 25, 26, 97, 97A, 223, 98, 99, 224, 225, 100, 226, 101, 102, 227 to 230, 103, 231 and 104.

Alex Neil: This will be another long contribution, but I am afraid that it has to be done.

The Convener: There’s a surprise.

Alex Neil: I put on record my appreciation of all the stakeholders involved in the development of the integration principles. The principles underpin the bill; they provide for a person-centred focus; and they reflect the key cornerstones of effective integration.

The integration planning principles provide for matters that health boards and local authorities must take into account when preparing an integration scheme. Their purpose is to ensure that, when planning for their integrated arrangements, health boards and local authorities do so from the perspective of, and for the benefit of, the service user, rather than for organisational or administrative convenience.

The integration delivery principles provide for matters that integration authorities must take into account when preparing a strategic plan. Their purpose is to ensure that, when integration authorities plan services using the totality of health and social care spend, they do so from the perspective of, and for the benefit of, the service user, rather than on the basis of historical service provision.

Amendments 19, 21 to 23, 26, 97, 99 to 101 and 104, in my name, are drafting amendments to sections 4 and 25 and change the term “recipients” to “service users”. I believe that the term “service users” is more appropriate as it more accurately provides for more active engagement and choice by persons who use health and social care services, rather than providing for them as passive recipients of services.

Amendments 20 and 98, in my name, are further technical amendments that will ensure that the language in the bill does not imply that there is a single way that integrated services can be planned.

I turn to amendments 19A, 205, 207, 97A, 224 and 226, in Malcolm Chisholm’s name. I acknowledge the concern raised by stakeholders that the bill should take a human rights-based approach and reflect the principles of independent living. Although I recognise that aim, the committee will already be aware of the requirement for all acts of the Scottish Parliament to comply with human rights as enshrined in the European convention on human rights. It is therefore not necessary for that to be repeated in the bill.

I have considered the use of the term “independent living”. Although I accept and agree that it is important to ensure that these principles and ideals are reflected in standards of planning,
delivery and design of services, terms such as "independent living" are, by their very nature, potentially subject to change or differing interpretation.

The integration principles must apply equally to all users of the health and social care services that are covered by the bill, not only vulnerable or disabled people. I believe that amendments 24 and 102, in my name, reflect stakeholders' concerns in that regard. They require the health board and the local authority, in taking account of the integration planning principles, to reflect the fundamentals of service users’ rights and independent living principles. They will ensure a high standard of service quality and will protect and improve the safety of users of health and social care services.

Amendment 143, in the name of Aileen McLeod, would add the requirements of safety and quality to the list of matters that health boards and local authorities must take into account when preparing their integration scheme. Aileen McLeod's amendment 143 copies across the effect in part of my amendment 102 to the integration delivery principles, so that the same point is made in both sets of principles. I am very sympathetic to Ms McLeod's amendment on that point and am therefore happy to accept it.

Amendments 102 and 143 together require improvement in the quality of services and forgo the need for amendment 228, in the name of Rhoda Grant. Furthermore, a quality service is based not only on the amount of time given to service users. Best practice guidance is the place for such matters, not principles in primary legislation.

I turn to amendments 206 and 225, in the name of Nanette Milne. I believe that the requirement outlined in the amendments is properly addressed by the requirement for health boards and local authorities to take account of the particular needs of service users, which can be fairly regularly quantified by health boards and local authorities. Health boards and local authorities, in their consideration of individuals' needs, must already take into account specific circumstances as part of a holistic, personalised approach to care, and are already subject to statutory requirements and guidance in relation to assessment. However, given the importance of considering individuals' needs within an integrated approach to care, I intend to provide statutory guidance on the matter, which will provide further support to health boards and local authorities to ensure that their understanding of need is appropriate.

In terms of individual choice, it is important to distinguish between the requirements placed on local authorities by the Social Care (Self-directed Support) (Scotland) Act 2013 to provide choice and control over social care services, and the purpose of the bill, which is to bring together responsibility, accountability, delivery and planning for health and social care services. Choice and control cannot equally apply to all service users in all circumstances and to all health and social care services under the bill. The integration planning and delivery principles importantly require the health board, local authority and integration authority to consider service users’ needs and to plan for integration and deliver services from the service user's perspective. I therefore cannot support amendments 209 and 230, in the name of Malcolm Chisholm.

I am, however, sympathetic to Rhoda Grant's amendment 223, which seeks to amend section 25. I believe that the intention in amendment 223 is to broaden the circumstances in which the integration delivery principles will apply. However, I believe that there is a conflict with the purpose of section 25(1)(a), which is to ensure that services are provided in a way that improves service users' wellbeing. Applying the principles to how services are commissioned conflicts with ensuring that the services are provided for the service user's benefit—in other words, with ensuring that services are planned and delivered in a person-centred way. Furthermore, the Scottish Government has already issued to partners guidance on strategic commissioning for the integration of health and social care, and that guidance will be revised as part of the process of implementing the bill. I therefore ask Rhoda Grant not to move amendment 223.

Rhoda Grant's amendment 227 requires services to be provided in a way that takes account of the needs of a service user who moves between two local authority areas. The basis on which a local authority provides a service to a service user is their physical presence in that local authority's area, so a local authority cannot begin to provide services until the service user is physically present in that area. We are aware that it can be difficult for people to move if they are unsure about whether the care services that they will need will be in place by the time that they move. We have therefore developed and have in place protocols to encourage local authorities to enter into transitional arrangements to help to facilitate moves.

We will continue to work with the Convention of Scottish Local Authorities and key stakeholders to ensure that local authorities are encouraged to set up voluntary schemes to work together in carrying out assessments in advance of the person being physically present. I appreciate the need for service users to make sure that when they move into a new local authority area they can access the services they need and that those are provided.
However, I do not believe that amendment 227 achieves that aim, so I cannot support it.

10:45

Turning to Mr Chisholm’s amendments 208 and 229, it is right that issues of quality and continuing improvement are raised. Indeed, as the policy memorandum states, that is one of the areas that the bill aims to address. However, I have a number of points to make on the amendments.

First, section 41 already gives the Scottish ministers a power regarding statutory guidance. An amendment to section 41 that will be considered on day 2 of stage 2 will require that that power applies to integration authorities. Secondly, integration authorities will not directly deliver services. Health boards and local authorities will continue to deliver health and social care—albeit integrated health and social care—and will continue to be subject to existing guidance and quality standards that apply across health and social care, as set out in the Scottish Government’s 2020 vision for health and social care. My amendment 102 will provide for continuous improvement. I therefore ask Mr Chisholm not to move amendments 208 and 229.

Amendments 25 and 103, in my name, reflect the concerns that were raised by stakeholders about the potential meaning and interpretation of the term “local professionals”. There are many people who deliver a range of services, advice and support, and they all contribute to the health and wellbeing of individuals, but they might not regularly see themselves as professionals or be recognised as such by statutory bodies. Amendments 25 and 103 provide the right balance and will reflect those concerns and the ethos of integration as a whole.

On amendment 231, in Rhoda Grant’s name, I have expressed my admiration, and will continue to do so, for the dedication, professionalism and enthusiasm that are demonstrated by those who deliver health and social care services across Scotland, many of whom are carers for family members or friends. However, placing the integration authorities under a requirement—in taking account of the integration delivery principles—to reward people who deliver services is not appropriate. I am not sure what rewards Ms Grant envisages, but I think that it is for all of us who are involved in the policy, planning and delivery of health and social care services, as well as users of those services, to ensure that people are supported and feel appreciated for the quality services that they provide. I therefore ask Rhoda Grant not to move amendment 231.

I support amendment 143 in Aileen McLeod’s name. I do not support amendments 19A, 205 to 209, 97A and 223 to 231.

I move amendment 19.

Malcolm Chisholm: There are quite a lot of issues to deal with, but I will mainly speak to the amendments that I lodged.

At the beginning of the cabinet secretary’s comments, he referred to the integration principles. It would have been my preference to have those integration principles right up at the front of the bill in section 1, but of course he has split them into planning and delivery principles. I do not think that it is worth falling out over that but I, like many stakeholders, would have preferred some general overarching principles that applied to planning and delivery, and to have those at the beginning of the bill.

On my amendment 19A, the cabinet secretary said that there is no recognised definition of the term “independent living”. I suppose that I could say, “Well, what’s new?” I remember making a speech last week about sustainable economic growth. Many people who gave evidence on that issue said that there was no recognised definition of the term, but there it is in a piece of Scottish Government legislation that was passed last week. Therefore, the cabinet secretary’s argument does not stand up, particularly given that he has accepted a definition of independent living in the document “Our Shared Vision for Independent Living in Scotland”, which states:

“Independent living means ‘disabled people of all ages having the same freedom, choice, dignity and control as other citizens at home, at work, and in the community. It does not mean living by yourself, or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life.’”

Therefore, there is an accepted definition.

The cabinet secretary says that that does not apply to everyone, but it mentions disabled people having

“the same freedom, choice, dignity and control as other citizens”.

Implicit in that is, of course, that we all have those things. Most of us have them without having to argue for them, but disabled people have had to argue to get on to the same footing as we are on. I therefore do not accept the cabinet secretary’s arguments about independent living.

Nor do I accept the cabinet secretary’s argument about rights. We want a rights-based approach to integrated health and social care planning and delivery. The cabinet secretary said that it is not necessary to use the word “rights” because we already follow the Human Rights Act 1998. I think that the use of that word is important
because there is a particular rights-based approach to health and social care, which of course he accepted in the Social Care (Self-directed Support) (Scotland) Act 2013. Section 2 of the 2013 act states that

"the right to dignity of the person is to be respected ... the person's right to participate in the life of the community in which the person lives is to be respected."

Clearly, the cabinet secretary did not follow his own principles in that legislation.

With reference to the cabinet secretary’s amendment 24, it would be preferable to lift the language from section 2 of the 2013 act. I have not proposed an amendment to that effect but may do so at stage 3. What I have proposed is to put a reference to rights in a general sense in two places in the bill. I think that that is important in order to emphasise the importance of the rights-based approach to integration.

Amendment 208 is about quality and proposes adding to the bill the wording

"recognised guidance and adherence to established quality standards and promotes continuous improvement in the standard and quality of care".

I believe that that is more comprehensive than a shorter reference to improving the quality of the service.

Again, I may not press amendment 208 today, but I may return to the matter at stage 3. What I have proposed is to put a reference to rights in a general sense in two places in the bill. I think that that is important in order to emphasise the importance of the rights-based approach to integration.

Nanette Milne has seconded amendment 209 and, without trying to pressurise her, I hope that she will speak about it. The amendment would add to section 4 the wording

"enables service-users to exercise choice and control and to participate——"

that is the key word——

"in decisions regarding their need for services and the provision of those services".

I think that every user of health and social care services should have the right to participate. I am not really sure why the cabinet secretary has a problem with that.

I will press most of my amendments, but I will not move amendment 208.

I move amendment 19A.

Nanette Milne: It is very welcome that the bill is person centred. However, a number of stakeholders feel strongly that amendment 206, in my name, emphasises that the bill should go beyond just people’s needs to their aspirations and abilities. I appreciate what the cabinet secretary said about guidance coming forward to health boards on the definition of needs, but I would like to see it made a bit more explicit in the bill. By explicitly referring to “aspirations” and “abilities” as well as needs, amendment 206 reflects the human rights approach of the bill. I will therefore move amendment 206.

I support amendment 209, in the name of Malcolm Chisholm, because I think that what it proposes would enable service users to “participate in decisions” regarding their need for services and give them “choice and control” in decision making, which I think we all feel is very important. I am happy to support that principle by supporting amendment 209.

Aileen McLeod (South Scotland) (SNP): I thank the cabinet secretary for his support for my amendment 143. During the committee’s consideration of the bill at stage 1, we received evidence from various stakeholders about their concerns around the need for principles on the quality and safety of care to be embedded in the core principles of both the planning and delivery of the integrated services that are set out in the bill. In the committee’s stage 1 report, we were sympathetic to those concerns and asked the Government to reconsider its approach to quality and safety in the bill.

I note that many of those concerns have been addressed in the amendments lodged by the cabinet secretary. In particular, new wording has been proposed in amendment 102, which will amend section 25 with respect to the integration delivery principles, at line 9 on page 11. That amendment will introduce the wording:

“protects and improves the safety of service-users” and

“improves the quality of the service”.

Amendment 143 seeks to replicate that wording in section 4, on the integration planning principles, so that there is consistency in both sets of principles. I believe that the quality and safety of care are fundamental, and I am keen for that to be emphasised in the planning principles, so that the requirements for the quality and safety of care must be taken into account by health boards and local authorities when they are preparing their integration schemes. I ask colleagues to support amendment 143.
Rhoda Grant: I will speak to amendments 223, 227, 228 and 231, which are in my name.

Amendment 223 ensures that the provisions in section 25(1)(b) apply to those services that are commissioned or contracted as they do to services from statutory providers. The cabinet secretary said that he has sympathy for amendment 223 but that it would perhaps have some unintended consequences. I will take the amendment away and possibly bring it back at stage 3 when I have considered what he has said about those unintended consequences.

Amendment 227 provides a new duty on the integrated authorities to enable service users to move between different board areas. Currently, service users moving to another authority area need to be assessed when they move, before their support package can be put in place. That is a major barrier to movement, especially for career and family reasons. If we believe in providing people with basic human rights, we need to ensure that they have confidence that there will be no gap in service provision and that they will not be detrimentally affected by their decision to move house. Amendment 227 places a duty on the integrated authorities to take that into account.

I have heard what the cabinet secretary has said on the matter, and he has pointed out that people need to be physically present in an area before transitional arrangements can be put in place. I intend to move amendment 227, because I think it is important to include that in the bill. It puts an onus on the integrated authorities to take that into account and to ensure that people have confidence that services will be available, which will allow them to move. Otherwise, people face a huge barrier to moving.

Amendment 228 addresses the 15-minute or seven-minute care visit. It places a duty on service providers to spend an adequate length of time for the delivery of the service that they have been commissioned to provide. It provides for service users’ wellbeing and dignity and, hopefully, it will ensure that service users receive adequate care and will put an end to care visits of 15 minutes or less.

Amendment 231 recognises that people working to provide care services are often low paid, and that they lack training or support to provide those services. We must all recognise the dedication and professionalism of staff who provide care, which often goes unrecognised. Staff are often paid the minimum wage and receive little or no training in order to fulfil their duties. That is especially the case regarding services that are contracted out. As we know, local government and NHS boards are signed up to paying a living wage, but that is not true in other sectors. Amendment 231 would hopefully call a halt to those practices and would ensure that front-line care providers are properly trained and remunerated, so that they can provide safe, high-quality care.

However, amendment 231 is dependent on amendment 223 to put the onus on those people who are commissioned to provide services, so I intend not to move amendment 231 and to bring it back at stage 3 once I find an appropriate place to put it, where it would not have any unintended consequences.

We should all aspire to people being paid the living wage, and we should ensure that that applies to all those who are paid from the public purse.

I support the other amendments in the group that seek to improve the principles of the bill by placing greater emphasis on the needs and aspirations of service users. It is important to include rights in the bill. As Malcolm Chisholm said, other legislation has already done that. I very much hope that the cabinet secretary might see his way to supporting the proposals in that regard.

11:00

Bob Doris (Glasgow) (SNP): I will make a couple of brief comments. I was not going to speak about amendment 228, but I will refer to it briefly. The first part of amendment 228 mentions improving

"the quality of the service to service-users".

I think that amendment 143 takes that into account. The second part of amendment 228 states that that is

"particularly in relation to the amount of time afforded to ... service-users".

We all have concerns, on occasion, about the practices of certain local authorities, but I am not sure whether the bill is the place to make provision in relation to that. I merely wanted to put that on the record. It is not a way of dismissing some of the concerns that are out there. I just do not think that the bill is the appropriate place to make such provision.

My more substantive comment is on amendment 209, on extending choice for service users, which was lodged by Malcolm Chisholm, supported by Nanette Milne. I would be interested to hear from the cabinet secretary when he sums up whether he agrees that the self-directed support rights that individuals have in relation to social care services, if they are properly applied, already give them much of that choice and control, and that service users could use them rather than our including something on that in the bill. Integration, under community planning and the forthcoming community empowerment and
renewal bill, is a way to extend the influence, choice and control of service users.

The Convener: I call on the cabinet secretary to wind up.

Alex Neil: I will try to deal with the main points that members have raised. We are all trying to end up in the same place. The issue is largely how we get there, and different routes have been suggested.

First, picking up on Bob Doris’s latter point, I note that I oppose a number of the amendments not because I disagree with their intention but because I believe that it is more appropriate for the issues to be addressed in full in secondary legislation and in guidance. The danger is that, if we tie ourselves down in language in the bill, we may at a later stage find ourselves restricted in our flexibility, particularly where there are changing circumstances. Secondary legislation and guidance can be changed and updated much more regularly to reflect changing circumstances than can primary legislation. Again, I am happy not just to discuss these matters with committee members but to have further discussions with stakeholders about what should be in the bill and what is better done in secondary legislation or in guidance.

Secondly, in response to a point that Malcolm Chisholm made, I point out that we did not incorporate the human rights legislation into the Social Care (Self-directed Support) (Scotland) Act 2013. What we did was to define independent living and the criteria for that. I am keen that we do everything that we can to encourage people with independent living, but it is not always appropriate in every circumstance. For example, if there is an extremely frail older person who is not capable of independent living, that is clearly something that we have to address in other ways. The amendments do not contain enough flexibility in relation to the different circumstances of the multitude of service users that we deal with in health and social care.

A good example of that arose yesterday—although the reporting was somewhat inaccurate in places—when BBC Scotland referred to people with long-term conditions, some of whom may be close to being in a vegetative state. Clearly, for them, independent living is not the appropriate package of care. We need to be able to deal with every eventuality and not constrain ourselves and have unintended consequences because of wording in the bill. I am anxious to ensure that we do not do that, particularly in relation to independent living, which is a core part of the philosophy and the delivery of services right across everything that we are doing in health and social care.

Finally, I come to the human rights issue. I stand by what I said—unlike Westminster, we are governed by the convention in absolutely everything that we do. However, I recognise that there is another body of opinion and people still feel strongly that there is a need to reflect rights more in the bill.

I am happy—indeed, I will undertake—to have further discussions with the key stakeholders who have made this point to find out whether I can do a bit more to accommodate their position at stage 3. There is no point in repeating in this bill something that is already in law, but I am happy to consider any area where those people feel that a shortfall still has to be addressed and to look again at the matter before we finalise stage 3.

The Convener: The question is, that amendment 19A be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 19A disagreed to.

Amendment 19 agreed to.

Amendments 20 and 21 moved—[Alex Neil]—and agreed to.

Amendment 205 moved—[Malcolm Chisholm].

The Convener: The question is, that amendment 205 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 205 disagreed to.

Amendment 206 moved—[Nanette Milne].

The Convener: The question is, that amendment 206 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 206 disagreed to.

Amendment 207 moved—[Alex Neil]—and agreed to.

The Convener: The question is, that amendment 207 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 207 disagreed to.

Amendments 23 and 24 moved—[Alex Neil]—and agreed to.

Amendment 143 moved—[Aileen McLeod]—and agreed to.

Amendment 208 not moved.

Amendment 209 moved—[Malcolm Chisholm].

The Convener: The question is, that amendment 209 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 209 disagreed to.

Amendments 25 and 26 moved—[Alex Neil]—and agreed to.

Section 4, as amended, agreed to.

The Convener: I propose a short comfort break of five minutes. I knew that that would make Richard Lyle happy—it is my purpose in life to put a smile on that man’s face.

11:11

Meeting suspended.

11:20

On resuming—

Section 5—Power to prescribe national outcomes

The Convener: Amendment 210, in the name of Bob Doris, is grouped with amendments 213, 215, 220, 232, 235 and 238.

Bob Doris: Section 1 of the bill provides that a local authority and health board must prepare an integration plan with regard to the delegation of functions and resources for the area of the local authority. The plan must set out which integration model will apply, the functions to be delegated, and the resources that will be available to support the effective delivery of those functions.

The integration plan will also have a key part to play in delivering the new framework being introduced by the legislation. Significantly, before submitting the integration plan to the Scottish ministers for approval, a local authority and health board must jointly consult various persons or groups of persons under section 6(2) of the bill.

Allied health professionals deliver a wide range of significant health and social care outcomes. They are experts in rehabilitation, re-ablement, preventative care, health promotion and self-
management. Indeed, allied health professionals are often the link that holds complex health and social care pathways together, especially for older people and those with long-term conditions. Many individuals value highly the person-centred therapeutic approach applied by allied health professionals. Significantly, the desired outcomes of the bill, particularly in relation to positive patient experience, are aligned with the approach and practice of the allied health professionals. Amendment 213 would ensure that allied health professionals are consulted in the preparation of integration plans.

Amendment 210 refers to section 3 of the bill. It provides that, when a local authority and a health board are preparing an integration plan, they must have regard to the integration planning principles and to the national health and wellbeing outcomes. Under section 5, the Scottish ministers may, by regulation, prescribe national outcomes in relation to health and wellbeing. Before making such regulations, however, the Scottish ministers are required, under section 5(3), to consult representatives of various bodies and groups and to involve them in the development of these outcomes. Amendment 213 would ensure that allied health professionals are consulted at that point.

Amendments 215 and 220 refer to integration joint boards and integration joint monitoring committees respectively. If passed, the amendments would give a statutory right to a place for allied health professionals on such boards and committees. If it is not desirable to put such a right on a statutory footing, I ask the cabinet secretary for reassurance that allied health professionals will be suitably consulted and have their expert views made known.

I turn to amendments 235 and 232. For the purposes of preparing a strategic plan, integration authorities must establish and consult groups. The term used is “such other persons as it considers appropriate”. If passed, amendments 235 and 232 would ensure that allied health professionals would be specified as such appropriate groups or persons to be consulted.

The final amendment in the group, amendment 238, gives a definition to a term that is used throughout the amendments: relevant profession. For the purposes of the amendments, it has the same meaning as in the Health Professions Order 2001.

One of the difficulties in preparing the amendments was that there seems to be no legal definition of allied health professionals. That is why the amendments would place the phrase “relevant profession” in the bill. Some other stakeholder groups suggested to me—correctly, in my view—that to define a relevant profession as an allied health profession is to apply a rather narrow definition. That shows the difficulties that arise when we try to specify in the bill different groups to have statutory rights as consultees or to be on boards.

I am convinced that allied health professionals have a vital role to play in health and social care integration and in other matters, such as seven-day healthcare provision, which the Parliament has considered in the recent past and will continue to consider as part of the 2020 vision. Therefore, the amendments are intended as probing amendments to get some assurances from the cabinet secretary that allied health professionals are a key stakeholder group. Depending on his response to the points that I have made, I would be content to withdraw amendment 210 and not to move the others at the appropriate stage.

I move amendment 210.

Malcolm Chisholm: I certainly support the thrust of what Bob Doris is saying. Often in the past, the vital contribution and role of allied health professionals have been overlooked. I do not know whether the amendments in this group are the right way to address that issue; I am open minded about that. I have an amendment coming later that, in a different context, recognises the importance of allied health professionals so, in general, I am anxious that that be recognised in the bill and accompanying guidance.

I support the spirit of what Bob Doris says, but we might need to revisit the wording subject to what the cabinet secretary says.

Rhoda Grant: I have sympathy with Bob Doris’s amendments as well. I very much hope that all health professionals who are involved in the delivery of front-line services will be involved in all the processes in the bill. When we visited Highland, one of the things that struck us most was that nursing staff, allied health professionals and everybody else involved in somebody’s care were speaking together—there were no barriers to that—and delivering good-quality care.

There is concern that allied health professionals have perhaps not been as fully involved in the past as they should have been. I hope that not only they but all health professionals will be involved.

Nanette Milne: I agree with that. Rhoda Grant spoke about our visit to Highland. We saw the same in West Lothian, where integration was working because all professionals were involved and focusing on the needs of the patients who were being looked after. It is crucial to involve them all, and it would be important to provide for that in the bill.

Alex Neil: Section 48 of the bill allows the Scottish ministers to prescribe via regulations a list
of health professionals. It is not clear whether amendment 210 is intended to define “health professionals” fully or expand the types of professional who must be consulted to cover a broader range of health professionals.

Given that the Scottish ministers have the power to prescribe via regulations what is meant by health professionals, it is not at all clear what added value amendment 210 would bring. The effect would be to remove some of the flexibility for the Scottish ministers to define health professionals.

The intended effect may be to provide clarity in the bill about which professionals working in health services must be consulted under sections 5, 6 and 7 and included under sections 12, 16 and 26, but the definition provided for in the amendments does not appear to achieve that outcome. It covers various professions but not, for example, doctors and nurses. Therefore, the effect is confusing and appears to add unnecessary complexity to the provision already made for the inclusion of health professionals in the consultation process.

11:30

Amendment 238 provides a definition of “relevant profession”, although it is not a comprehensive definition. I fully understand that the intention is to ensure that all health professionals, including allied health professionals, are properly consulted, particularly on regulations, guidance and secondary legislation, but I believe that the existing provisions already do that. I will undertake to ensure that that consultation happens because we are very keen that it should.

As Nanette Milne and Bob Doris rightly said, the success of integration projects that are already up and running, such as that in West Lothian, proves their benefits and the necessity to involve all professionals in every stage of the design and delivery of health and social care services. Unfortunately, the amendments in this group would not do the job. The job is better done elsewhere in the bill and regulations.

The Convener: I call on Bob Doris to wind up and press or withdraw amendment 210.

Bob Doris: I thank the cabinet secretary for his reassurances. He has put on public record the central role that allied health professionals and others will have in making a success of not just health and social care integration but other challenges that will be faced by social care and public health in the years ahead. Given those reassurances, I would like to withdraw amendment 210.

Amendment 210, by agreement, withdrawn.
The Convener: The question is, that amendment 211 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 211 disagreed to.

Section 5 agreed to.

Section 6—Consultation

Amendments 27 and 28 moved—[Alex Neil]—and agreed to.

The Convener: Amendment 212, in the name of Rhoda Grant, is in a group on its own.

Rhoda Grant: Amendment 212 is part of a suite of amendments that seek to ensure co-production with service users and their carers. It ensures the involvement of service users and their carers in the preparation of integration plans and that they, along with their representative groups, will be involved in the process. It ensures co-production in proposing the integration plans, which is important in involving people in the services that are provided for them.

I move amendment 212.

Alex Neil: Amendment 212 adds the requirement for health boards and local authorities to involve service users, unpaid carers, third sector organisations and others in the process of developing and agreeing their integration plans.

The committee will wish to note the list of stakeholders that is within the policy statement on section 6 and that the Scottish ministers intend to require them to be consulted on integration schemes. The list of stakeholders includes all those who are noted within amendment 212 as well as a number of other groups of people who I believe should also be consulted, such as health and social care professionals. I draw the committee’s attention to section 6(3), which requires that

"the local authority and the Health Board must take account of any views expressed"

by those who they must consult as noted in the policy statement.

The requirement to consult and take account of views goes beyond a duty to involve, as amendment 212 would provide. Therefore, the existing provisions in section 6 and the regulations that I intend to make under that section already go further than would the effect of amendment 212. I therefore ask Rhoda Grant to withdraw the amendment.

Rhoda Grant: I believe that the amendment would go further than consultation. It seeks to involve people in genuine co-production and planning of services that they will be using. I therefore press amendment 212.

The Convener: The question is, that amendment 212 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 212 disagreed to.

Amendment 213 not moved.

Amendment 29 moved—[Alex Neil]—and agreed to.

Section 6, as amended, agreed to.

Section 7—Approval of integration plan

Amendments 30 to 34 moved—[Alex Neil]—and agreed to.

The Convener: Amendment 144, in the name of the cabinet secretary, is grouped with amendment 145.

Alex Neil: The bill, as introduced, does not clearly establish the process for approval, modification and resubmission of integration schemes. The amendments will ensure that that process is made explicit and is conducted within a set timeframe.

The amendments will require that, when the Scottish ministers refuse to approve an integration scheme, the health board and the local authority will be given one opportunity to provide a modified
integration scheme. The amendments require the Scottish ministers to provide detailed information on why the scheme was not approved and advice on how it can be amended to meet approval.

The Scottish ministers will set a timescale in which the resultant modified scheme must be submitted for consideration. The amendments make it clear that, if ministers find cause to reject a modified integration scheme—if, for example, the detailed information and advice that they have provided has not been taken into account—they will use their default powers, which are outlined in section 39, to ensure that integration occurs.

The amendments will ensure that fit-for-purpose integration schemes are established across Scotland in good time to progress integration.

I move amendment 144.
Amendment 144 agreed to.
Amendments 35 and 145 moved—[Alex Neil]—and agreed to.
Section 7, as amended, agreed to.

Section 8—Publication of integration plan
Amendment 36 moved—[Alex Neil]—and agreed to.
Section 8, as amended, agreed to.

Section 9—Functions delegated to integration joint board
Amendment 37 moved—[Alex Neil]—and agreed to.

The Convener: Amendment 38, in the name of the cabinet secretary, is grouped with amendments 61 to 63.

Alex Neil: Section 9, as introduced, covers the delegation of functions where the integration joint board model is used. Section 9(3) establishes that functions for integration must "be delegated before the prescribed day."

Amendment 38 enables the delegation of functions to take place at any date after the integration scheme has been approved by the Scottish ministers, provided that the formal requirements of the bill in relation to the strategic plan are complied with. The Scottish ministers may also prescribe a day by which all functions must be delegated and strategic plans must commence. That enables integration authorities to put integrated arrangements in place as soon as they are ready and makes provision for a date by which integrated arrangements must be in place.

Amendment 38 responds to feedback from stakeholders that indicates that different areas are at different stages of development in relation to integration and that those that are further ahead do not want to be artificially held back by a single go-live date that applies to all areas.

Amendments 61 and 62 provide clarification on the date on which a lead agency arrangement will go live. They also provide for certainty in start dates for lead agency arrangements, which enables the Scottish ministers to prescribe a day by which functions must be delegated. The result is that all integrated health and social care arrangements in Scotland will be in place by that date at the latest. Locally, partners will also have flexibility to delegate functions earlier than that.

Amendment 63 is consequential to amendment 62.
I move amendment 38.
Amendment 38 agreed to.
Section 9, as amended, agreed to.

Section 10—Chief officer of integration joint board
Amendments 39 and 40 moved—[Alex Neil]—and agreed to.
Section 10, as amended, agreed to.

Section 11—Other staff of integration joint board

11:45
The Convener: Amendment 41, in the name of the cabinet secretary, is grouped with amendments 42, 43, 45, 214, 46 to 48, 51 and 217.

Alex Neil: Amendments 41 and 42 seek to provide further clarity on the ability of the Scottish ministers to make an order under section 11 that would allow integration joint boards to recruit staff other than the chief officer. Amendment 41 provides for flexibility in the use of the powers, so an order made under section 11 can apply to a single integration joint board or to some integration joint boards.

Amendment 42 places a requirement on the Scottish ministers to consult with health boards, local authorities and integration joint boards, where established, before exercising the power to make an order under section 11 to enable integration joint boards to employ staff directly. Enabling integration joint boards to employ staff provides for a significant change in the delivery of health and social care, so I recognise the wide-ranging nature of those powers.

Amendments 41 and 42 will establish a flexible and collaborative approach to the further
empowerment of integration joint boards, which I believe is more appropriate.

Amendments 43, 45, 46, 47, 48 and 52 all relate to section 12, which sets out further provisions that relate to integration joint boards. Amendment 43 aims to clarify that “their functions” means both functions conferred directly on the integration joint board by virtue of the bill, such as a duty to prepare a strategic plan, and delegated functions by virtue of an integration scheme, and that in either case those powers can be conferred on the integration joint board only by an order made by the Scottish ministers.

Amendment 45 enables the Scottish ministers to make an order allowing integration joint boards to establish committees or to delegate functions conferred upon them by an integration scheme. That will be necessary for the effective delivery of functions should direct delivery of delegated functions by the integration joint board be permitted in future. It is important that the responsibility for the effective carrying out of both the delegated functions and the functions conferred on the integration joint board by virtue of the bill, such as preparing the strategic plan, continues to rest with the integration joint board. Therefore, it is only the delegated functions that may be sub-delegated to committees of the integration joint board, the chief officer of the integration joint board or employees of the integration joint board.

Amendment 214, in the name of Rhoda Grant, would add a requirement that, when the Scottish ministers prescribe the membership of the integration joint board, they must include service users, unpaid carers and non-commercial organisations. The committee will wish to note the policy statement provided for section 12, which provides detailed information on the requirements that the Scottish ministers intend to set out in regulations in relation to the membership and proceedings of the integration joint board. The list of members of the integration joint board includes all those noted in amendment 214 and a number of other groups of people that I believe should be involved, such as health and social care professionals.

I believe that it is disproportionate to set out in the bill the groups noted in amendment 214, thus treating the representation of those groups in a different way from the representation of, for example, local authorities and health boards. I believe that the proper place to list the membership of the integration joint board is in regulations and I intend to include all those noted in amendment 214. I therefore cannot support amendment 214.

Amendment 46 seeks to ensure that the Scottish ministers’ powers in section 12 are subject to appropriate restrictions. It will allow the Scottish ministers to set out a standard set of arrangements for integration joint boards, covering membership and general proceedings to be introduced, and prevent those arrangements from being varied when it is not appropriate.

Amendment 47 seeks to specify that an order made under section 12 does not require to make general provision for all integration joint boards, except for general orders noted in amendment 46, but can also be for either one or some integrated joint boards. This drafting amendment clarifies the use of the power in section 12.

With regard to amendment 48, stakeholders have raised concerns that the powers in section 12 are far-reaching and, should they be exercised, could significantly change the delivery of health and social care. In recognition of the concerns that have been expressed, especially by local government, I have lodged amendment 48, which seeks to require the Scottish ministers to consult the health board, the local authority and the integration joint board, where it has been established, to ensure that empowerment of integration health boards, where appropriate, is taken forward in a collaborative way.

Amendment 51 seeks to require integration joint boards to have an officer responsible for their financial affairs; to keep accounts; and to have their accounts audited and to provide for the audit to be carried out by the Accounts Commission for Scotland. That will ensure that the bill provides for the proper stewardship, accounting and audit of the money that is received and paid by integration joint boards and for a duty upon integration joint boards to achieve value for money.

Amendment 217, in the name of Rhoda Grant, which seeks to create a new complaints and appeals system for integration joint boards, is, I believe, unnecessary. Health boards and local authorities already have complaints systems. We fully recognise that the current system for social work complaints is no longer up to date or fit for purpose and have been working to produce a new system that will be more accessible, allow complaints to be completed far faster and provide the user with greater transparency. We expect that complaints about services provided by local authorities or health boards will be handled in accordance with new regulations that we expect to introduce shortly and which will produce a joined-up, seamless complaints service and a coordinated response for the complainant. In any case, the Public Bodies (Joint Working) (Scotland) Bill is not the appropriate legislative vehicle for making changes to the complaints system, especially when we have not consulted on them as part of this bill.
I move amendment 41 and invite Rhoda Grant not to move amendments 214 and 217.

Rhoda Grant: Amendment 214 seeks to ensure that all service users, carers and their representatives have a representative member on integration boards. Although by necessity that board member will have to represent a very wide group, it is nevertheless important that they are at the very heart of the board and I welcome the cabinet secretary’s comments about setting that out in regulations.

The cabinet secretary also said that he did not want to treat those people differently from other groups involved in the board but I suggest that they are different. After all, those are the people for whom the services will be devised and, coming back to the issue of co-production in the bill, I hope that they will be involved in the decisions that are made for them.

As the cabinet secretary will introduce regulations to put what I have suggested into practice, this amendment might have no meaning, so I will not move it. However, I hope that the cabinet secretary will consider whether there is some way of putting users and carers at the heart of the bill to make it very clear that this legislation is for them, and of ensuring that co-production is employed in creating the services that they use and which support them.

Amendment 217 seeks to ensure the introduction of an integrated complaints procedure that will be devised by the Government and which will provide some uniformity with regard to the integration boards. I note the cabinet secretary’s comments about introducing a joined-up complaints procedure. It is really important that service users do not have to try to find out which authority, health board or integration board the person in question works for before they can instigate a complaint and, as a result, we need a joined-up scheme. I will wait and see what the cabinet secretary proposes and, for the moment, will not move amendment 217.

The Convener: As no other members wish to speak, I call the cabinet secretary to wind up.

Alex Neil: I thank Rhoda Grant for agreeing not to move her amendment. I will stick to the commitments that I have given and take on board her comments.

Amendment 41 agreed to.

Amendment 42 moved—[Alex Neil]—and agreed to.

Section 11, as amended, agreed to.

Section 12—Integration joint boards: further provision

Amendments 43 to 45 moved—[Alex Neil]—and agreed to.

Amendments 214 and 215 not moved.

Amendments 46 to 49 moved—[Alex Neil]—and agreed to.

The Convener: Amendment 50, in the name of the cabinet secretary, is grouped with amendments 216, 218, 66, 80 and 81.

Alex Neil: The order-making power in section 12 provides for the Scottish ministers by scheme to enable the staff, property, rights and so on of a local authority or a health board to be transferred to an integration joint board. Integration joint boards will not be initially established with employees of their own, but will instead discharge their duties via directions to the health boards and local authorities.

Section 12(3) allows for a possible future decision by the Scottish ministers that integration joint boards should be able to employ staff directly. I fully realise that that has wide-ranging implications for the delivery of health and social care. I therefore lodged amendment 50, which requires the Scottish ministers to consult the relevant integration joint board, health board and local authority before making such a scheme as an appropriate and proportionate mechanism to ensure a collaborative approach for the transfer of staff, property, rights and liabilities to integration joint boards.

Similarly, amendment 66 places a requirement on the Scottish ministers to consult the health board and local authority before making any such scheme under section 15 on the transfer of staff between health board and local authority employment in either direction under lead agency arrangements in order to ensure that their views are taken into account.

Amendments 216 and 218, in the name of Rhoda Grant, would require the Scottish ministers, before making such a scheme under section 12 or section 15 with regard to staff, to consult health and social care professionals and other groups of persons whom the Scottish ministers consider to have an interest. I recognise the concerns expressed during stage 1 that staff should be given a voice in any decision to transfer their employment from a health board or a local authority to an integration joint board. I welcome Rhoda Grant’s amendments in that regard and I accept amendments 216 and 218.

Furthermore, section 36(3) makes similar provision for the Scottish ministers, by scheme, to make provision about the transfer of staff in consequence of a new integration scheme. For
consistency, I therefore intend to lodge an amendment at stage 3 that will replicate the effect of amendments 216 and 218 in relation to section 36(3).

12:00

Amendment 80 seeks to clarify the circumstances in which section 19 applies. Section 19 already makes it clear that it applies to transfers of employment under the circumstances that are set out in sections 12 and 15. The amendment proves beyond doubt that section 19 also applies to transfers of employment that take place when a scheme is made as a result of a new integration scheme under section 35.

Amendment 81 clarifies the intention of section 19(3)(b) in relation to pension obligations in circumstances in which staff transfer between employers, such as between a local authority and a health board or to an integration joint board. When such a transfer takes place, there will be no transfer of any liability for any deficit or right to a share in any surplus in respect of the transferred employee’s membership of a pension scheme for their employment prior to the transfer. The amendment ensures that such transfers correspond to the requirements of international accounting standards and avoids the risk of a potential misinterpretation resulting in a material additional expense to the original employer.

I move amendment 50 and support Rhoda Grant’s amendments 216 and 218.

Rhoda Grant: Amendments 216 and 218 recognise the impact on staff of the changes to integration boards. In the public sector, there are already efficient and well-established procedures for consulting, negotiating and involving staff in changes to their working conditions and arrangements. I hope that those good practices will continue into the partnership authorities, especially during the time of transition, and it is important that we put that in the bill to ensure that it happens. I am grateful to the cabinet secretary for his support for those amendments.

On amendment 81, which relates to pensions, I understand what the cabinet secretary says but I seek assurance that the amendment will not interfere with a person’s right to transfer their pension if they see fit and if that gives them the best deal when they move employer. I seek some reassurance on that.

Alex Neil: I reassure Rhoda Grant that amendment 81 does not affect an employee’s right to transfer their pension.

Amendment 50 agreed to.

Amendment 216 moved—[Rhoda Grant]—and agreed to.

Section 12, as amended, agreed to.

After section 12

Amendment 51 moved—[Alex Neil]—and agreed to.

Amendment 217 not moved.

Section 13—Payments to integration joint boards in respect of delegated functions

Amendments 52 and 53 moved—[Alex Neil]—and agreed to.

Amendment 146 not moved.

Amendments 54 to 59 moved—[Alex Neil]—and agreed to.

Section 13, as amended, agreed to.

Section 14—Functions delegated to local authority or Health Board

Amendments 60 to 63 moved—[Alex Neil]—and agreed to.

Section 14, as amended, agreed to.

Section 15—Transfer of staff where functions delegated to local authority or Health Board

Amendment 64 moved—[Alex Neil]—and agreed to.

Amendment 218 moved—[Rhoda Grant]—and agreed to.

Amendments 65 and 66 moved—[Alex Neil]—and agreed to.

Section 15, as amended, agreed to.

Section 16—Integration joint monitoring committees: further provision

The Convener: Amendment 219, in the name of Rhoda Grant, is in a group on its own.

Rhoda Grant: Amendment 219 deals with the principles of co-production by ensuring that service users and carers or their representative groups are included in the membership of monitoring committees, which would ensure their involvement at every stage in the process. I very much hope that members will support the amendment, which would ensure that service users and carers are involved in monitoring the care that is provided for them.

I move amendment 219.

Alex Neil: I believe that amendment 219 should refer to section 16(1)(b), which is the power to make regulations regarding membership of a committee, rather than section 16(1)(a), which is
the power to make an order regarding its establishment. I will proceed on that basis.

Amendment 219 would add a requirement that when Scottish ministers prescribe the membership of the integration joint monitoring committee, they must include service users, unpaid carers and non-commercial organisations. The committee will wish to note the policy statement provided for in section 16, which provides detailed information on Scottish ministers’ intentions in relation to the provision that will be made for the membership and proceedings of the integration joint monitoring committee.

The list of members of the integration joint monitoring committee that I intend to prescribe includes all those noted in amendment 219 and a number of other very important groups of people, such as health and social care professionals and a staff representative. I believe that it is disproportionate to set out in the bill that we should include the groups noted in amendment 219 but not provide in that way for, for example, the representation of local authorities and health boards, health and social care professionals or service users themselves.

I believe that the proper place to list the membership of the integration joint monitoring committee is in secondary legislation. I intend to include all those noted in amendment 219 in such secondary legislation. On that basis, I ask Rhoda Grant to withdraw amendment 219.

Rhoda Grant: Given the cabinet secretary’s reassurance, I seek to withdraw amendment 219.

Amendment 219, by agreement, withdrawn.

Amendment 220 not moved.

Section 16 agreed to.

Section 17—Payments to Health Boards in respect of delegated functions

Amendments 67 to 70 moved—[Alex Neil]—and agreed to.

Section 17, as amended, agreed to.

Section 18—Payments to local authorities in respect of delegated functions

Amendments 71 to 78 moved—[Alex Neil]—and agreed to.

Section 18, as amended, agreed to.

After section 18

Amendment 79 moved—[Alex Neil]—and agreed to.

Section 19—Transfer of staff: effect on contract of employment

Amendments 80 and 81 moved—[Alex Neil]—and agreed to.

Section 19, as amended, agreed to.

Section 20—Co-operation

Amendments 82 and 83 moved—[Alex Neil]—and agreed to.

Section 20, as amended, agreed to.

After section 20

The Convener: Amendment 84, in the name of the cabinet secretary, is grouped with amendments 85 and 87 to 89.

Alex Neil: Amendments 84 and 85 will allow functions that are conferred by statute directly on an officer of a health board or a local authority, when those functions relate to a function that is delegated as part of an integration scheme, to be treated as being conferred on officers of the other bodies that prepared the integration scheme. That will ensure that no barriers to fully integrating health and social care arise from the fact that certain statutes confer functions directly on officers of local authorities or health boards. The amendments will allow flexibility in the exercise of such functions, which is consistent with the aim of integration.

As for amendment 87, section 21 covers the effect of the delegation of functions on the rights, duties and powers of health boards, local authorities and integration authorities. The provisions are particularly important to establishing liability in the event of any failure of integrated services. In the bill as introduced, liability for failure rests entirely with the authority to which functions were delegated. I now consider that to be an impractical approach to liability, which will as time goes on be complex by definition, given the complexity of people’s needs and the resulting health and social care provision to support them.

12:15

Amendment 87 follows the principle that responsibility should rest with control and makes clear that the integration authority or either of the delegating bodies may be liable for any claims arising from the exercise of delegated functions. In particular, the integration authority might be liable for claims that can be attributed to failures in relation to its role, such as failures of strategic planning. However, that does not preclude the possibility that a health board or local authority should be liable for acts that have been carried out in the exercise of a direction of the integrated
authority through the strategic plan and that were factually within that board’s or authority’s control.

Since the bill was introduced, a great deal of work has been undertaken with stakeholders to clarify questions relating to governance and, as part of that, liability in the event of things going wrong under integration. Amendment 87 sets out a practical approach to the potential complexities of liability under integrated arrangements. It allows responsibility for the exercise of the functions to be determined on a case-by-case basis. Given the complexities of health and social care planning and provision for an ageing population, I judge that to be an appropriate and proportionate solution. Work is on-going with stakeholders to plan for any liabilities that may arise under the exercise of integrated health and social care provision. A working group is planned that will comprise all members of the Society of Local Authority Lawyers and Administrators in Scotland, NHS Scotland’s central legal office and the Scottish Government legal directorate to develop guidance for integration authorities that will enable them to set out provisions regarding liability in their integration schemes.

With regard to amendment 88, section 22 provides for integration authorities to give directions to health boards and local authorities with respect to carrying out functions. The section enables integration authorities to ensure that health boards or local authorities provide the services that are set out under the strategic plan. The purpose of amendment 88 is to close the loop that enables the integration joint board to oversee the strategic planning process by giving directions to health boards and local authorities for the delivery of services.

The amendment will change section 22 to reflect the different integration models. It provides that, where an integration authority is an integration joint board—that is, where the corporate body model is used—that integration joint board must provide direction to the health board and local authority on the provision of services. Integration joint boards will not—initially at least—employ their own staff and directly deliver services. Therefore, for services to be delivered, it will be necessary for directions always to be given to either the health board or the local authority. On the other hand, where the lead agency model is used, the bill enables but does not require the lead agency—whether it is a health board or local authority—to give direction to the delegating agency for the delivery of services where necessary. The lead agency will also deliver services, and so a requirement to give directions is not mandatory in this instance.

Amendment 88 supports the circumstances in which more than one local authority agrees a lead agency arrangement with a health board. In that situation, the local authority that is the lead agency can choose to direct only one of the local authorities to carry out a function for the entire area that is covered by the integration scheme.

In proposed new section 22(3), amendment 88 provides that the person to whom the direction is given must provide such information as is necessary to enable the integration authority to judge whether a direction is necessary. That will ensure that such information as is necessary for effective strategic planning is shared between the integration authority, the health board and the local authority.

In proposed new sections 22(4) and 22(5), amendment 88 provides that a direction can be given to more than one person. That means that an integration joint board will be able to give a direction to both the health board and the local authority, and that such a direction can require each party to carry out parts or all of the direction, depending on the circumstances. That will enable an integration authority to give directions in such a way as to support integrated service delivery by bringing together the activities of delivery teams in the health board and local authority.

Section 22 provides for integration authorities to give directions to health boards and local authorities with respect to carrying out functions. The new section that will be inserted by amendment 89 will enable integration authorities to ensure that health boards and local authorities provide the services that are set out under the strategic plan.

Subsection (1) of the new section ensures that directions issued under section 22 make adequate provision for the carrying out of functions, particularly in relation to the making of payments and the manner of carrying out the function. The effect of subsection (1) is that it will be clear to the person to whom a direction is issued how the integration authority expects the function to be provided, and the integration authority will be better placed to ensure delivery of integrated functions in accordance with the strategic plan.

Subsection (2) of the new section ensures that integration authorities are able to use directions to manage any difficult relationships with the health board and/or local authority. The effect is that where an integration authority needs to take action to protect its interests—for example, to obtain information, enforce any court order or pursue any claim against the health board or local authority—it can do that by way of a direction. Subsection (2) also provides for the situation in which any liability that is incurred by the integration authority necessitates a payment to be made by the health board or the local authority.
Subsection (3) of the new section clarifies that it is the integration authority that must make payments to the health board and local authority in support of the directions given. Subsections (6) and (7) provide for the situation in which a health board and local authority agree that an integration joint board should be enabled to deliver some functions directly by itself. Those provisions apply for the possible future position in which an integrated board is to employ such staff and manage such contractual arrangements as are necessary to deliver services directly.

Amendment 89 enables Scottish ministers to make an order preventing the joint board from giving direction to the health board and local authority, thus enabling it to carry out the function directly itself. Such an application must be made to Scottish ministers in writing by the health board and local authority. Scottish ministers may in response make an order relating to the relevant functions and the integration joint board may decline the request entirely or may make the order in relation to only some of the functions concerned, depending on whether they are of the view that doing so would improve performance in terms of the national health and wellbeing outcomes.

Subsection (8) of the new section provides for circumstances in which ministers do not believe that quality of outcomes would be improved by enabling an integration joint board to deliver some functions directly by itself and allows ministers to exclude such functions from the order.

I move amendment 84.

Amendment 84 agreed to.

Amendment 85 moved—[Alex Neil]—and agreed to.

Section 21—Effect of delegation of functions

Amendments 86 and 87 moved—[Alex Neil]—and agreed to.

Section 21, as amended, agreed to.

Section 22—Further powers of persons to whom functions are delegated

Amendment 88 moved—[Alex Neil]—and agreed to.

Section 22, as amended, agreed to.

After section 22

Amendment 89 moved—[Alex Neil]—and agreed to.
**The Convener:** I now call Nanette Milne to speak to amendments 236 and other amendments in the group. [Interruption.] No, I have jumped the gun again. I call on the cabinet secretary to speak to amendment 90 and other amendments in the group.

**Alex Neil:** The amendments in this group deal with the process of strategic planning.

Malcolm Chisholm’s amendments 147 and 201 highlight in particular the role of locality planning within strategic planning. They would give the Scottish ministers, subject to affirmative procedure, the power to set out the key principles of locality planning in regulation.

I am sure that the committee will agree that locality arrangements will be fundamental to the success of the agenda as they are at the sharp end of where health and social care services will be drawn together and delivered. Getting that right within and outwith the legislation is absolutely key.

During the past two years, the Scottish Government has had extensive discussions with stakeholders about how best to reflect locality arrangements in the legislation. The overwhelming response has been that we should require that they are established in every area of Scotland, that they are embedded within the strategic planning process, and that they involve the full range of local stakeholders in their establishment and operation.

Other than those three key areas, the response has been that the rest of the arrangements should be left to guidance to allow local flexibility on how the localities should operate. To prescribe the arrangements runs the risk of hampering local innovation, disengaging stakeholders from the start, creating unnecessary bureaucracy, and creating arrangements that are unsuitable for the majority of localities in Scotland.

12:30

I have considerable sympathy for the intention behind Mr Chisholm’s amendments 147 and 201, but I do not believe that they are the best way to achieve the aim of strengthening the basis of locality planning.

First, the bill already contains principles that integration authorities must have regard to in the development of locality arrangements. Adding a second set of principles via regulation will not add much to those arrangements.

Secondly, regulations are used to set out the detail of arrangements that must be put in place rather than principles that organisations must have regard to. That is why we have already established principles on the face of the bill that define how integration must be taken forward.

Thirdly, stakeholders have been clear that they believe that the most effective way of developing locality arrangements is to provide flexibility, underpinned with statutory guidance. The bill makes provision in section 41 to ensure that all statutory partners must have regard to the statutory guidance that we produce. I intend to provide statutory guidance on locality planning that goes beyond just the setting of principles to consider far more of the detail of how localities can be made to be successful.

Finally, the message has been clear from stakeholders that they should be left to make successful locality arrangements in the way that suits them locally. I believe that that is the right thing to do. The bill sets out clear arrangements for annual reporting and, as noted in the policy statement for the regulation, that will include a duty to report on the success of the locality arrangements. I intend to hold integration authorities to account for that. I therefore invite Malcolm Chisholm to withdraw amendment 147 and not to move amendment 201.

My amendments in this group focus on ensuring appropriately robust and flexible arrangements for strategic planning. Amendment 90 allows the health board and local authority to choose to delegate functions on a day that is earlier than the day that is prescribed by the Scottish ministers. When that is done, the integration authority must make clear in the strategic plan the date when functions are to be delegated. That will ensure transparency and clarity as to when delegation will take place. It also allows for local flexibility where good progress in integration is being made.

Amendment 91 requires the integration authority to have prepared a strategic plan before the functions can be delegated by the health board and local authority. That is important in order to ensure that services are planned for and delivered in an integrated way.

Amendment 92 removes the requirement to restrict the first strategic plan to a period of three years. As introduced, the bill requires the first strategic plan prepared by an integration authority to relate to the period of three years beginning with the prescribed day on which integration begins. While the integration authority can plan for a longer period, the plan must be reviewed and revised at least every three years. For example, if an integration authority wishes to produce strategic plans covering a five-year period, it can do so, but it will need to develop a new five-year plan at least every three years. The strategic plan can and should be reviewed at any other time within that three-year period and, if revised earlier than the end of the three-year period, a new three-year period will commence from the new start date.
Amendment 92 responds to discussion with stakeholders that has led to the conclusion that restricting the strategic planning period to a maximum of three years is unnecessary and inconsistent with good practice in relation to commissioning and planning services.

Amendment 93 removes a requirement for strategic plans following the first strategic plan to be prepared every three years, before the anniversary of the day on which the integration began. Instead, amendments 127 and 129, to be debated in group 20, require the integration authority to keep the strategic plan under continual review and to establish a new strategic plan for a period of three years.

Amendment 94 is a drafting amendment that provides for a definition of “integration start day”. The amendment provides the start of integration to be the date set out in the strategic plan or the prescribed date for integration authorities that are integration joint boards and lead agency.

Amendment 116 makes it clear that section 27 refers to the development of the strategic plan, and the strategic planning group is formed for that purpose. Amendment 118 is a technical change that updates the numbering of the section. Amendment 123 will enable the integration joint board to obtain relevant information from the health board and local authority for the purposes of preparing the strategic plan.

Amendment 124 will remove section 28, which relates to the lead agency model. In the bill as introduced, a lack of approval for the strategic plan under section 28 requires a lead agency to modify the strategic plan but does not prevent the lead agency from implementing a plan that has not been approved. To give the delegating agency a greater power over the strategic plan than that held by the lead agency would undermine the principle of delegation. The provision as it stands would therefore be an unnecessary complication to the strategic planning process, without benefit for patients or service users.

Amendment 125 will require the integration authority in a lead agency arrangement to publish the strategic plan as soon as practicable after it has been finalised. That is the same requirement that applies to an integration authority in a body corporate arrangement.

Amendment 126 will simplify section 29. As a result of removing section 28 via amendment 124, it will no longer be necessary to make different provision for different models of integration in relation to publication of strategic plans.

Amendment 131 will require the integration authority to publish an annual financial statement on commencement of its first strategic plan and every year after that. In order to support transparency regarding use of the integrated budget, the financial statement must set out the total resources that the integration authority intends to allocate under the provisions of the strategic plan.

In conclusion, I urge Malcolm Chisholm to withdraw amendment 147 and not to move amendment 201, and I urge Nanette Milne not to move amendment 236.

The Convener: I now call Nanette Milne to speak to amendment 236 and the other amendments in the group.

Nanette Milne: Amendment 236 is suggested as an approach to get third sector sign-off of strategic plans in the bill. As we know, the third sector is a key partner, alongside health boards and local authorities, and many stakeholders want to see its role clearly articulated in statutory guidance, as the cabinet secretary said, and secondary legislation.

I am seeking third sector sign-off of strategic plans prepared by the health and social care partnerships because the joint sign-off under reshaping care for older people has enabled many areas to overcome barriers to partnership and has been a key driver for the cultural change that is widely acknowledged as the essential foundation for successful integration. That is why I lodged amendment 236.

Alex Neil: I assure Nanette Milne that I totally agree with her on the need for the proper representation of the third sector, which we will provide in the secondary legislation and guidance.

The Convener: I ask Malcolm Chisholm to wind up and press or withdraw amendment 147.

Malcolm Chisholm: I listened with interest to what the cabinet secretary said. There could have been a contradiction between his strong words about statutory guidance and his previous words about leaving everything to localities so that innovation is not curtailed.

I want to look further at the issue. I may well want to lodge amendments with different wording at stage 3, but I am prepared to withdraw amendment 147 at present.

Amendment 147, by agreement, withdrawn.
Amendments 90 to 94 moved—[Alex Neil]—and agreed to.
Section 23, as amended, agreed to.

The Convener: That ends today’s consideration of the bill at stage 2. I thank everyone for their patience and co-operation.

Meeting closed at 12:39.
Public Bodies (Joint Working) (Scotland) Bill

2nd Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

Sections 1 to 53 Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 24

Alex Neil

95 In section 24, page 10, line 32, leave out from beginning to <local> and insert <This section applies where an integration authority in relation to the area of a local authority is preparing a strategic plan.

( ) The integration>

Rhoda Grant

221 In section 24, page 10, line 35, at end insert—

<( ) outcomes agreed for the area of the local authority through community planning.

( ) In this section “community planning” means planning to which the provisions of section 15(1) of the Local Government in Scotland Act 2003 (community planning) apply.>

Alex Neil

96 In section 24, page 10, line 35, at end insert—

<(3) The integration authority must have regard to the effect which any arrangements which it is considering setting out in the strategic plan in pursuance of section 23(2)(a) may have on services, facilities or resources—

(a) utilised by arrangements set out in pursuance of that section in a strategic plan prepared by another integration authority,

(b) which would be utilised by arrangements which another integration authority is considering setting out in pursuance of that section in a strategic plan which it is preparing.

(4) The references in subsections (3)(a) and (b) to a strategic plan are to a strategic plan relating to the same period as, or relating to part of the same period as, the strategic plan which is being prepared by the integration authority.>
After section 24

Malcolm Chisholm

222 After section 24, insert—

<24A Duty to seek, record and have due regard to advice

(1) In preparing a strategic plan, an integration authority for the area of a local authority must, where appropriate, seek, record and have due regard to the professional advice of the persons specified in subsection (3) in respect of issues relating to quality and safety.

(2) An integration authority for the area of a local authority must set out arrangements for how it will, where appropriate, seek, record and have due regard to the professional advice of the persons specified in subsection (3) in respect of issues relating to quality and safety in the carrying out of the integration functions for the area of the local authority.

(3) The persons are—

(a) the chief social work officer of the local authority,
(b) a registered medical practitioner nominated by the relevant Health Board,
(c) a registered nurse nominated by the relevant Health Board,
(d) a registered allied health professional nominated by the relevant Health Board,
(e) any other person prescribed by regulations made by the Scottish Ministers.>

Section 25

Alex Neil

97 In section 25, page 11, line 1, leave out from <must> to end of line 3 and insert <are provided in pursuance of functions which are delegated under an integration scheme is to improve the wellbeing of service-users,>

Malcolm Chisholm

97A As an amendment to amendment 97, line 3, after <wellbeing> insert <and independent living>

Rhoda Grant

223 In section 25, page 11, line 5, after <provided> insert <or commissioned>

Alex Neil

98 In section 25, page 11, line 5, leave out <the> and insert <a>

Alex Neil

99 In section 25, page 11, line 6, leave out <recipients> and insert <service-users>

Malcolm Chisholm

224 In section 25, page 11, line 7, after <the> insert <rights and>

Nanette Milne

225 In section 25, page 11, line 7, after <needs> insert <, aspirations, abilities, characteristics and circumstances>
Alex Neil
100 In section 25, page 11, line 7, leave out <recipients> and insert <service-users>

Malcolm Chisholm
226 In section 25, page 11, line 8, after first <the> insert <rights and>

Alex Neil
101 In section 25, page 11, line 8, leave out <recipients> and insert <service-users>

Alex Neil
102 In section 25, page 11, line 9, at end insert—
   <(  ) takes account of the dignity of service-users,
   (  ) takes account of the participation by service-users in the community in which service-users live,
   (  ) protects and improves the safety of service-users,
   (  ) improves the quality of the service,>

Rhoda Grant
227 In section 25, page 11, line 9, at end insert—
   <(  ) takes account of the particular needs of service-users moving into the area of the local authority from the area of another local authority,>

Rhoda Grant
228 In section 25, page 11, line 9, at end insert—
   <(  ) improves the quality of the service to service-users in the community, particularly in relation to the amount of time afforded to those service-users,>

Malcolm Chisholm
229 In section 25, page 11, line 9, at end insert—
   <(  ) is based on recognised guidance and adherence to established quality standards and promotes continuous improvement in the standard and quality of care,>

Malcolm Chisholm
Supported by: Nanette Milne
230 In section 25, page 11, line 9, at end insert—
   <(  ) enables service-users to exercise choice and control and to participate in decisions regarding their need for services and the provision of those services to them,>

Alex Neil
103 In section 25, page 11, line 11, leave out <and local professionals> and insert <(including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)>
Rhoda Grant

231 In section 25, page 11, line 12, at end insert—

<( ) supports and rewards people who deliver those services in the provision of high quality care to service-users, and>

Alex Neil

104 In section 25, page 11, line 14, leave out <“recipients”> and insert <“service-users”>

Section 26

Alex Neil

105 In section 26, page 11, line 17, leave out <For the purpose of preparing a> and insert <Before preparing its first>

Alex Neil

106 In section 26, page 11, line 18, after <group> insert <(its “strategic planning group”)>.

Alex Neil

107 In section 26, page 11, line 19, leave out from <one> to end of line 21 and insert—

<(i) at least one person nominated by the Health Board which is a constituent authority in relation to the integration joint board,>

(ii) where one local authority is a constituent authority in relation to the integration joint board, at least one person nominated by it,

(iii) where two or more local authorities are constituent authorities in relation to the integration joint board, at least one person nominated by the authorities,>

Alex Neil

108 In section 26, page 11, line 22, leave out <one person nominated by the local authority> and insert <at least one person nominated by the local authority or authorities>

Alex Neil

109 In section 26, page 11, line 23, leave out <plan> and insert <scheme>

Alex Neil

110 In section 26, page 11, line 25, after <authority,> insert <at least>

Alex Neil

111 In section 26, page 11, line 26, leave out <plan> and insert <scheme>

Bob Doris

232 In section 26, page 11, line 32, after <are> insert—

<( ) persons working as a member of a relevant profession,>

( )>
Rhoda Grant

233 In section 26, page 11, line 33, at end insert <and must include—

(a) service-users,
(b) unpaid carers, and
(c) non-commercial organisations who represent the interests of service-users and unpaid carers.>

Alex Neil

112 In section 26, page 11, line 33, at end insert—

<(2A) The integration authority is to determine—

(a) the number of members of its strategic planning group,
(b) so far as not set out in this section, the processes for appointment, removal and replacement of members.

(2B) The integration authority may—

(a) appoint members of its strategic planning group from persons nominated under subsection (1),
(b) in such circumstances as the authority considers appropriate, remove persons appointed under paragraph (a) from membership of the group,
(c) appoint members in place of members who resign or are removed from membership of the group.

(2C) A constituent authority may—

(a) remove from its strategic planning group a member appointed to represent it,
(b) nominate under subsection (1) another person in place of a member of the group appointed to represent it.

(2D) A member of a strategic planning group may resign at any time.

(2E) During the period to which any strategic plan of an integration authority relates, its strategic planning group is also to comprise a person to represent the interests of each locality set out in the plan in pursuance of section 23(3)(a).

(2F) It is for the integration authority to—

(a) decide which persons are suitable to represent the interests of a locality, and
(b) select the representative.

(2G) An integration authority may under subsection (2F)(b) select a single person in respect of two or more localities.

(2H) The validity of anything done by an integration authority’s strategic planning group is not affected by any vacancy in its membership.>

Alex Neil

113 In section 26, page 11, line 34, leave out second <the> and insert <an integration authority’s strategic planning>
In section 26, page 11, line 35, leave out first <The> and insert <An>.

In section 26, page 11, line 35, leave out second <the> and insert <its strategic planning>.

In section 26, page 11, line 36, at end insert—

<(5) The integration authority must make such arrangements as it considers necessary to secure the effective involvement of persons representing the groups mentioned in subsection (2)(a), (b) and (c).

(6) Arrangements under subsection (5) may, in particular, include arrangements for—

(a) paying such expenses as appear to the authority to be necessary, including the cost of replacement care,

(b) providing information in a timely fashion and in a format that is accessible to members of the group,

(c) ensuring the accessibility of venues for any meetings of the group,

(d) ensuring access to appropriate training for members of the group.>

In section 27, page 11, line 38, leave out from beginning to <local> in line 39 and insert <This section applies where an integration authority in relation to the area of a local authority is preparing a strategic plan.>

(1A) The integration>

In section 27, page 12, line 1, leave out second <the> and insert <its strategic planning>.

In section 27, page 12, line 2, leave out <(1)(b)> and insert <(1A)(b)>.

In section 27, page 12, line 5, leave out second <the> and insert <its strategic planning>.

In section 27, page 12, line 15, leave out from second <the> to end of line 17 and insert <each constituent authority,>.

In section 27, page 12, line 19, leave out <plan> and insert <scheme>.

In section 27, page 12, line 22, leave out <plan> and insert <scheme>.
Bob Doris
235 In section 27, page 12, line 26, after <are> insert—

\(<(\ )\) persons working as a member of a relevant profession,

\((\ )\)>

After section 27

Alex Neil
123 After section 27, insert—

<Provision of information for purpose of preparing strategic plan>

(1) A constituent authority must provide an integration authority which is an integration joint board with such information as the authority may reasonably require for the purpose of preparing a strategic plan.

(2) The person mentioned in subsection (3) must provide an integration authority which is a Health Board or a local authority with such information as the integration authority may reasonably require for the purpose of preparing a strategic plan.

(3) That person is the local authority or the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions.>

Section 28

Nanette Milne
236 In section 28, page 12, line 41, at end insert—

\(<(\ )\) groups appearing to the integration authority to be representative of non-commercial organisations contributing to the health and wellbeing of service-users in the area covered by the strategic plan.>

Alex Neil
124 Leave out section 28

Section 29

Alex Neil
125 In section 29, page 13, line 4, leave out <occurrence of the event mentioned in subsection (2)> and insert <finalisation of the plan under section 27>

Alex Neil
126 In section 29, page 13, line 6, leave out subsection (2)

Section 30

Alex Neil
127 In section 30, page 13, line 19, leave out <in its next strategic plan> and insert <by virtue of revising its strategic plan under section (Review of strategic plan)>
In section 30, page 13, line 23, after <must> insert—

<( ) seek and have regard to the views of its strategic planning group, and>

In section 30, page 13, line 25, at end insert—

<( ) non-commercial providers of health care or social care, and
( ) other relevant bodies who may be affected by the decision.>

After section 30

After section 30, insert—

<Review of strategic plan

(1) An integration authority—

(a) must before the expiry of the relevant period review the effectiveness of its strategic plan,

(b) may from time to time carry out such a review.

(2) In carrying out a review under subsection (1), the integration authority must—

(a) have regard to—

(i) the integration delivery principles, and

(ii) the national health and wellbeing outcomes, and

(b) seek and have regard to the views of its strategic planning group on—

(i) the effectiveness of the arrangements for the carrying out of the integration functions in the area of the local authority, and

(ii) whether the integration authority should prepare a replacement strategic plan.

(3) Following a review under subsection (1), an integration authority may prepare a replacement strategic plan.

(4) Subject to subsection (2), the process of such a review is to be such as the integration authority determines.

(5) A constituent authority must provide an integration authority which is an integration joint board with such information as the integration authority may reasonably require for the purpose of carrying out a review under subsection (1).

(6) The person mentioned in subsection (7) must provide an integration authority which is a Health Board or a local authority with such information as the integration authority may reasonably require for the purpose of carrying out a review under subsection (1).

(7) That person is the local authority or the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions.

(8) A strategic plan prepared in pursuance of this section must specify a day on which the period of the plan is to begin.
In subsection (1), “relevant period”, in relation to an integration authority, means—
(a) the period of 3 years beginning with the integration start day (as defined in section 23(4)), and
(b) each subsequent period of 3 years beginning with—
(i) where a replacement strategic plan is prepared following a review under subsection (1), the day specified under subsection (8),
(ii) where no replacement strategic plan is prepared following such a review, the day on which the integration authority decides not to prepare a revised strategic plan.

Alex Neil

130 After section 30, insert—

<Requirement to prepare replacement strategic plan

(1) This section applies where the integration authority in relation to the area of a local authority is an integration joint board.

(2) If it appears to a constituent authority that the strategic plan is preventing, or is likely to prevent, the constituent authority from carrying out any of its functions appropriately or in a way which is consistent with the integration delivery principles and the national health and wellbeing outcomes, the constituent authorities acting jointly may direct the integration authority to prepare a replacement strategic plan.

(3) A direction under subsection (2) must—
(a) be in writing,
(b) include a statement summarising the reasons for giving it.

(4) A direction under subsection (2) must specify—
(a) a day by which the replacement strategic plan must be prepared, and
(b) a day on which the period of the plan is to begin.

(5) The constituent authorities acting jointly may by direction substitute a different day for a day specified under subsection (4).

(6) An integration authority must comply with a direction given to it under subsection (2).

Alex Neil

131 After section 30, insert—

<Strategic plan: annual financial statement

(1) Each integration authority must publish an annual financial statement—
(a) when it publishes its first strategic plan, and
(b) each year after that.

(2) An annual financial statement must set out in relation to the strategic plan to which it relates the amount that the integration authority intends to spend in implementation of the plan.
Section 32

Alex Neil

132 In section 32, page 13, line 33, after <where> insert—

<( ) an integration authority carrying out an integration function for the area of a local authority proposes to take a decision which the authority considers might significantly affect the provision in a locality of the area of a service provided in pursuance of the function, or

( )>

Alex Neil

133 In section 32, page 14, line 1, leave out <person must take such action as the> and insert <integration authority or, as the case may be, person must take such action as the authority or>

Alex Neil

134 In section 32, page 14, line 4, at end insert—

<( ) The integration authority may pay to members of groups consulted under subsection (3) such expenses and allowances as the authority determines.>

Section 33

Alex Neil

135 In section 33, page 14, line 6, leave out <and publish>

Alex Neil

136 In section 33, page 14, line 9, after <year> insert <to which it relates>

Alex Neil

137 In section 33, page 14, leave out line 12 and insert—

<(3A) An integration authority must—

(a) publish each performance report before the expiry of the period of 4 months beginning with the end of the reporting year, and

(b) provide a copy of it to the persons mentioned in subsection (3B).

(3B) Those persons are—

(a) where the integration authority is an integration joint board, each constituent authority,

(b) where the integration authority is a local authority and a Health Board acting jointly, the integration joint monitoring committee,

(c) where the integration authority is a Health Board or a local authority—

(i) the integration joint monitoring committee, and

(ii) the other authority.

(3C) A constituent authority must provide an integration authority which is an integration joint board with such information as the authority may reasonably require for the purpose of preparing a performance report.
(3D) The other authority must provide an integration authority which is a Health Board or a local authority with such information as the integration authority may reasonably require for the purpose of preparing a performance report.

Alex Neil

138 In section 33, page 14, line 13, after <section> insert—

<“other authority” means the local authority or the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions.>

Alex Neil

139 In section 33, page 14, line 14, leave out <23(4)(b)> and insert <9(3) or, as the case may be, 14(1A)>

After section 33

Alex Neil

240 After section 33, insert—

<Reports by integration joint monitoring committee

Reports

(1) An integration joint monitoring committee may give reports to the integration authority on any aspect of the carrying out of the integration functions for the area of the local authority for which the integration joint monitoring committee is established.

(2) A report may include recommendations as to how those integration functions should be carried out in future.

(3) Where a report is given to an integration authority under subsection (1), the integration authority must—

(a) have regard to the report and any recommendations included in it,

(b) take such action as the authority considers necessary, and

(c) if the report includes recommendations, give the integration joint monitoring committee a response to them in writing as soon as is reasonably practicable after the authority is given the report.

(4) An integration joint monitoring committee may publish—

(a) reports given under subsection (1),

(b) responses given under subsection (3)(c).

(5) The local authority and the Health Board which prepared the integration scheme by virtue of which the integration joint monitoring committee is established must provide the committee with such reports, information or other assistance as the committee may reasonably require for the purpose of preparing a report under subsection (1).>
Before section 34

Alex Neil

241 Before section 34, insert—

<Review of integration scheme

(1) This section applies where an integration scheme has been approved by the Scottish Ministers under section 7.

(2) The local authority and the Health Board must carry out a review of the scheme before the expiry of the relevant period for the purpose of identifying whether any changes to the scheme are necessary or desirable.

(3) Sections 3 and 6 apply to a review of an integration scheme under subsection (2) as they apply to the preparation of an integration scheme (but as if the words “Before submitting the integration scheme for approval under section 7,” in section 6(2) were omitted).

(4) After taking account of any views of persons consulted under section 6 (as applied by subsection (3)), the local authority and the Health Board must decide whether any changes to the scheme are necessary or desirable.

(5) In subsection (2), the “relevant period” means—

(a) the period of 5 years beginning with the day on which the scheme was approved under section 7, and

(b) each subsequent period of 5 years beginning with—

(i) where the local authority and the Health Board vary the scheme under section 34, the day specified under subsection (5) of that section,

(ii) where the local authority and the Health Board decide no changes to the scheme are necessary or desirable, the day on which that decision is made.>

Alex Neil

242 Before section 34, insert—

<Requirement to review integration scheme

(1) This section applies where an integration scheme has been approved by the Scottish Ministers under section 7.

(2) On the request of the local authority or the Health Board, the local authority and the Health Board must jointly carry out a review of the scheme for the purpose of identifying whether any changes to the scheme are necessary or desirable.

(3) Where matters are prescribed under section 1(3)(e), the Scottish Ministers may require the local authority and the Health Board jointly to carry out a review of the integration scheme for the purpose of identifying whether any changes to the scheme are necessary or desirable.

(4) Sections 3 and 6 apply to a review of an integration scheme under subsection (2) or (3) as they apply to the preparation of an integration scheme (but as if the words “Before submitting the integration scheme for approval under section 7,” in section 6(2) were omitted).
(5) After taking account of any views of persons consulted under section 6 (as applied by subsection (3)), the local authority and the Health Board must decide whether any changes to the scheme are necessary or desirable.

Section 34

Alex Neil

243 In section 34, page 14, line 19, leave out from <an> to end of line 20 and insert <a local authority and a Health Board decide under section (Review of integration scheme) or (Requirement to review integration scheme) that changes to an integration scheme are necessary or desirable.>

Alex Neil

148 In section 34, page 14, line 19, leave out <plan> and insert <scheme>

Alex Neil

149 In section 34, page 14, line 21, leave out <plan> and insert <scheme>

Alex Neil

150 In section 34, page 14, line 22, leave out <plan> and insert <scheme>

Alex Neil

151 In section 34, page 14, line 23, leave out <plan> and insert <scheme>

Alex Neil

152 In section 34, page 14, line 24, leave out <plan> and insert <scheme>

Alex Neil

153 In section 34, page 14, line 26, leave out <plan> and insert <scheme>

Alex Neil

154 In section 34, page 14, line 28, leave out <plan> and insert <scheme>

Alex Neil

155 In section 34, page 14, line 31, leave out <plan> and insert <scheme>

Alex Neil

156 In section 34, page 14, line 33, at end insert—

<(< ) change the method of determining amounts to be made available as mentioned in section 1(3)(ca).>

Alex Neil

157 In section 34, page 14, line 34, leave out <calculating> and insert <determining>
Alex Neil

244 In section 34, page 14, line 34, at end insert—

<(f) change or remove any information included in the plan by virtue of section 1(3)(e).>.

Alex Neil

245 In section 34, page 14, line 34, at end insert—

<(3A) Before complying with subsection (4) or (as the case may be) (4A), the local authority and the Health Board must jointly consult—

(a) such persons or groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed, and

(b) such other persons as the local authority and the Health Board think fit.

(3B) In finalising the revised integration scheme, the local authority and the Health Board must take account of any views expressed by virtue of subsection (3A).>

Alex Neil

246 In section 34, page 14, line 35, at beginning insert <If a revised integration scheme includes provision of the type mentioned in any of paragraphs (a) to (e) of subsection (3),>

Alex Neil

158 In section 34, page 14, line 35, leave out <plan> and insert <scheme>

Alex Neil

247 In section 34, page 14, line 36, at end insert—

<(4A) If a revised integration scheme includes provision of the type mentioned in paragraph (f) of subsection (3), the local authority and the Health Board must jointly give notice of the change to the Scottish Ministers.>.

Alex Neil

159 In section 34, page 14, line 37, leave out <plan> and insert <scheme>

Alex Neil

248 In section 34, page 14, line 38, at end insert—

<( ) As soon as practicable after a revised integration scheme takes effect, the local authority and the Health Board must publish it.>

Section 35

Alex Neil

249 In section 35, page 15, line 2, leave out from <an> to end of line 3 and insert <a local authority and a Health Board decide under section (Review of integration scheme) or (Requirement to review integration scheme) that changes to an integration scheme are necessary or desirable.>

Alex Neil

160 In section 35, page 15, line 2, leave out <plan> and insert <scheme>
In section 35, page 15, line 5, leave out <plan> and insert <scheme>.

In section 35, page 15, line 5, at end insert <or (as the case may be) 2(2)>.

In section 35, page 15, line 7, leave out <plan> and insert <scheme>.

In section 35, page 15, line 8, at end insert —

<(  )  This Act applies in relation to a new integration scheme prepared by virtue of subsection (2) as it applies in relation to an integration scheme which requires to be prepared by section 1 or (as the case may be) 2(2).>

Section 36

In section 36, page 15, line 10, leave out <plan> and insert <scheme>.

In section 36, page 15, line 12, leave out <plan by a new integration plan> and insert <scheme by a new integration scheme>.

In section 36, page 15, line 15, leave out <plan by a new integration plan> and insert <scheme by a new integration scheme>.

In section 36, page 15, line 18, at end insert —

<(  )  Before making a scheme under subsection (3), the Scottish Ministers must consult—
(a) the person from whom it is proposed to transfer staff, and
(b) the person to whom it is proposed that the staff be transferred.>

Section 37

In section 37, page 15, line 21, leave out <plan> and insert <scheme>.

In section 37, page 15, line 23, leave out <plan> and insert <scheme>.

In section 37, page 15, line 25, leave out <plan> and insert <scheme>.
Alex Neil
169 In section 37, page 15, line 26, leave out <plan> and insert <scheme>

Alex Neil
170 In section 37, page 15, line 35, leave out <plan> and insert <scheme>

Section 39

Alex Neil
253 In section 39, page 16, line 10, after <7> insert <, or the day specified under subsection (4)(c) of that section,>

Alex Neil
171 In section 39, page 16, line 10, leave out <plan> and insert <scheme>

Section 40

Alex Neil
172 In section 40, page 16, line 27, leave out <plan> and insert <scheme>

Alex Neil
173 In section 40, page 16, line 28, leave out <plan> and insert <scheme>

Alex Neil
174 In section 40, page 16, line 33, leave out <plan> and insert <scheme>

Alex Neil
175 In section 40, page 16, line 34, leave out <plan> and insert <scheme>

Alex Neil
176 In section 40, page 16, line 39, leave out <plan> and insert <scheme>

Alex Neil
254 In section 40, page 17, line 5, at end insert—

<( ) The Scottish Ministers may not under subsection (1) or (2) give a direction requiring a local authority or Health Board to make a written application of the type mentioned in section (Section (Directions by integration authority): supplementary).>

Section 41

Alex Neil
255 In section 41, page 17, line 7, leave out from beginning to <board> and insert <A person mentioned in subsection (2)>

Alex Neil
256 In section 41, page 17, line 8, leave out <their> and insert <its>
Alex Neil

257 In section 41, page 17, line 9, at end insert—

<(2) Those persons are—
(a) a local authority,
(b) a Health Board,
(c) an integration joint board,
(d) an integration joint monitoring committee.> 

After section 41

Alex Neil

258 After section 41, insert—

<Social Care and Social Work Improvement Scotland

In section 53 of the Public Services Reform (Scotland) Act 2010 (inspections by Social Care and Social Work Improvement Scotland)—

(a) in subsection (1), after paragraph (b), add—

“(c) where social services, services provided under the health service or services provided by an independent health care service are provided in pursuance of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 (“the 2014 Act”), the co-ordination of those services.”,

(b) in subsection (2), after paragraph (e), add—

“(f) where the inspection is carried out under subsection (1)(c)—

(i) reviewing and evaluating the extent to which the social service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(ii) reviewing and evaluating the extent to which the co-ordination of social services, services provided under the health service and services provided by an independent health care service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(iii) reviewing and evaluating the effectiveness of a strategic plan prepared under section 23 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(iv) encouraging improvement in the extent to which implementation of a strategic plan prepared under section 23 of the 2014 Act complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, and

(v) enabling consideration as to the need for any recommendations to be prepared as to any such improvement to be included in the report prepared under section 57.”, and

(c) after subsection (6), add—
“(7) In this section—

“independent health care service” has the meaning given by section 10F(1) of the National Health Service (Scotland) Act 1978;

“integration delivery principles” has the meaning given by section 25 of the 2014 Act.”.

Alex Neil

259* After section 41, insert—

<Healthcare Improvement Scotland

(1) The National Health Service (Scotland) Act 1978 is amended as follows.

(2) In section 10I (Healthcare Improvement Scotland: inspection of services provided under the health service)—

(a) after subsection (1), insert—

“(1A) Where a service provided under the health service is provided by virtue of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 (“the 2014 Act”), HIS may inspect the service for any of the purposes mentioned in subsection (1B).

(1B) The purposes are—

(a) reviewing and evaluating the extent to which the service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(b) reviewing and evaluating the extent to which the co-ordination of services provided under the health service and social services is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(c) reviewing and evaluating the effectiveness of a strategic plan prepared under section 23 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(d) encouraging improvement in the extent to which implementation of a strategic plan prepared under section 23 of the 2014 Act complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, and

(e) enabling consideration as to the need for any recommendations to be prepared as to any such improvement to be included in the report prepared under section 10N.”, and

(b) after subsection (2), insert—

“(3) In this section—

“integration delivery principles” has the meaning given by section 25 of the 2014 Act;

“social services” has the meaning given by section 46 of the Public Services Reform (Scotland) Act 2010.”.

(3) In section 10J (inspections of independent health care services)—
(a) in subsection (1), after paragraph (b), add—

“(c) where services provided by an independent health care service and social services are provided in pursuance of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 (“the 2014 Act”), the co-ordination of those services.”;

(b) in subsection (2), after paragraph (e), add—

“(f) where the inspection is carried out under subsection (1)(c)—

(i) reviewing and evaluating the extent to which the independent health care service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(ii) reviewing and evaluating the extent to which the co-ordination of services provided by an independent health care service and social services is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(iii) reviewing and evaluating the effectiveness of a strategic plan prepared under section 23 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(iv) encouraging improvement in the extent to which implementation of a strategic plan prepared under section 23 of the 2014 Act complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, and

(v) enabling consideration as to the need for any recommendations to be prepared as to any such improvement to be included in the report prepared under section 10N.”;

(c) after subsection (7), add—

“(8) In this section—

“integration delivery principles” has the meaning given by section 25 of the Public Bodies (Joint Working) (Scotland) Act 2014;

“social services” has the meaning given by section 46 of the Public Services Reform (Scotland) Act 2010.”.

Alex Neil

260* After section 41, insert—

<Joint inspections of health services and social services

(1) The Public Services Reform (Scotland) Act 2010 is amended as follows.

(2) In section 115(11) (meaning of “confidential information”), for “section”, where it second occurs, substitute “sections 116A(4) and”.

(3) After section 116, insert—
“116A Joint inspections of social services and health services

(1) Social Care and Social Work Improvement Scotland (“SCSWIS”) and Healthcare Improvement Scotland (“HIS”) may jointly conduct an inspection in relation to—

(a) any social services, services provided under the health service or services provided by an independent health care service which are provided in pursuance of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 (“the 2014 Act”), or

(b) a local authority, Health Board or integration joint board (as defined in section 1(4)(a) of the 2014 Act) which is required by section 23 of the 2014 Act to prepare a strategic plan.

(2) The purposes of an inspection under this section may be any of those mentioned in section 10I(1) or (1B) or 10J(2) of the National Health Service (Scotland) Act 1978 or section 53(2) of this Act.

(3) In conducting an inspection under this section, SCSWIS and HIS must have regard to any code of practice or practice note issued by the Scottish Ministers for the purpose of—

(a) giving practical and general guidance on matters relating to such an inspection (including, without prejudice to that generality, such matters as access to confidential information and the holding, sharing and destruction of such information),

(b) promoting what appear to them to be desirable practices with regard to such matters.

(4) After conducting an inspection under this section, SCSWIS and HIS must—

(a) prepare a report, and

(b) give any person to whom the report relates an opportunity to comment on the report.

(5) SCSWIS and HIS must—

(a) give the report to the Scottish Ministers,

(b) give copies of the report to any person to whom the report relates, and

(c) make copies of the report available at their offices for inspection by any person at any reasonable time.

(6) In this section—

“independent health care service” has the meaning given by section 10F of the National Health Service (Scotland) Act 1978;

“social services” has the meaning given by section 46.”.

(4) In section 117 (regulations relating to joint inspections), after subsection 5, add—

“(6) In this section, “joint inspection” means an inspection conducted under section 115 or 116A.”.
<Amendments of section 56 of Local Government (Scotland) Act 1973>

In section 56 of the Local Government (Scotland) Act 1973 (arrangements for discharge of functions by local authorities)—

(a) after subsection (7), insert—

“(7A) A local authority is not to make arrangements under this section for the discharge of any of its functions under the Public Bodies (Joint Working) (Scotland) Act 2014 by any other local authority.”, and

(b) after subsection (15), add—

“(16) In this section, “Act” includes an Act of the Scottish Parliament.”.

Section 42

Alex Neil

177 In section 42, page 17, line 13, leave out <plan> and insert <scheme>

Alex Neil

178 In section 42, page 17, line 15, leave out <plan> and insert <scheme>

Alex Neil

179 In section 42, page 17, line 16, leave out <plan> and insert <scheme>

Alex Neil

180 In section 42, page 17, line 19, leave out <plan> and insert <scheme>

Alex Neil

181 In section 42, page 17, line 22, leave out <plan> and insert <scheme>

Section 43

Alex Neil

182 In section 43, page 17, line 29, leave out <plan> and insert <scheme>

Alex Neil

183 In section 43, page 17, line 31, leave out <plan> and insert <scheme>

Alex Neil

184 In section 43, page 17, line 32, leave out <plan> and insert <scheme>

Alex Neil

185 In section 43, page 17, line 34, leave out <plan> and insert <scheme>

Alex Neil

186 In section 43, page 17, line 36, leave out <plan> and insert <scheme>
Alex Neil
187 In section 43, page 17, line 38, leave out <plan> and insert <scheme>

Alex Neil
188 In section 43, page 18, line 1, leave out <plan> and insert <scheme>

Alex Neil
189 In section 43, page 18, line 4, leave out <plan> and insert <scheme>

Alex Neil
190 In section 43, page 18, line 7, leave out <plan> and insert <scheme>

After section 43

191 After section 43, insert—

<Meaning of “constituent authority”>
For the purposes of this Part, each local authority and the Health Board which prepared the integration scheme in pursuance of which an integration joint board was, or is to be, established is a “constituent authority” in relation to that board.>

Section 44

Alex Neil
262 In section 44, page 18, line 22, at end insert—

<(  ) any body corporate formed by a Health Board or by the Agency, or in the formation of which a Health Board or the Agency participated, by virtue of a delegation of the power in section 84B(1) of the National Health Service (Scotland) Act 1978 (joint ventures).>

Alex Neil
263 In section 44, page 18, line 26, at end insert—

<(  ) other professional services,
(  ) accommodation services.>

Alex Neil
264 In section 44, page 18, line 28, at end insert—

<(4A) The Scottish Ministers may by order amend subsection (2) so as to add or remove a person, or a description of a person, for the time being mentioned in or falling within that subsection.>

Alex Neil
265 In section 44, page 18, line 32, leave out <, and “Scottish public authority” have the meanings> and insert <has the meaning>
Alex Neil

266 In section 44, page 18, line 35, at end insert—

<“Scottish public authority” has the meaning given by section 126(1) of that Act except that it does not include—

(a) a Health Board,

(b) a Special Health Board (constituted under section 2(1)(b) of the National Health Service (Scotland) Act 1978), or

(c) Healthcare Improvement Scotland.>

Alex Neil

267 In section 44, page 18, line 36, leave out from <is> to end of line 38 and insert <means persons, bodies and office-holders (other than the Agency) listed in schedule 5 to the Public Services Reform (Scotland) Act 2010 (improvement of public functions: listed bodies) under the heading “Scottish public authorities with mixed functions or no reserved functions”.

After section 44

Alex Neil

268 After section 44, insert—

Section 44: consequential provision

(1) The National Health Service (Scotland) Act 1978 is amended in accordance with subsections (2) and (3).

(2) In section 10 (Common Services Agency)—

(a) in subsection (1), the words from “which” to the end are repealed, and

(b) after that subsection, insert—

“(1A) The Agency has the functions conferred on it by—

(a) this Act, and

(b) section 44 of the Public Bodies (Joint Working) (Scotland) Act 2014.”

(3) In section 15 (supply of goods and services to local authorities etc.)—

(a) in subsection (1)—

(i) for “, a Health Board or the Agency”, in the first two places where it occurs, substitute “or a Health Board”, and

(ii) in paragraph (e), the words “or the Agency” are repealed,

(b) after that subsection, insert—

“(1ZA)Paragraph (a) of subsection (1) applies to the Agency as it applies to a Health Board.”,

(c) in subsection (2), after “including” insert “paragraph (a) as applied by subsection (1ZA) and”, and

(d) subsections (2A) to (2D) are repealed.

(4) In section 17(2) of the Patient Rights (Scotland) Act 2011, for “that Act” substitute “the 1978 Act”.”
Alex Neil
269 After section 44, insert—

<Common Services Agency for the Scottish Health Service: residual liabilities
In section 2(1) of the National Health Service (Residual Liabilities) Act 1996 (certain
Scottish health bodies; duty to transfer residual liabilities on ceasing to exist), for “or a
Special Health Board” substitute “, a Special Health Board or the Common Services
Agency for the Scottish Health Service”.

Section 45

Alex Neil
192 In section 45, page 19, line 22, leave out <plan> and insert <scheme>

Alex Neil
193 In section 45, page 19, line 25, leave out <plan> and insert <scheme>

Section 48

Alex Neil
194 In section 48, page 20, line 23, leave out <plan> and insert <scheme>

Bob Doris
238 In section 48, page 20, line 24, at end insert—

<“relevant profession” has the same meaning as in the Health Professions Order
2001,>

Alex Neil
195 In section 48, page 20, line 35, leave out <and 37(1)> and insert <, 37(1) and (Meaning of
“constituent authority”)>
Section 49

Alex Neil

270 In section 49, page 21, line 8, at end insert—

<(  ) make different provision for different cases or classes of case,>

Alex Neil

200 In section 49, page 21, line 11, leave out <section> and insert <sections 1(4H) and>

Malcolm Chisholm

201 In section 49, page 21, line 11, after <5(1)> insert <and 23(3ZA)>

Malcolm Chisholm

239 In section 49, page 21, line 11, after <5(1)> insert <and 24A(3)(e)>

Alex Neil

271 In section 49, page 21, line 11, at end insert—

<(  ) An order under section 44(4A) is subject to the affirmative procedure.>

Section 51

Alex Neil

272 In section 51, page 21, line 25, at end insert—

<(  ) Section 5A of the Social Work (Scotland) Act 1968 (which makes provision about local authority plans for community care services) is repealed.>

Alex Neil

273 In section 51, page 21, line 33, at end insert—

<(  ) Section 17(1) of the Patient Rights (Scotland) Act 2011 is repealed.>

Alex Neil

274 In section 51, page 21, line 36, at end insert—

<(  ) The Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013 (S.S.I. 2013/220) is revoked.>

Section 52

Alex Neil

275 In section 52, page 21, line 38, leave out from beginning to <comes> and insert <Sections 1(3) to (7), 5, 37 and 41 and this Part (other than section 51) come>
2nd Groupings of Amendments for Stage 2

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted;
- a list of any amendments already debated;
- the text of amendments to be debated on the second day of Stage 2 consideration, set out in the order in which they will be debated. THIS LIST DOES NOT REPLACE THE MARSHALLED LIST, WHICH SETS OUT THE AMENDMENTS IN THE ORDER IN WHICH THEY WILL BE DISPOSED OF.

Groupings of amendments

**Strategic plan: preparation considerations**
95, 221, 96, 222, 239

**Strategic planning group**

**Strategic plan: review and replacement**
127, 128, 237, 129, 130

**Consultation regarding proposed decision which may significantly affect service provision**
132, 133, 134

**Integration authority: performance report**
135, 136, 137, 138, 139

**Reports by integration joint monitoring committee**
240

**Review and revisal of integration scheme**
241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252

*Notes on amendments in this group*
Amendment 243 pre-empts amendment 148
Amendment 249 pre-empts amendment 160

**Default power of Scottish Ministers**
253
Directions by the Scottish Ministers
254

Guidance
255, 256, 257

Inspection by Social Care and Social Work Improvement Scotland and/or Healthcare Improvement Scotland
258, 259, 260

Discharge of local authority functions
261

Shared services
262, 263, 264, 265, 266, 267, 268, 269, 271, 273, 274

Subordinate legislation
270

Repeal
272

Commencement
275

Amendments already debated

“Integration plan” to “integration scheme”
With 1 - 109, 111, 121, 122, 148, 149, 150, 151, 152, 153, 154, 155, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 192, 193, 194, 196, 197, 198, 199

Notes on amendments in this group
Amendments 148 and 160 in this group (already debated on Day 1) are preempted by amendments 243 and 249 respectively (both of which are in the group “Review and revisal of integration scheme”)

Budget for delegated functions
With 3 – 156, 157

Functions which may, must or may not be delegated
With 5 – 200

Minor and technical
With 11 – 120, 191, 195

Principles
With 19 - 97, 97A, 223, 98, 99, 224, 225, 100, 226, 101, 102, 227, 228, 229, 230, 103, 231, 104
Consultation and involvement of persons working as members of a “relevant profession”
With 210 - 232, 235, 238

Strategic plan: process
With 147 - 116, 118, 123, 236, 124, 125, 126, 131, 201
HEALTH AND SPORT COMMITTEE

EXTRACT FROM THE MINUTES

3rd Meeting, 2014 (Session 4)

Tuesday 28 January 2014

Present:
Malcolm Chisholm (Committee Substitute) Bob Doris (Deputy Convener)
Rhoda Grant Colin Keir
Richard Lyle Aileen McLeod
Duncan McNeil (Convener) Nanette Milne
Dennis Robertson (Committee Substitute)

Also present: Alex Neil (Cabinet Secretary for Health and Well-being)

Apologies were received from Gil Paterson, Dr Richard Simpson.

Public Bodies (Joint Working) (Scotland) Bill: The Committee considered the Bill at Stage 2 (Day 2).


The following amendments were disagreed to (by division)—
   222 (For 4, Against 5, Abstentions 0)
   225 (For 4, Against 5, Abstentions 0)
   227 (For 4, Against 5, Abstentions 0)
   228 (For 4, Against 5, Abstentions 0)
   233 (For 4, Against 5, Abstentions 0)
   236 (For 4, Against 5, Abstentions 0).

The following amendments were pre-empted: 148 and 160.

The following amendments were not moved: 221, 97A, 223, 224, 226, 229, 230, 231, 232, 234, 235, 237, 238, 201 and 239

The following provisions were agreed to without amendment: sections 38, 46, 47, 50 and 53 and the long title.
The following provisions were agreed to as amended: sections 24, 25, 26, 27, 29, 30, 31, 32, 33, 34, 35, 36, 37, 39, 40, 41, 42, 43, 44, 45, 48, 49, 51 and 52.

The Committee completed Stage 2 consideration of the Bill.
Scottish Parliament

Health and Sport Committee

Tuesday 28 January 2014

[The Convener opened the meeting at 09:45]

Public Bodies (Joint Working) (Scotland) Bill: Stage 2

The Convener (Duncan McNeil): Good morning and welcome to the third meeting in 2014 of the Health and Sport Committee. As usual, I ask everyone in the room to switch off mobile phones, BlackBerrys and other wireless devices, although I ask you to note that some members and officials are using tablet devices instead of hard copies of their papers.

I have apologies from Richard Simpson and Gil Paterson. Malcolm Chisholm joins us once again as the Labour substitute, and I also welcome Dennis Robertson as the Scottish National Party’s substitute.

The first item on the agenda is the second day of stage 2 of the Public Bodies (Joint Working) (Scotland) Bill. Members should have copies of the bill, the marshalled list of amendments and the groupings. We will pick up where we left off last week, which was at the end of section 23. I am confident that we can get to the end of stage 2 today. I welcome back to the committee the Cabinet Secretary for Health and Wellbeing, Alex Neil, and his officials.

Section 24—Considerations in preparing strategic plan

The Convener: Amendment 95, in the name of the cabinet secretary, is grouped with amendments 221, 96, 222 and 239.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): Good morning.

Section 24 of the bill requires the integration authorities to take account of the integration delivery principles and the national health and wellbeing outcomes in preparing a strategic plan. Rhoda Grant’s amendment 221 seeks to add community planning outcomes to that list.

As I stated to the committee on day 1 of stage 2, the Government intends to introduce a community empowerment and renewal bill that will include integration authorities, along with health boards, local authorities and others, as bodies that must participate in community planning. A requirement to include integration authorities in community planning itself is a much stronger way to ensure the proper place of integrated health and social care in community planning than referring to community planning outcomes, which do not at present exist in law.

Rhoda Grant inquired on day 1 about the timing of the proposed community empowerment and renewal bill with regard to the bill that is before us today. The Government intends to introduce the community empowerment bill in the current parliamentary year. The exact timetable for the bill’s progress after its introduction will of course be a matter for the parliamentary authorities, but the Government intends that the requirements should apply to community planning partners from approximately April 2015.

That timescale fits well with our timescale for integration, as health boards and local authorities are expected to establish their integration arrangements from April 2015. I therefore invite Rhoda Grant—as I did previously—to agree that the Scottish Government’s position with regard to community planning and integration is stronger than her proposal, and I invite her not to move amendment 221.

I turn to amendments 95 and 96, which are in my name. The bill as introduced does not place any requirement on the integration authorities to take account of other strategic plans. That could allow issues to arise in relation to the cumulative effect of the use of services, facilities and resources that are used in common by more than one integration authority. Amendment 96 ensures that each integration authority, in preparing a strategic plan, takes account of any other strategic plan that has been or is being prepared where that plan sets out or proposes to set out arrangements for the use of services, facilities or resources that are used by another integration authority. Amendment 95 makes a drafting change to clarify that section 24 applies to the initial strategic plan and to subsequent strategic plans.

On amendments 222 and 239, in the name of Malcolm Chisholm, sections 24, 26 and 27 together provide robust mechanisms for the preparation of a strategic plan and for involving and consulting people in that. The persons who are to be involved will be set out in regulations and their views must be taken into account. There is therefore no need for additional provisions that would require the integration authority to take account of the views of specific individuals.

I, too, consider that professional oversight of the planning and delivery of integrated services is essential. The bill, regulations and guidance provide for that. Integration authorities will be required to put in place clinical and care governance arrangements via the integration scheme to monitor and improve the quality of care that is provided to service users. I intend to require the involvement of health and social care...
professionals in integration joint boards, strategic planning groups, localities and integration joint monitoring committees, ensuring a strong voice for health and social care professionals at all stages of integration. I believe that that goes beyond the effect of Mr Chisholm’s amendment.

I move amendment 95, and ask Rhoda Grant not to move amendment 221 and Malcolm Chisholm not to move amendments 222 and 239.

Rhoda Grant (Highlands and Islands) (Lab): I am grateful to the cabinet secretary for giving us that information and ensuring that there is no gap between the integration boards being set up and their involvement in community planning. Because of that, I will not move amendment 221.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I listened carefully to what the cabinet secretary said, but it does not seem to me that the proposed regulations that he referred to, or, indeed, the policy statements that he has issued, cover what has been included in the bill. For example, in the policy statement about the integration joint board, the Scottish Government proposed only that the clinical director of the national health service board would be afforded a non-voting seat on the integration joint board. Similarly, the associate medical director/clinical director is to be on the joint monitoring committee, and consultations on strategic planning, the integration plan and membership of the strategic planning group will include, vaguely, health and social care professionals “who operate within the boundaries of the proposed integration authority”.

As members will understand, most clinical directors with NHS boards are doctors, but the largest group of NHS clinicians who will be delivering care within the integrated arrangements will be nurses. Nurses and allied health professionals are mentioned explicitly just once in the Scottish Government’s set of proposed regulations in the policy statement on localities. Once again, it seems that the significant strategic expertise and experience of senior clinical leads outwith the medical profession has been ignored. Each of the professions has expertise to share with those making difficult decisions. Each lead officer remains accountable for care that is delivered by their profession.

It seems to me that the bill does not say nearly enough about care quality governance, and focuses more on the pillars of general corporate governance in the new structures. Amendment 222 is intended to ensure that integration authorities are under a duty to seek, record and have due regard to the advice of professional leads from the parent bodies, who are experts at the issue that is at the heart of the reform agenda, which is the delivery of quality care services. It does not, of course, bind the integration authority to act on any professional advice that is given.

Although we appreciate that many partnerships will want to make such arrangements, even if such a duty is not included in the bill, primary legislation should set out the minimum expectations of any partnership, whether that partnership is functioning well or otherwise. The amendment will provide a minimum guarantee that those who are able to make professional judgments on the quality of care can support innovation and development, improve decision making and raise concerns where appropriate.

As recent cases have highlighted, when things go wrong in health or social care services, the consequences for individuals and families can be catastrophic. Regulated professionals such as nurses are, rightly, accountable for the care that they deliver to their clients and patients, as well as to their regulatory bodies, which can strip them of their career if they are found to fall short. That accountability holds from front-line practitioners to professional leads with strategic and governance responsibilities. Professionals take that accountability seriously, but structures must support them to discharge their responsibilities meaningfully. I do not, therefore, accept the cabinet secretary’s view that his proposals go beyond what the amendment proposes—I would just say gently that saying that his amendment is better than someone else’s amendment seems to be a recurring technique of the cabinet secretary in our discussions in committee. In my view, his proposals do not go nearly far enough in recognising the important place and contribution of all healthcare professionals, not just doctors.

It is important to mention specifically nurses and allied health professionals, as well as doctors and the chief social work officer. It is very important to name those key individuals in the bill. I shall certainly move amendment 222.

Alex Neil: I thank Rhoda Grant for saying that she will not move amendment 221. I reiterate the absolute undertaking on the Government’s behalf that we will ensure that the community empowerment and renewal bill is synchronised with the Public Bodies (Joint Working) (Scotland) Bill.

As for Malcolm Chisholm’s points, I say at the risk of being accused of using a repetitive technique in the committee that we are all trying to get to the same place, albeit by slightly different routes. As I made clear to the committee on day 1 of stage 2, all of what Mr Chisholm proposes will be provided for in secondary legislation and guidance. There is no dispute in principle about the need to have such professionals round the table and heavily involved at every level—board,
locality and strategic commissioning levels and so on. The only issue is about whether to put an exhaustive list in the bill.

I will give some perspective. In the medical world, the composition of any area clinical forum for any health board involves four broad categories of representation of clinicians. They are the acute sector—doctors, consultants, junior doctors and so on; general practitioners; the nursing profession; and the 11 allied health professions. It could be argued that, in theory, all 11 of those professions should be represented on a board. They should be included as is appropriate to the board level and the locality, but not all of them would necessarily be included in all structures at all times, as that would be a gross waste of manpower, of the professionals' time and of resources.

Our approach is to state a minimum representation at the board, so the clinical director must attend the board, as must the chief social work officer. However, that is not exclusive. If the partnership requires other people to attend, the partnership will have the power to force them to attend on a one-off basis or permanently. Similarly, the partnership will have a duty to involve all the relevant professionals at every level of decision making.

Mr Chisholm’s one point that is worthy of further consideration is about whether the chief nursing officer in each board area should be included in the list that is in the bill. I am prepared to consider a stage 3 amendment to that effect. I accept his point, as 43 per cent of health service employees in Scotland are nurses and midwives.

On the other points, we are going much further than Mr Chisholm proposes, but we will do so through secondary legislation and guidance rather than through providing an exhaustive list in the bill, which would also carry the danger that primary legislation would be required to add anyone who was missed out or to change the provisions if professional structures changed, and primary legislation might be difficult to achieve. It is much more appropriate, flexible and comprehensive to proceed in the way that we propose.

Amendment 95 agreed to.
Amendment 221 not moved.
Amendment 96 moved—[Alex Neil]—and agreed to.

Section 24, as amended, agreed to.

After section 24
Amendment 222 moved—[Malcolm Chisholm].
Amendments 101 and 102 moved—[Alex Neil]—and agreed to.

Amendment 227 moved—[Rhoda Grant].

The Convener: The question is, that amendment 227 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Campbell, Aileen (Clydesdale) (SNP)
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
Robertson, Dennis (Aberdeen West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 227 disagreed to.

Amendment 228 moved—[Rhoda Grant].

The Convener: The question is, that amendment 228 be agreed to. Are we agreed?

Members: No.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Campbell, Aileen (Clydesdale) (SNP)
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
Robertson, Dennis (Aberdeen West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 228 disagreed to.

Amendments 229 and 230 not moved.

Amendment 103 moved—[Alex Neil]—and agreed to.

Amendment 231 not moved.

Amendment 104 moved—[Alex Neil]—and agreed to.

Section 25, as amended, agreed to.

Section 26—Establishment of consultation group

The Convener: Amendment 105, in the name of the cabinet secretary, is grouped with amendments 106 to 108, 110, 233, 112 to 115, 234, 117 and 119.

Alex Neil: It is important that strategic planning supports the principles of co-production and joint working. The amendments in the group focus on the operation of the strategic planning group, which has a key role to play in improving outcomes.

Amendment 105 will allow the integration authority to establish a single strategic planning group from the outset of the strategic planning process. The group will continue to play a part in the on-going review and amendment of subsequent strategic plans. That reflects the continual strategic commissioning cycle.

Amendment 106 will change the name of the consultation group so that it will be known instead as the strategic planning group, which more accurately reflects its function.

The integration authority has full responsibility for the strategic planning group and strategic planning process, for which it is accountable. However, it is important that the bill does not unduly restrict the representation of constituent authorities in the membership of the group. Amendments 107, 108 and 110 will allow greater flexibility to the local authority and health board with respect to the number and combination of representatives that they can nominate to represent their interests in the process.

Amendment 233, in the name of Rhoda Grant, seeks to add a requirement that would establish in primary legislation that membership of the strategic planning group must include service users, unpaid carers and non-commercial organisations. I recognise that the aim of the amendment is to provide for a co-production approach. I reassure Rhoda Grant that the bill provides a robust involvement process for strategic planning, and I have set out in the policy statement, in relation to section 26, the Scottish ministers’ intentions to include all those that are noted within amendment 233, and a number of other groups that I believe should be involved—including health and social care professionals—in the membership of the strategic planning group.

I believe that it would be disproportionate to set out in the bill that we should include the groups that are noted in amendment 233, but not to make similar provision for the numerous other people who should, equally, be involved in the strategic planning group. I believe that the proper place to set out the detail of the membership of the strategic planning group is in regulations. I therefore urge Rhoda Grant not to move amendment 233.

Amendment 112 will ensure that the integration authority will oversee the appointment, removal
and replacement of members of the strategic planning group. The constituent authorities will be responsible for nominating members as well as for replacing or removing their nominees if required. The amendment will also ensure that the views of localities are taken into account by requiring the integration authority to identify the most appropriate person to represent each locality on the strategic planning group. Amendment 112 also provides for local flexibility, so that an individual can represent more than one locality, which will ensure that the integration authority’s ability to make decisions is not undermined by any vacancy in representation of localities.

Amendments 113, 114 and 115 are drafting amendments that will make it clear that section 26(4) applies to all integration authorities and reflect the amendment that provides that the consultation group is to be known as the strategic planning group.

Amendment 234, in Rhoda Grant’s name, seeks to introduce an additional requirement on the integration authority in its dealings with the strategic planning group and gives examples of the types of arrangement that the integration authority may decide to make. The level of detail that is proposed is not appropriate for primary legislation, but I sympathise with the desire to ensure that the strategic planning process is truly inclusive and effective. Section 26 already provides for payment of expenses to members of the group, through subsection (4). I assure Rhoda Grant that I will produce extensive guidance on all relevant matters relating to the strategic planning group. I therefore urge her not to move amendment 234.

Amendments 117 and 119 make it clear that it is the strategic planning group’s views on the strategic planning proposals and the draft strategic plan that are sought.

I invite Rhoda Grant not to move amendments 233 and 234.

I move amendment 105.

Rhoda Grant: Amendment 233 would ensure that carers and their representatives would be included in the strategic planning group. That follows the principles of co-production at every level. What is missing from the bill is the involvement of users and carers, which should run through the bill like letters in a stick of rock. That is the only way we can genuinely ensure that people are involved in designing and organising their care. People need to participate, and care should be designed on their behalf to allow them to go about their business in a normal way.

There is something missing from the bill. I welcome the involvement of staff and the people who deliver care, but the recipients of care are much more important. The bill’s having something at its core to ensure that users and carers are involved in the design of services, rather than services being things that are done to them, would be worthwhile. I look forward to some commitments on that from the cabinet secretary when he winds up.

On amendment 234, I welcome what the cabinet secretary said about considering guidance to take away the barriers. However, cost is not the only barrier. Obviously, expenses need to be paid, but there are many other barriers, especially to people with disabilities. For example, is the venue where meetings are held accessible? If someone has a sight problem, will they have delivered to them papers that will allow them to participate? Will carers get assistance with the person that they are caring for to enable the carer to attend meetings? The bill may not be the place to address those barriers, but I hope that, in writing guidance, the cabinet secretary will be clear that the person who is participating needs to be consulted about the barriers that they face, and that steps must be taken to ensure their full participation. Only then will we see real participation.

10:15

The Convener: As no other members wish to comment, I ask the cabinet secretary to wind up.

Alex Neil: We are absolutely on the same page about what we are trying to achieve. Our only difference is on what should be in the bill and what should be in secondary legislation, guidance and regulations. I agree 110 per cent with Rhoda Grant that the whole philosophy underlying the bill must be co-production and that service users are people who we work with and not people who we deliver to. They should not be seen as recipients in the sense that they will do what they are told. The whole point is co-production and to have a completely different philosophy from what has gone before. We are absolutely as one on that.

I agree with Rhoda Grant that concept of the role of service users should permeate the bill like letters in a stick of rock. I argue that the bill does that. For example, it repeatedly lists, at each stage of engagement and planning, the role of service users and the need to take them with us and for them to be involved in design of services. I give her a total commitment that the regulations or the secondary legislation will reflect absolutely that philosophy. Similarly, on barriers, whether they are faced by disabled people, by people who have learning disabilities or by ethnic minority or other minority groups, the whole point of the bill is to make it as user-friendly as possible and geared to users’ needs—not as defined by the service providers, but as agreed between the service providers and users. I give Rhoda Grant a total
commitment that we will not only reflect in the bill the importance of removing those barriers, but will take action to remove those barriers or to prevent their being erected in the first place, where appropriate, in all the secondary legislation, regulations and guidance.

Amendment 105 agreed to.

Amendments 106 to 111 moved—[Alex Neil]—and agreed to.

The Convener: Amendment 232, in the name of Bob Doris, was debated with amendment 210 on day 1 of our stage 2 deliberations. Does Bob Doris wish to move or not move amendment 232?

Bob Doris (Glasgow) (SNP): Given the reassurances that were given on day 1, I will not move amendment 232.

Amendment 232 not moved.

Amendment 233 moved—[Rhoda Grant].

The Convener: The question is, that amendment 233 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Campbell, Aileen (Clydesdale) (SNP)
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
Robertson, Dennis (Aberdeen West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions, 0.

Amendment 236 disagreed to.

Amendment 124 moved—[Alex Neil]—and agreed to.

Section 28—Requirement for agreement to certain strategic plans
Amendment 236 moved—[Nanette Milne].

The Convener: The question is, that amendment 236 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)

Against
Campbell, Aileen (Clydesdale) (SNP)
Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
Robertson, Dennis (Aberdeen West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions, 0.

Amendment 236 disagreed to.

Amendment 124 moved—[Alex Neil]—and agreed to.

Section 29—Publication of strategic plans
Amendments 125 and 126 moved—[Alex Neil]—and agreed to.

Section 29, as amended, agreed to.

Section 30—Significant decisions outside strategic plan: public involvement

The Convener: Amendment 127, in the name of the cabinet secretary, is grouped with amendments 128, 237, 129 and 130.

Alex Neil: It is my intention that a strategic plan should not necessarily last for a fixed period of three years but will, rather, be subject to continual review and possible amendment. Ensuring that the planning process is a continual cycle should mean that few significant decisions will be made that are not part of that process. However, should such decisions be necessary—such circumstances should be very rare—they may take effect outwith any revision of a plan.

Section 30, as introduced, requires consultation only with service users, and amendment 128 seeks to make it clear that the strategic planning group should also be consulted when a decision is taken under the procedure in section 30, to ensure that the process cannot be used to circumvent the consultative procedure for reviewing strategic plans and to reflect the strategic planning group’s importance.
Amendment 237 in the name of Rhoda Grant would require the integration authority to involve and consult

“non-commercial providers of health care or social care, and ... other relevant bodies who may be affected”

by a significant decision taken outside the strategic plan. Section 32, together with the regulations that I intend to make under section 32(4), will already achieve that purpose for non-commercial providers of health or social care by involving them in locality planning and as members of the strategic planning group. Given that I intend that the regulations under section 32(4) will include third sector providers of health and social care among those who must be involved and consulted in significant decisions about services in a locality, I believe that Rhoda Grant’s amendment 237 is unnecessary so, on that basis, I ask her not to move it.

Strategic plans must be subject to a continuous cycle of analysis, planning, delivering and reviewing. Amendment 129 will introduce a new section that makes it clear that integration authorities must review their strategic plans as often as necessary, or at least every three years and must, if required, prepare a replacement strategy plan. In carrying out such a review, integration authorities must take into account the national health and wellbeing outcomes, the integration delivery principles, and reviews of the strategic planning group that they will be required to establish. Amendment 129 will also require the health board and local authority to provide the integration authority with the necessary information to carry out the review properly.

It is important that amendment 130 will allow for the local authority and the health board—acting jointly—to require a replacement plan where they jointly feel that the strategic plan prohibits their carrying out any of their functions. I do not envisage that such circumstances will arise frequently, given that the health board and local authority will, as members of the strategic planning group, be part of any review and revision of the strategic plan. However, amendment 130 is needed to provide an additional safeguard for circumstances that may arise outwith the strategic planning process in order that local authorities and health boards may effectively deliver their responsibilities.

I ask Rhoda Grant not to move amendment 237.

I move amendment 127.

Rhoda Grant: Amendment 237 would ensure that third sector providers are consulted on significant decisions outside the strategic plan. In many localities, third sector organisations identify need often, and more often than not actually go and meet that need by finding solutions within their communities. They therefore provide a joined-up approach and should be consulted. I mean by third sector organisations a wider selection than just those that are involved in health and social care. I know what the cabinet secretary said about that group, which is why I have included in amendment 237 the reference to “other relevant bodies” that may be affected by a decision.

For example, in my area we have the Badenoch & Strathspey Community Transport Company’s car scheme, which is paid for through community transport scheme funding and which promotes people’s social life by helping them to go shopping, and by providing them with softer social options to promote their independence and wellbeing by getting them to doctors’ appointments and the like. That scheme would not be considered to be involved in health and social care, because it is a transport organisation, but it has identified and meets need within its local community, which could be seen as preventative spending that promotes the wellbeing of the people who live in the area.

There are in our communities huge numbers of such small organisations meeting various needs that are not always under health and social care, but which approach the promotion of people’s wellbeing and independence from a slightly different angle. For that reason, I will press amendment 237, unless the cabinet secretary intends to lodge amendments at stage 3 that will ensure that those groups are involved in locality planning, as I believe they should be. I will wait to hear what the cabinet secretary says in winding up.

Bob Doris: I am supportive of what Rhoda Grant is trying to achieve, but the more I hear about various stakeholder groups wanting to be involved in locality planning, monitoring and other devices, the more minded I am that the right place for what she proposes is secondary legislation or guidance. I wanted to put that on the record. However, I have listened very carefully and am supportive of and sympathetic to Rhoda Grant’s points.

Alex Neil: At the risk of repeating my technique, I would say that we are all on the same page and trying to achieve exactly the same thing. I think that the premise of Rhoda Grant’s amendment 237 is that there is a narrow interpretation of the third sector, whereas we have a wide interpretation that incorporates the kind of organisation to which Rhoda Grant referred and of which I am sure we have many examples in all our constituencies.
I am happy to consider the issue to see whether—either in the bill or in subsequent regulations and other secondary legislation—we need to be clearer about the definition, so that there is no dubiety about the fact that it can incorporate groups such as those to which Rhoda Grant has referred. I am happy to consider that as a possible stage 3 amendment, and to add it to the agenda for discussion at the meeting that we have arranged with members of the committee. The meeting is next week and is open to all members of the committee. I am happy to consider the matter for stage 3, so that there is no dubiety in the bill, or in any subsequent regulations or other secondary legislation.

Amendment 127 agreed to.

Amendment 128 moved—[Alex Neil]—and agreed to.

Amendment 237 not moved.

Section 30, as amended, agreed to.

After section 30

Amendments 129 to 131 moved—[Alex Neil]—and agreed to.

Section 31 agreed to.

Section 32—Carrying out of integration functions: localities

**The Convener:** Amendment 132, in the name of the cabinet secretary, is grouped with amendments 133 and 134.

**Alex Neil:** Section 32 requires that bodies that deliver integrated services involve and consult localities in any decisions that will have a significant impact on their locality. Amendments 132 and 133 extend that duty to the decision-making processes of the integration authority that fall outside the strategic planning cycle. That will ensure the full involvement in all decision-making processes of all those who deliver, support or receive health and social services in a locality.

In its stage 1 report, the committee recommended that we include a provision in section 32 to allow the integration authority to reimburse any necessary expenses and allowances to the participants in locality planning arrangements. I agree with the committee’s recommendation, and amendment 134 gives the integration authority that ability.

I move amendment 132.

**The Convener:** No members wish to speak. I do not expect that the cabinet secretary wishes to say any more.

**Alex Neil:** No—I waive my right, convener.

**The Convener:** I am on page 19 of 48—that is the page that I am on today, cabinet secretary.

Amendment 132 agreed to.

Amendments 133 and 134 moved—[Alex Neil]—and agreed to.

Section 32, as amended, agreed to.

Section 33—Integration authority: performance report

**The Convener:** Amendment 135, in the name of the cabinet secretary, is grouped with amendments 136 to 139.

**Alex Neil:** Amendments 135 and 136 are technical. They ensure that the provisions as originally drafted now relate properly to the amended section 33.

Amendments 137 and 138 strengthen the duties that the bill places on the integration authority, the health board and the local authority with regard to publication of the integration authority’s annual performance report. The amendments introduce a statutory timescale within which the report must be published, ensure that the integration authority has access to the data that it requires and oblige the integration authority to send the performance report to the health board and/or the local authority, as appropriate to the model of integration that is used. That will be essential for the integration authorities to prepare their performance reports effectively and provide a coherent picture of how care and support has been delivered for their communities.

Amendment 139 ensures that the reporting year will be the same for all integration authorities. Performance reports will therefore cover the same time period and be published broadly at the same time to aid comparison and benchmarking.

I move amendment 135.

Amendment 135 agreed to.

Amendments 136 to 139 moved—[Alex Neil]—and agreed to.

Section 33, as amended, agreed to.

After section 33

**The Convener:** Amendment 240, in the name of the cabinet secretary, is in a group on its own.

**Alex Neil:** Amendment 240 strengthens the role of the integration joint monitoring committee by giving it the ability to require information from the statutory partners and write reports on how integrated services are being planned and delivered. The amendment gives the integration joint monitoring committee the ability to make recommendations on how service planning and
delivery should be changed to better deliver the national outcomes. It places the lead agency under a duty to have regard to any reports that the committee publishes and to respond to any recommendation that it makes. The amendment provides appropriate accountability in the lead agency model and gives the integration joint monitoring committee the necessary teeth to do its job of holding the lead agency to account.

I move amendment 240.

Amendment 240 agreed to.

Before section 34

The Convener: Amendment 241, in the name of the cabinet secretary, is grouped with amendments 242 to 252. I point out that, if amendments 243 and 249 are agreed to, I will be unable to call amendments 148 and 160, which are in the group entitled "Integration plan to integration scheme", which we debated on day 1, due to pre-emption.

Alex Neil: The bill as introduced contains no requirement for health boards and local authorities, with stakeholders, to review the integration scheme. We believe that the scheme should be reviewed periodically to ensure that it remains fit for purpose. Amendment 241 requires that integration schemes are reviewed at least every five years and that health boards and local authorities are required to include and consult their stakeholders in the same way as when the scheme was originally developed. Amendment 242 establishes that either the health board or the local authority can trigger a review of the integration scheme, which both parties must then jointly take forward.

Our concern is that, particularly in a lead agency arrangement, if a delegating authority was not content that the lead agency was carrying out its functions to the delegating authority's satisfaction, it could not review the basis of that delegation—the integration scheme—without the lead agency's agreement. That could result in a conflict of interest for the lead agency and an inability for the delegator to properly exercise its statutory accountability over its functions.

Amendment 242 establishes that, should the Scottish ministers amend the regulations that specify other matters that must be included within integration schemes, they can require all integration schemes to be reviewed. For example, if professional advice on clinical and care governance was to change, we would want to ensure that all integration schemes were reviewed and considered by stakeholders locally.

Amendments 243 and 249 are technical amendments that ensure that other relevant provisions in the bill are updated to account for the changes to the review process. In particular, the amendments ensure that the power to vary a scheme under section 34 and the duty to vary a scheme under section 35 may only follow a review of a scheme, which will become a requirement.

Amendments 244 and 247 ensure that constituent authorities are required to notify the Scottish ministers if the detail of certain parts of the integration scheme, as prescribed in regulation under the power noted in section 1(3)(e), are changed. The amendments ensure continued oversight of important areas of agreement between the constituent authorities, such as clinical and care governance arrangements.

Amendment 245 requires that, when constituent authorities wish to make changes to the parts of their integration scheme that they have a statutory obligation to include, they must consult a list of stakeholders as prescribed by the Scottish ministers. The amendment ensures that appropriate stakeholders will be involved in any significant changes to the terms of integration in their area.

Amendment 246 is a technical amendment that ensures that the requirement to seek the Scottish ministers' approval of revised integration schemes properly relates to the provisions in section 34(3).

Amendment 248 requires the constituent authorities to publish a revised integration scheme once it takes effect, which will ensure that the most up-to-date integration schemes are always publicly available.

Amendment 250 is a technical amendment that ensures that provisions relating to new integration schemes as set out in section 35 are applicable to multicouncil integrated arrangements.

Amendment 251 puts it beyond doubt that the bill applies to a new integration scheme that is created under section 35 as it applies to a scheme that is prepared under sections 1 or 2.

Amendment 252 places a requirement on the Scottish ministers to consult the local authority and the health board before putting in place a scheme for the transfer of staff as a consequence of a new integration scheme. The amendment reflects other amendments that were previously discussed by the committee, and responds to requests from health boards and local authorities to ensure that their views are heard in any matter relating to staffing under integration.

I move amendment 241.

Rhoda Grant: With regard to amendment 252, I understand why people are being consulted, but it makes no mention of the staff who are to be transferred or their trade unions. One would assume that transferring staff would require a consultation that involves the staff and their trade
unions as well as the receiving authority and the authority that is losing the staff.

Alex Neil: Rhoda Grant is absolutely right, but those points are already covered in employment law and the national and local negotiating machinery. It would not be appropriate for us to cut across that in this bill—that would require another bill.

Amendment 241 agreed to.

Amendment 242 moved—[Alex Neil]—and agreed to.

Section 34—Revised integration plan

The Convener: Amendment 243, in the name of the cabinet secretary, has already been debated with amendment 241. I remind members that, if amendment 243 is agreed to, I cannot call amendment 148, as a consequence of the pre-emption rule.

Amendment 243 moved—[Alex Neil]—and agreed to.

Amendments 149 to 157, 244 to 246, 158, 247, 159 and 248 moved—[Alex Neil]—and agreed to.

Section 34, as amended, agreed to.

Section 35—New integration plan

10:45

The Convener: Amendment 249, in the name of the cabinet secretary, has already been debated with amendment 241. I remind members that, under the pre-emption rule, if amendment 249 is agreed to, I cannot call amendment 160.

Amendment 249 moved—[Alex Neil]—and agreed to.

Amendments 161, 250, 162 and 251 moved—[Alex Neil]—and agreed to.

Section 35, as amended, agreed to.

Section 36—Power to make provision in consequence of new integration plan

Amendments 163 to 165 and 252 moved—[Alex Neil]—and agreed to.

Section 36, as amended, agreed to.

Section 37—Information-sharing

Amendments 166 to 170 moved—[Alex Neil]—and agreed to.

Section 37, as amended, agreed to.

Section 38 agreed to.

Section 39—Default power of Scottish Ministers

The Convener: Amendment 253, in the name of the cabinet secretary, is in a group on its own.

Alex Neil: This technical amendment seeks to ensure that section 39 properly relates to the now amended section 7 by enabling the Scottish ministers, where a modified scheme is to be submitted, to use their default powers if the modified scheme is not submitted by the date specified under section 7(4)(c).

I move amendment 253.

Amendment 253 agreed to.

Amendment 171 moved—[Alex Neil]—and agreed to.

Section 39, as amended, agreed to.

Section 40—Directions

Amendments 172 to 176 moved—[Alex Neil]—and agreed to.

The Convener: Amendment 254, in the name of the cabinet secretary, is in a group on its own.

Alex Neil: Section 40 enables the Scottish ministers to give directions to a health board, local authority or integration joint board on the carrying out of functions under integration. The new section that has been inserted after section 22 provides that the Scottish ministers can make an order only to enable the integration joint board to carry out functions directly rather than arranging for service delivery via direction to the health board and local authority on receipt of a written application from the health board and local authority. The Scottish ministers cannot make such an order without the prior written application of the health board and local authority, and the amendment also ensures that ministers cannot direct the health board and local authority to make such a written application.

I move amendment 254.

Amendment 254 agreed to.

Section 40, as amended, agreed to.

Section 41—Guidance

The Convener: Amendment 255, in the name of the cabinet secretary, is grouped with amendments 256 and 257.

Alex Neil: Section 41 requires each local authority, health board and integration joint board to have regard to any guidance that is issued by the Scottish ministers on their functions under or in relation to this legislation. As it stands, the bill does not require the integration joint monitoring committees to have regard to such guidance. Amendment 257 seeks to require integration joint
monitoring committees to have regard to any guidance that is issued by the Scottish ministers on their functions under or in relation to this legislation and, in doing so, brings those committees into line with the requirements for health boards, local authorities and integration joint boards. That will provide for a more robust framework that will apply equally in a lead agency arrangement.

Amendments 255 and 256 are technical amendments that are linked to amendment 257 and simply pave the way for the list in new section 41(2) as inserted by amendment 257.

I move amendment 255.

Amendment 255 agreed to.

Amendments 256 and 257 moved—[Alex Neil]—and agreed to.

Section 41, as amended, agreed to.

After section 41

The Convener: Amendment 258, in the name of the cabinet secretary, is grouped with amendments 259 and 260.

Alex Neil: In the policy memorandum accompanying the bill, the Scottish ministers committed to ensuring that the inspection and scrutiny of integrated health and social care services were provided for. Social Care and Social Work Improvement Scotland was established to inspect social care and social work services, while Healthcare Improvement Scotland was established to inspect healthcare services. Amendments 258 and 259 seek to provide for both organisations respectively to inspect services provided to? in pursuance of an integration scheme, regardless of the delivery body.

Furthermore, the amendments seek to expand the purpose and the matters to be considered when inspecting such services. It is important that inspections can account for and reflect the aims of integration and provide appropriate improvement advice, reports and recommendations in that respect. The amendments seek to ensure that SCSWIS and HIS have that ability.

Amendment 260 provides for HIS and SCSWIS to jointly inspect health and social care services delivered by health boards, local authorities and integration joint boards in pursuance of an integration scheme.

Importantly, in carrying out joint inspections, SCSWIS and HIS are to adhere to current codes of practice that are issued by the Scottish ministers, and may carry out joint inspections for any of the purposes that are provided for by section 10(1B) or 10J of the National Health Service (Scotland) Act 1978, or section 53(2) of the Public Services Reform (Scotland) Act 2010. High standards and levels of scrutiny are thereby applicable to joint inspections of integrated services.

Scrutiny of integrated services is key to achieving the aim of improving the quality, consistency and safety of services for service users. Enabling joint inspections without recourse to the Scottish ministers reflects the need for a new approach to inspection and scrutiny to support, develop and redesign services to deliver the aim of integration of improving outcomes for users of health and social care services.

I move amendment 258.

Rhoda Grant: I have concerns about the practicality of the proposal. It seems quite messy, with two organisations that could come in. Will they have to work together, especially with regard to services that are jointly delivered by health and social care? It seems to me that the people who provide inspections could conduct different visits if they were not obligated to work together and carry out joint inspections.

Alex Neil: Actually, they already engage in joint working very effectively, for obvious reasons. However, at the moment, they need my explicit permission if they are to carry out a joint inspection. I do not believe that that is appropriate, particularly when we are talking about an integrated agenda. I foresee a much closer working relationship in future between HIS and SCSWIS—the Care Inspectorate—with regard to inspection.

The arrangement pretty much reflects what happens at the moment, but the degree of approval at ministerial level is no longer appropriate, given that we are to move forward with the integration of service provision.

The Convener: Who would the reports be provided to? If there were joint inspection reports, what would the formal structure be? How independent would the reports be?

Alex Neil: The bodies are entirely independent, in the sense that, for example, they decide, within their statutory duties, which organisations to inspect, what the remit of the inspection is, what the timing of the inspection is and whether it is an announced or an unannounced inspection. They report to the body and, simultaneously, to the Scottish ministers because if the conclusions and recommendations in any inspection report require action on the part of the Scottish ministers, we have to take that on board.

All the reports are published—they are perfectly open and transparent—and they can be commissioned. For example, an NHS employee who is whistleblowing about alleged malpractice in
the health board can write to HIS and ask it to undertake an investigation and an inspection of the point that they are making. Anyone can ask for that, and I can mandate it.

The Convener: I am taking advantage of my position as convener, as I should not be continuing to ask questions, but is that matter something that can be included in our informal discussion? I am not sure how it plays into the situation with regard to HIS, SCSWIS or, indeed, local government. There seems to be a lot going on there.

11:00

Alex Neil: If we have time, prior to the discussion, we will try to provide a briefing about the existing arrangements, because this largely reflects—

The Convener: I appreciate that. I am not supposed to be asking questions at this point, of course.

Alex Neil: I am here to serve and please.

The Convener: You are here to put a smile on my face.

Bob Doris: Let us move on quickly, convener.

The Convener: Yes—quickly.

Amendment 258 agreed to.

Amendments 259 and 260 moved—[Alex Neil]—and agreed to.

The Convener: Amendment 261, in the name of the cabinet secretary, is in a group on its own.

Alex Neil: The amendments in the group relate to the Common Services Agency for the Scottish health service. Section 44 sets out the ability of the CSA—or NHS National Services Scotland as it is now more commonly known—to provide goods and services to Scottish public bodies. Amendment 262 allows for the CSA to provide services to publicly owned companies or bodies and in particular any corporations that health boards or local authorities own or which are a joint venture between them.

Section 44(3) provides a list of examples of the types of services that the CSA may provide to other bodies. Amendment 263 extends the list in section 44(3) to make clearer and put beyond doubt the types of services that the CSA may provide.

Amendment 264 allows for the Scottish ministers, by order, to amend the list in section 44(3) to make clearer and put beyond doubt the types of services that the CSA may provide.

Amendment 265 allows for the Scottish ministers, by order, to amend the list in section 44(3) to make clearer and put beyond doubt the types of services that the CSA may provide.

Section 44(3) provides a list of examples of the types of services that the CSA may provide to other bodies. Amendment 263 extends the list in section 44(3) to make clearer and put beyond doubt the types of services that the CSA may provide.

Amendment 264 allows for the Scottish ministers, by order, to amend the list in section 44(4A) to make clearer and put beyond doubt the types of services that the CSA may provide.

Amendment 271 provides that an order made under new section 44(4A) is subject to the affirmative procedure. Given the nature of the order-making power, the affirmative procedure is considered appropriate.
Amendments 265 and 266 seek to clarify and remove any potentially confusing duplication between section 44 of the bill and existing provisions in the National Health Service (Scotland) Act 1978 as to the bodies with which the CSA may enter into arrangements for the provision of services. The amendments provide for a clearer definition of “Scottish public authority”, making clear that section 44 does not apply to health bodies with which the CSA is already able to enter into arrangements.

Amendment 267 inserts an updated definition of one of the groups of Scottish public authorities with which the CSA can enter into arrangements. The amendment provides for the definition to be linked to that in schedule 5 to the Public Services Reform (Scotland) Act 2010. That will allow the CSA to provide services to a wider group of public authorities, including certain publicly owned companies. Should the Scottish ministers amend schedule 5, that would also alter the bodies to which the CSA could provide services.

Amendments 268 and 273 make amendments to the National Health Service (Scotland) Act 1978 and the Patient Rights (Scotland) Act 2011 in consequence of section 44.

Amendment 269 seeks to address an anomaly in the National Health Service (Residual Liabilities) Act 1996 concerning the transfer of liabilities if the CSA is dissolved. Before 2010, the CSA could be dissolved only by primary legislation. That would have addressed the need to transfer existing liabilities at the point of dissolution. Since 2010, it has been possible to dissolve the CSA using a public services reform order and, therefore, bodies entering into long-term contractual arrangements with the CSA have less protection regarding debts and obligations owed by the CSA than other NHS Scotland bodies have. The amendment addresses that anomaly and means that bodies entering into contracts with the CSA are offered the same protection as is given when contracting with other NHS bodies.

Amendment 274 revokes the Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) Order 2013 as a consequence of section 44.

I move amendment 262.

Amendment 262 agreed to.

Amendments 263 to 267 moved—[Alex Neil]—and agreed to.

Section 44, as amended, agreed to.

After section 44

Amendments 268 and 269 moved—[Alex Neil]—and agreed to.
amendment 147 on day 1. Is the amendment moved or not moved?

Malcolm Chisholm: I think that my amendment falls because the previous amendment was withdrawn.

The Convener: Not according to my script. Are you moving or not moving?

Malcolm Chisholm: It does not make sense to move the amendment.

The Convener: Okay.

Amendment 201 not moved.

Amendment 239 not moved.

Amendment 271 moved—[Alex Neil]—and agreed to.

Section 49, as amended, agreed to.

Section 50 agreed to.

Section 51—Repeals

The Convener: Amendment 272, in the name of the cabinet secretary, is in a group on its own.

Alex Neil: Section 5A of the Social Work (Scotland) Act 1968 makes provision for the preparation by local authorities of community care plans that cover adult community services. I understand that the requirement has not been fully implemented, and has largely fallen out of use. Community care plans are, in any case, inconsistent with the requirements of the bill for integrated planning of adult health and social services.

Amendment 272 repeals section 5A of the 1968 act and puts beyond doubt that community care plans should no longer be prepared. Indeed, the requirement in the bill for integration authorities to prepare a strategic plan for the area of the local authority will provide for a plan for adult community services—health services and social care services—rendering section 5A redundant.

I move amendment 272.

Amendment 272 agreed to.

Amendments 273 and 274 moved—[Alex Neil]—and agreed to.

Section 51, as amended, agreed to.

Section 52—Commencement

The Convener: Amendment 275, in the name of the cabinet secretary, is in a group on its own.

11:15

Alex Neil: Section 52 is concerned with the commencement of provisions in the bill. Amendment 275 will enable early commencement of sections 1(3) to 1(7), 5, 37 and 41. The Scottish ministers have expressed their wish to enable and support effective progress of integration of health and social care.

Before local authorities and health boards can begin to act in accordance with the requirements of the bill, the Scottish ministers require to make subordinate legislation, which will operate alongside the provisions of the bill to establish the framework for integration.

Amendment 275 will bring into force certain additional provisions on the day following royal assent. Those provisions relate to the requirements of an integration scheme, functions of health boards and local authorities that must be delegated, and the establishment of the national health and wellbeing outcomes that underpin the framework for integration and must be taken into account when preparing an integration scheme.

I move amendment 275.

Malcolm Chisholm: When I moved one of my amendments earlier, I raised the issue that health boards and local authorities might not be able to get on with their integration schemes because they were waiting for regulations about what they were allowed to include in them. What are the cabinet secretary’s intentions in respect of introducing regulations, so that health boards and local authorities know what they are able to include in their integration schemes?

Alex Neil: That is a fair question. First, we are not waiting for the passage of the bill before we start any work on the subsequent secondary legislation or on regulation and guidance. Pretty well all local authority areas, with one or two exceptions, have already established partnership arrangements and, in most cases, joint shadow boards for integration. West Lothian has been doing that for quite a few years and Highland, which has been doing it for less time, uses an integrated model. My message to local authorities is that there is no reason why they cannot proceed as quickly as possible, operating under existing legislation, until we finally pass all the secondary legislation and issue all the relevant guidance and regulation.

Having said that, we are conscious of the need for there to be clarity on a range of issues as soon as possible. We are also conscious of the need to have appropriate consultation before introducing secondary legislation, regulation and guidance. Amendment 275 will allow us, from the day after royal assent, not only to make a start on the statutory implementation of the bill but to get moving on the necessary consultation on secondary legislation and everything that flows from that.
We have well-established groups, including a ministerial strategy group, which will continue to work with all the key stakeholders at national level. I chair that group and Michael Matheson is the deputy chair. That group will continue. Although our discussions are at a strategic level, we very much look at implementation and the group will move from working on what we want to do with the bill to the implementation of the bill.

A series of other joint groups involving all the stakeholders is looking at specific areas of activity such as funding, accountability, governance and so on. A lot of work is already going on. We have the infrastructure to move that along very quickly in terms of the consultative bodies and the strategy group. I believe that we will be able to bring forward the secondary legislation, albeit that it will be a substantial piece of work, very timeously indeed.

Amendment 275 agreed to.

Section 52, as amended, agreed to.

Section 53 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill.

Alex Neil: I want to record my gratitude to the committee for getting through so much work in two sessions. I thank you, convener, and the committee members. Your co-operation is much appreciated.

The Convener: Thank you, cabinet secretary.

Members should note that the bill will now be reprinted as amended. The Parliament has not yet decided when stage 3 will take place, but members can lodge stage 3 amendments at any time with the legislation team. Members will be informed of the deadline for amendments once it has been determined.
CONTENTS

Section

PART 1
FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

Integration schemes
1 Integration schemes: same local authority and Health Board area
2 Integration schemes: two or more local authorities in Health Board area
3 Considerations in preparing integration scheme
4 Integration planning principles
5 Power to prescribe national outcomes
6 Consultation
7 Approval of integration scheme
8 Publication of integration scheme

Implementation of integration scheme
9 Functions delegated to integration joint board
10 Chief officer of integration joint board
11 Other staff of integration joint board
12 Integration joint boards: further provision
12A Integration joint boards: finance and audit
13 Payments to integration joint boards in respect of delegated functions
14 Functions delegated to local authority or Health Board
15 Transfer of staff where functions delegated to local authority or Health Board
16 Integration joint monitoring committees: further provision
17 Payments to Health Boards in respect of delegated functions
18 Payments to local authorities in respect of delegated functions
18A Health funding: further provision
19 Transfer of staff: effect on contract of employment
20 Co-operation
20A Carrying out of functions conferred on officers of local authorities
20B Carrying out of functions conferred on officers of Health Boards

Carrying out of delegated functions
21 Effect of delegation of functions
22 Directions by integration authority
22A Section 22: supplementary

Strategic planning etc.
23 Requirement to prepare strategic plans
24 Considerations in preparing strategic plan
25 Integration delivery principles
26 Establishment of strategic planning group
27 Preparation of strategic plan
27A Provision of information for purpose of preparing strategic plan
28 Requirement for agreement to certain strategic plans
29 Publication of strategic plans
30 Significant decisions outside strategic plan: public involvement
30A Review of strategic plan
30B Requirement to prepare replacement strategic plan
30C Strategic plan: annual financial statement

Carrying out of integration functions
31 Carrying out of integration functions: general
32 Carrying out of integration functions: localities
33 Integration authority: performance report

Reports by integration joint monitoring committee
33A Reports

Review of integration scheme
33B Review of integration scheme
33C Requirement to review integration scheme
34 Revised integration scheme
35 New integration scheme
36 Power to make provision in consequence of new integration scheme

Supplementary
37 Information-sharing
38 Grants to local authorities
39 Default power of Scottish Ministers
40 Directions
41 Guidance
41A Social Care and Social Work Improvement Scotland
41B Healthcare Improvement Scotland
41C Joint inspections of health services and social services
41D Amendments of section 56 of Local Government (Scotland) Act 1973
42 Meaning of “integration authority”
43 Meaning of “integration functions”
43A Meaning of “constituent authority”

PART 2

Shared services
44 Shared services
44A Section 44: consequential provision
44B Common Services Agency for the Scottish Health Service: residual liabilities
45 Extension of schemes for meeting losses and liabilities of health service bodies
PART 3

HEALTH SERVICE: FUNCTIONS

46 Scottish Ministers: power to form companies etc.
47 Health Boards: carrying out of functions

PART 4

GENERAL

48 Interpretation
49 Subordinate legislation
50 Ancillary provision
51 Repeals and revocation
52 Commencement
53 Short title

Schedule—Enactments conferring on local authorities functions which may be delegated
Public Bodies (Joint Working) (Scotland) Bill  
[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

PART 1

FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

Integration schemes

1 Integration schemes: same local authority and Health Board area

(1) Subsection (2) applies where the area of a local authority is the same as the area of a Health Board.

(2) The local authority and the Health Board must jointly prepare an integration scheme for the area of the local authority.

(3) An integration scheme is a scheme setting out—

(a) which integration model mentioned in subsection (4) is to apply,

(b) the functions that are to be delegated in accordance with that model,

(c) where functions are to be delegated in accordance with the model mentioned in subsection (4)(b), (c) or (d), the functions of the person to whom functions are to be delegated which are to be carried out in conjunction with the delegated functions,

(ca) where subsection (5A) applies, a method of determining amounts to be made available by the Health Board in respect of functions that are to be delegated by the Health Board,

(d) where subsection (5A) does not apply (or where it applies but the Health Board deems it not to apply), a method of determining payments that are to be made in respect of a delegated function by the person delegating the function to the person to whom the function is delegated,

(e) prescribed information about such other matters as may be prescribed.

(4) The integration models are—
Public Bodies (Joint Working) (Scotland) Bill
Part 1—Functions of local authorities and Health Boards

(a) delegation of functions by the local authority to a body corporate that is to be established by order under section 9 (an “integration joint board”) and delegation of functions by the Health Board to the integration joint board,

(b) delegation of functions by the local authority to the Health Board,

(c) delegation of functions by the Health Board to the local authority,

(d) delegation of functions by the local authority to the Health Board and delegation of functions by the Health Board to the local authority.

(4A) A local authority may delegate a function under an integration scheme only if the function is conferred by an enactment listed in the schedule.

(4B) A Health Board may delegate a function under an integration scheme only if the function is prescribed.

(4C) The Scottish Ministers may by regulations prescribe which of the functions conferred by enactments listed in the schedule local authorities must delegate under an integration scheme so far as the functions are exercisable in relation to persons of at least 18 years of age where the integration model mentioned in subsection (4)(a) or (b) is to apply under the scheme.

(4D) The Scottish Ministers may by regulations prescribe functions of Health Boards which Health Boards must delegate under an integration scheme so far as the functions are exercisable in relation to persons of at least 18 years of age where the integration model mentioned in subsection (4)(a) or (c) is to apply under the scheme.

(4E) If the integration model mentioned in subsection (4)(d) is to apply under an integration scheme either—

(a) the local authority must delegate the functions prescribed under subsection (4C) so far as the functions are exercisable in relation to persons of at least 18 years of age, or

(b) the Health Board must delegate the functions prescribed under subsection (4D) so far as the functions are exercisable in relation to persons of at least 18 years of age.

(4F) The Scottish Ministers may by regulations prescribe functions of Health Boards that a Health Board—

(a) must delegate under an integration scheme other than in prescribed circumstances,

(b) may not delegate under an integration scheme in prescribed circumstances.

(4G) The Scottish Ministers may by regulations prescribe which of the functions conferred by enactments listed in the schedule local authorities may not delegate in prescribed circumstances.

(4H) The Scottish Ministers may by regulations remove an enactment from the schedule.

(5) A function may not be set out under subsection (3)(c) if it is a function which may not be delegated under an integration scheme.

(5A) This subsection applies where functions that a Health Board proposes to delegate under an integration scheme—

(a) are carried out in a hospital in the area of the Health Board, and

(b) are provided for the areas of two or more local authorities.
(7) In this section, “Health Board” means a Health Board constituted under section 2(1)(a) of the National Health Service (Scotland) Act 1978 (c.29).

2 Integration schemes: two or more local authorities in Health Board area

(1) This section applies where the areas of two or more local authorities fall within the area of a Health Board.

(2) Each local authority and the Health Board must comply with subsection (3) or (4).

(3) Each local authority and the Health Board must jointly prepare an integration scheme for the area of the local authority.

(4) Two or more local authorities and the Health Board must jointly prepare an integration scheme for the areas of those local authorities.

(4A) For the purposes of subsection (4), if the local authorities and the Health Board decide that the integration model mentioned in paragraph (c) or (d) of section 1(4) is to apply—

(a) functions are to be delegated under those models to only one of the local authorities,

(b) the authorities and the Health Board must set out in the integration scheme which local authority the functions are to be delegated to (the “lead authority”),

(c) paragraph (c) of section 1(4) applies as if for the words “to the local authority” there were substituted the words “and the local authority or authorities to the lead authority”, and

(d) paragraph (d) of section 1(4) applies as if for the words from “to”, where it first occurs, to “local” there were substituted “or authorities to the Health Board and delegation of functions by the Health Board and the local authority or authorities to the lead”.

(5) In preparing an integration scheme under subsection (3) or (4), a local authority must take into account—

(a) any other integration scheme that has been, or is being, prepared in relation to the area of the same Health Board, and

(b) the likely effect on the Health Board of both or all the schemes prepared under this section.

3 Considerations in preparing integration scheme

(1) This section applies where a local authority and a Health Board are preparing an integration scheme.

(2) The local authority and the Health Board must have regard to—

(a) the integration planning principles (see section 4), and

(b) the national health and wellbeing outcomes (see section 5).

4 Integration planning principles

(1) The integration planning principles are—
Part 1—Functions of local authorities and Health Boards

(a) that the main purpose of services which are provided in pursuance of functions which are delegated under an integration scheme is to improve the wellbeing of service-users,

(b) that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible—
   (i) is integrated from the point of view of service-users,
   (ii) takes account of the particular needs of different service-users,
   (iii) takes account of the particular needs of service-users in different parts of the area in which the service is being provided,
   (iiia) takes account of the dignity of service-users,
   (iiib) takes account of the participation by service-users in the community in which service-users live,
   (iiic) protects and improves the safety of service-users,
   (iid) improves the quality of the service,
   (iv) is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care),
   (v) best anticipates needs and prevents them arising, and
   (vi) makes the best use of the available facilities, people and other resources.

(2) In subsection (1), “service-users” means persons to whom or in relation to whom the services are provided.

5 Power to prescribe national outcomes

(1) The Scottish Ministers may by regulations prescribe outcomes in relation to health and wellbeing.

(2) Such outcomes are to be known as “the national health and wellbeing outcomes”.

(3) Before making regulations under subsection (1), the Scottish Ministers must consult—
   (a) each local authority,
   (b) each Health Board,
   (c) each integration joint board at the time established,
   (d) in respect of each group mentioned in subsection (4), such persons appearing to be representative of the group as the Scottish Ministers think fit.

(4) The groups mentioned in subsection (3)(d) are—
   (a) health professionals,
   (b) users of health care,
   (c) carers of users of health care,
   (d) commercial providers of health care,
   (e) non-commercial providers of health care,
   (f) social care professionals,
(g) users of social care,
(h) carers of users of social care,
(i) commercial providers of social care,
(j) non-commercial providers of social care.

6 Consultation

(1) This section applies where a local authority and a Health Board are required by section 1(2) or 2(2) to prepare an integration scheme.

(2) Before submitting the integration scheme for approval under section 7, the local authority and the Health Board must jointly consult—

(a) such persons or groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed, and

(b) such other persons as the local authority and the Health Board think fit.

(3) In finalising the integration scheme, the local authority and the Health Board must take account of any views expressed by virtue of subsection (2).

7 Approval of integration scheme

(1) After complying with section 6 and before the prescribed day, a local authority and a Health Board must jointly submit an integration scheme to the Scottish Ministers for approval.

(2) Any information included in an integration scheme by virtue of section 1(3)(e) need not be approved by the Scottish Ministers but may be taken into account by them in deciding whether to approve the scheme.

(3) The Scottish Ministers may—

(a) approve the scheme submitted under subsection (1),

(b) refuse to approve it.

(4) If the Scottish Ministers refuse to approve the scheme they must—

(a) give the local authority and the Health Board reasons for the refusal (including identifying which particular parts of the scheme caused them to decide to refuse approval),

(b) explain how the scheme should be modified, and

(c) specify a day by which the local authority and the Health Board must jointly modify the scheme and submit it for approval.

(4A) Following submission of a modified scheme under subsection (4), the Scottish Ministers may—

(a) approve the modified scheme, or

(b) refuse to approve it.

(4B) Where the Scottish Ministers refuse to approve a modified scheme, the local authority and the Health Board are to be treated as if they failed before the prescribed day to submit an integration scheme under this section; and section 39 applies accordingly.
(5) The Scottish Ministers may, on their own account or on the request of the local authority and the Health Board, specify that subsection (1) applies as if the prescribed day were such later day as the Scottish Ministers may specify.

(6) A request under subsection (5) must be made in writing and must include the reasons for the request.

(7) A day specified under subsection (5) is to be treated as if it were the prescribed day for the purposes of the other provisions of this Act.

8 **Publication of integration scheme**

As soon as practicable after an integration scheme is approved under section 7, the local authority and the Health Board must publish it.

**Implementation of integration scheme**

9 **Functions delegated to integration joint board**

(1) This section applies where the Scottish Ministers approve under section 7 an integration scheme setting out that the integration model in section 1(4)(a) is to apply.

(2) The Scottish Ministers may by order establish the integration joint board to which the functions are to be delegated.

(3) If the functions are not delegated on the day specified by virtue of section 23(3A), they are delegated on the prescribed day.

10 **Chief officer of integration joint board**

(1) An integration joint board is to appoint, as a member of staff, a chief officer.

(2) Subsection (3) applies where the person to be appointed is an existing member of staff of a constituent authority.

(3) The person is to be seconded to the board by that authority.

(4) Where subsection (3) does not apply, the person to be appointed—

   (a) is to be appointed as a member of staff of a constituent authority, and

   (b) is then to be seconded to the board by that authority.

(5) The Scottish Ministers may in relation to any integration joint board by order—

   (a) disapply the requirements of subsections (2) to (4), and

   (b) make provision enabling the board to employ a chief officer on such terms and conditions as the board determines.

(6) Before appointing a person as chief officer an integration joint board is to consult each constituent authority.

(7) The responsibilities of a chief officer are subject to the agreement of the Scottish Ministers.

11 **Other staff of integration joint board**

(1) The Scottish Ministers may by order make provision enabling integration joint boards to appoint staff other than a chief officer.
(2) Such an order may include such further provision as regards such staff as the Scottish Ministers think fit, including in particular provision as to—
   (a) the appointment of staff,
   (b) the numbers of staff,
   (c) the terms and conditions of staff.

(3) Provision as to a matter mentioned in subsection (2)(a), (b) or (c) may include provision making the matter subject to the determination, direction or agreement of any person.

(4) Without prejudice to section 49(1)(a), an order under this section may—
   (a) make provision in relation to only one integration joint board, or some integration joint boards,
   (b) make different provision in relation to different integration joint boards.

(5) Before making an order under this section, the Scottish Ministers must consult—
   (a) if the order relates to integration joint boards generally, each—
      (i) local authority,
      (ii) Health Board, and
      (iii) integration joint board then established,
   (b) if the order relates to one integration joint board, or some integration joint boards—
      (i) the constituent authorities in relation to that or those boards, and
      (ii) that or those boards, to the extent then established.

12 Integration joint boards: further provision

(1) The Scottish Ministers may by order make provision—
   (a) about the membership of integration joint boards,
   (b) about the proceedings of integration joint boards,
   (c) giving integration joint boards general powers (such as powers to contract, acquire or dispose of property or rights or borrow money or incur other liabilities) in connection with the carrying out of functions conferred on them by or by virtue of this Act,
   (d) about the supply of services or facilities to integration joint boards by a constituent authority,
   (da) enabling integration joint boards to establish committees for any purpose,
   (db) about such other matters relating to any such committee as the Scottish Ministers think fit,
   (dc) enabling an integration joint board to delegate to its chief officer, any other member of its staff or any such committee functions delegated to the integration joint board in pursuance of an integration scheme,
   (e) about any other matter relating to the establishment or operation of integration joint boards that the Scottish Ministers think fit.
(2) Without prejudice to section 49(1)(a), an order under subsection (1) (other than an order containing provision of the type mentioned in paragraph (a) or (b) of that subsection) may—

(a) make provision in relation to only one integration joint board, or some integration joint boards,

(b) make different provision in relation to different integration joint boards.

(2A) Before making an order under this section, the Scottish Ministers must consult—

(a) if the order relates to integration joint boards generally, each—

(i) local authority,

(ii) Health Board, and

(iii) integration joint board then established,

(b) if the order relates to one integration joint board, or some integration joint boards—

(i) the constituent authorities in relation to that or those boards, and

(ii) that or those boards, to the extent then established.

(3) The Scottish Ministers may by scheme make provision about the transfer to an integration joint board of staff, property, rights, liabilities or obligations of their constituent authorities.

(3A) Before making a scheme under subsection (3), the Scottish Ministers must consult—

(a) the integration joint board to which the scheme relates, and

(b) the constituent authorities in relation to that board.

(4) Before making a scheme under subsection (3) in relation to staff, the Scottish Ministers must consult in respect of each group mentioned in subsection (5), such persons appearing to be representative of the group as the Scottish Ministers think fit.

(5) The groups mentioned in subsection (4) are—

(a) health professionals,

(b) social care professionals,

(c) such other groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

12A Integration joint boards: finance and audit

(1) The chief officer of an integration joint board has responsibility for the administration of the financial affairs of the integration joint board.

(2) In section 106 of the Local Government (Scotland) Act 1973 (application of Part 7 of Act to bodies other than local authorities etc.)—

(a) in subsection (1), after paragraph (ba) insert—

“(bb) an integration joint board established by order under section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014 (but subject to subsection (1A)),”, and

(b) after that subsection, insert—
“(1A) Despite subsection (1), sections 95, 101A and 105A of this Act do not apply with respect to an integration joint board.”.

13 Payments to integration joint boards in respect of delegated functions

(1) Subsections (2) and (3) apply where—

(a) an integration scheme sets out that the integration model in section 1(4)(a) is to apply, and

(b) the scheme is approved by the Scottish Ministers under section 7.

(2) The local authority must make a payment to the integration joint board of the amount determined in accordance with the method set out in the scheme in relation to each function delegated by it.

(2A) Where an integration scheme contains provision of the type mentioned in section 1(3)(ca), the Health Board must set aside for use by the integration joint board an amount determined in accordance with the method set out in the scheme in relation to each function delegated by it.

(3) Where an integration scheme contains provision of the type mentioned in section 1(3)(d), the Health Board must make a payment to the integration joint board of the amount determined in accordance with the method set out in the scheme in relation to each function delegated by it.

14 Functions delegated to local authority or Health Board

(1) This section applies where the Scottish Ministers approve under section 7 an integration scheme setting out that the integration model in section 1(4)(b), (c) or (d) is to apply.

(1A) If the functions are not delegated on the day specified by virtue of section 23(3A), they are delegated on the prescribed day.

(2) Before the functions are delegated, the local authority and the Health Board must jointly establish a committee (an “integration joint monitoring committee”) for the purpose of monitoring the carrying out of the integration functions for the area of the local authority.

15 Transfer of staff where functions delegated to local authority or Health Board

(1) The Scottish Ministers may by scheme make provision about the transfer of staff from a person who is to delegate functions under an integration scheme falling within subsection (2) to the person to whom the functions are to be delegated.

(1A) Before making a scheme under subsection (1) in relation to staff, the Scottish Ministers must consult in respect of each group mentioned in subsection (1B), such persons appearing to be representative of the group as the Scottish Ministers think fit.

(1B) The groups mentioned in subsection (1A) are—

(a) health professionals,

(b) social care professionals,

(c) such other groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.
(2) An integration scheme falls within this subsection if it sets out that the integration model in section 1(4)(b), (c) or (d) is to apply.

(3) Before making a scheme under subsection (1), the Scottish Ministers must consult—
   (a) the person who is to delegate functions under an integration scheme falling within subsection (2), and
   (b) the person to whom the functions are to be delegated.

16 **Integration joint monitoring committees: further provision**

(1) The Scottish Ministers may by order make provision about—
   (a) the establishment of integration joint monitoring committees,
   (b) the membership of integration joint monitoring committees,
   (c) the proceedings of integration joint monitoring committees,
   (d) any other matter relating to the operation of integration joint monitoring committees that the Scottish Ministers think fit.

(2) Without prejudice to section 49(1)(a), an order under subsection (1) may make different provision in relation to different integration joint monitoring committees.

17 **Payments to Health Boards in respect of delegated functions**

(1) Subsection (2) applies where—
   (a) an integration scheme sets out that the integration model in section 1(4)(b) or (d) is to apply, and
   (b) the scheme is approved by the Scottish Ministers under section 7.

(2) The local authority must make a payment to the Health Board of the amount determined in accordance with the method that is set out in the scheme in relation to each function delegated to the Health Board.

18 **Payments to local authorities in respect of delegated functions**

(1) This section applies where—
   (a) an integration scheme sets out that the integration model in section 1(4)(c) or (d) is to apply, and
   (b) the scheme is approved by the Scottish Ministers under section 7.

(1A) Where an integration scheme contains provision of the type mentioned in section 1(3)(ca), the Health Board must set aside for use by the local authority an amount determined in accordance with the method set out in the scheme in relation to each function delegated to the local authority.

(2) Where an integration scheme contains provision of the type mentioned in section 1(3)(d), the Health Board must make a payment to the local authority of the amount determined in accordance with the method set out in the scheme in relation to each function delegated to the local authority.
(3) Each local authority which delegates functions to another local authority (the “lead authority”) under the scheme must make a payment to the lead authority of the amount determined in accordance with the method set out in the scheme in relation to each function delegated by the authority to the lead authority.

18A Health funding: further provision

(1) This section applies where under section 13(2A) or 18(1A) a Health Board is required to set aside an amount in respect of certain functions delegated to an integration authority.

(2) The integration authority may by direction require a Health Board—
   (a) to carry out a function delegated to the integration authority by the Health Board and in relation to which amounts have been set aside, and
   (b) to use an amount of the set aside amount specified in the direction (the “specified amount”) for that purpose.

(3) If the integration authority gives a direction under subsection (2) and, despite the direction, the Health Board does not use all of the specified amount, the integration authority may require the Health Board to pay to it the unused amount of the specified amount.

(4) If the integration authority gives a direction under subsection (2) and, despite the direction, the Health Board requires to use more than the specified amount, the Health Board may require the integration authority to reimburse it for the additional amount used.

(5) The Health Board must give reports to the integration authority about such matters relating to the amounts set aside as the integration authority may specify.

(6) Reports under subsection (5) must be given at such times and in relation to such periods as the integration authority may specify.

19 Transfer of staff: effect on contract of employment

(1) This section applies where by virtue of section 12(3), 15(1) or 36(3) a person is to be transferred from the employment of one person (“the original employer”) to another (“the new employer”).

(2) If, before the day of the transfer, the person informs the original employer that the person does not wish to become an employee of the new employer, the person’s contract of employment is terminated on the day before the day of the transfer.

(3) Otherwise—
   (a) the contract of employment between the person and the original employer has effect on and after the day of the transfer as if originally made between the person and the new employer,
   (b) the rights, powers, duties and liabilities of the original employer under or in connection with the contract of employment are by virtue of this section transferred to the new employer on the day of the transfer, and
   (c) anything done before the day of the transfer by or in relation to the original employer in respect of the contract of employment or the person is to be treated on and after that day as having been done by or in relation to the new employer.

(3A) Nothing in subsection (3)—

(a) imposes on the new employer any liability for a share in any deficit in a pension scheme of the original employer that—

(i) is attributable to the person’s membership of the scheme, and

(ii) accrued before the day of the transfer, or

(b) confers any right on the new employer in respect of a share in any surplus in such a pension scheme that is so attributable and that so accrued.

(4) A person is not to be treated for any purpose as being dismissed by reason of the operation of any provision of this section in relation to the person.

(5) Nothing in this section affects any right of a person to terminate the person’s contract of employment if a substantial detrimental change in the person’s working conditions is made.

(6) No such right arises by reason only that, by virtue of this section, the identity of the person’s employer changes.

20 Co-operation

(1) This section applies where the Scottish Ministers approve under section 7 one or more schemes prepared by virtue of section 2(3) or (4) in relation to the same Health Board.

(2) The persons mentioned in subsection (3) must co-operate with each other in relation to the efficient and effective use of their resources (including in particular buildings, staff and equipment) in pursuance of the scheme or schemes.

(3) The persons are—

(a) each local authority,

(b) the Health Board.

20A Carrying out of functions conferred on officers of local authorities

(1) This section applies where a function conferred by an enactment on an officer of a local authority relates to a function delegated to an integration authority under an integration scheme.

(2) Where the integration authority is an integration joint board, the function is deemed to have been conferred also on an officer of the Health Board and any other local authorities that are the constituent authorities of the integration joint board.

(3) Where the integration authority is a local authority or Health Board, the function is deemed to have been conferred also on an officer of the Health Board and any other local authority which prepared the integration scheme.

20B Carrying out of functions conferred on officers of Health Boards

(1) This section applies where a function conferred by an enactment on an officer of a Health Board relates to a function delegated to an integration authority under an integration scheme.

(2) Where the integration authority is an integration joint board, the function is deemed to have been conferred also on an officer of the local authority or authorities that are the constituent authorities of the integration joint board.
(3) Where the integration authority is a local authority or Health Board, the function is deemed to have been conferred also on an officer of the local authority or authorities which prepared the integration scheme.

Carrying out of delegated functions

Effect of delegation of functions

(1) This section applies where a function is delegated in pursuance of an integration scheme.

(2) The integration authority to which the function is delegated is to carry out the function.

(3) The integration authority has all of the powers and duties from time to time applying in connection with the carrying out of the function.

(4) Despite subsection (2), the delegation of the function in pursuance of an integration scheme does not prevent the carrying out of the function by the person by whom the delegation is made.

(5) The Scottish Ministers may by order provide that an integration authority which is an integration joint board must or must not exercise a power of the type mentioned in subsection (3) in connection with the carrying out of a function specified in the order.

Directions by integration authority

(1) Where the integration authority is an integration joint board, it must give a direction to a constituent authority to carry out on its behalf each function delegated to the integration authority.

(2) Where the integration authority is a local authority or a Health Board, it may give a direction to the Health Board or local authority which prepared the integration scheme by virtue of which it is the integration authority to carry out on its behalf any function delegated to the integration authority.

(3) A person to whom a direction under this section may be given must provide the integration authority with such information as the integration authority may reasonably require for the purpose of its deciding—

(a) whether to give the direction,

(b) the content of the direction.

(4) A direction under this section may be given to more than one person in relation to the same function.

(5) If a direction such as is mentioned in subsection (4) is given, the direction may—

(a) require the persons to carry out the function jointly or only in so far as is specified in the direction,

(b) require each person to carry out the function in relation to an area specified in the direction,

(c) require each person to do particular things in relation to the function.

Section 22: supplementary

(1) A direction under section 22—
(a) must set out, or set out a method of determining, payments that are to be made by
the integration authority to the person who is to carry out the function on its
behalf,
(b) may—

5  (i) regulate the manner in which the function is to be carried out,
(ii) make such supplementary, incidental or consequential provision as the
integration authority considers appropriate.

(2) The provision referred to in subsection (1)(b)(ii) may include in particular the
imposition on the person who is to carry out the function of requirements—

(a) to provide information to the integration authority,
(b) to take action to enable the integration authority to comply with any order of a
court made against it in connection with the carrying out of the function,
(b) to reimburse the integration authority in relation to any liabilities incurred by the
integration authority in connection with the carrying out of the function.

(3) The integration authority must make payments in accordance with the provision
included in the direction by virtue of subsection (1)(a).

(4) A person to whom a direction under section 22 is given must comply with the direction.

(5) A direction under section 22—

(a) may vary or revoke an earlier direction under that section given by the same
integration authority,
(b) must be in writing.

(6) If the conditions in subsection (7) are met, the Scottish Ministers may by order provide
that an integration authority which is an integration joint board—

(a) may decide not to give a direction under section 22 in relation to the carrying out
of a function specified in the order, or
(b) may give a direction under that section, despite the making of the order.

(7) The conditions are—

(a) that the Scottish Ministers receive a written application from the constituent
authorities requesting that an order be made in relation to the functions specified
in the application, and
(b) that the Scottish Ministers consider that the making of an order in relation to some
or all of those functions would improve compliance with the national health and
wellbeing outcomes.

(8) If the Scottish Ministers do not consider under subsection (7)(b) that the making of an
order under subsection (6) would improve compliance with the national health and
wellbeing outcomes in relation to any functions, they need not include those functions in
the order.

Strategic planning etc.

23  Requirement to prepare strategic plans

(1) The integration authority for the area of a local authority must prepare strategic plans in
accordance with this section.
(2) A strategic plan is a document—
   (a) setting out the arrangements for the carrying out of the integration functions for the area of the local authority over the period of the plan,
   (b) setting out how those arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes, and
   (c) including such other material as the integration authority thinks fit.

(3) The provision required to be included in a strategic plan by virtue of subsection (2)(a) is to include provision—
   (a) dividing the area of the local authority into two or more localities, and
   (b) setting out separately arrangements for the carrying out of the integration functions in relation to each such locality.

(3A) If the functions of the integration authority are not to be delegated to the authority on the day prescribed under section 9(3) or, as the case may be, section 14(1A), the first strategic plan must specify the day on which functions are to be delegated to the authority.

(4) The first strategic plan of an integration authority is to be prepared before the integration start day.

(6) In this section, “integration start day” means—
   (a) in relation to an integration authority which is an integration joint board, the day on which functions are delegated to the authority by virtue of subsection (3A) or, as the case may be, section 9(3),
   (b) in relation to any other integration authority, the day on which functions are delegated by virtue of subsection (3A) or, as the case may be, section 14(2) to, or to the constituent authorities of, the integration authority.

24 Considerations in preparing strategic plan

(1) This section applies where an integration authority in relation to the area of a local authority is preparing a strategic plan.

(2) The integration authority must have regard to—
   (a) the integration delivery principles (see section 25), and
   (b) the national health and wellbeing outcomes (see section 5).

(3) The integration authority must have regard to the effect which any arrangements which it is considering setting out in the strategic plan in pursuance of section 23(2)(a) may have on services, facilities or resources—
   (a) utilised by arrangements set out in pursuance of that section in a strategic plan prepared by another integration authority,
   (b) which would be utilised by arrangements which another integration authority is considering setting out in pursuance of that section in a strategic plan which it is preparing.

(4) The references in subsections (3)(a) and (b) to a strategic plan are to a strategic plan relating to the same period as, or relating to part of the same period as, the strategic plan which is being prepared by the integration authority.
25 **Integration delivery principles**

(1) The integration delivery principles are—

(a) that the main purpose of services which are provided in pursuance of functions which are delegated under an integration scheme is to improve the wellbeing of service-users,

(b) that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible—

(i) is integrated from the point of view of service-users,

(ii) takes account of the particular needs of different service-users,

(iii) takes account of the particular needs of service-users in different parts of the area in which the service is being provided,

(iii) a) takes account of the dignity of service-users,

(iii) b) takes account of the participation by service-users in the community in which service-users live,

(iii) c) protects and improves the safety of service-users,

(iii) d) improves the quality of the service,

(iv) is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care),

(v) best anticipates needs and prevents them arising, and

(vi) makes the best use of the available facilities, people and other resources.

(2) In subsection (1), “service-users” means persons to whom or in relation to whom the services are provided.

26 **Establishment of strategic planning group**

(1) Before preparing its first strategic plan, an integration authority in relation to the area of a local authority is to establish a group (its “strategic planning group”) comprising—

(a) where the integration authority is an integration joint board—

(i) at least one person nominated by the Health Board which is a constituent authority in relation to the integration joint board,

(ii) where one local authority is a constituent authority in relation to the integration joint board, at least one person nominated by it,

(iii) where two or more local authorities are constituent authorities in relation to the integration joint board, at least one person nominated by the authorities,

(b) where the integration authority is a Health Board, at least one person nominated by the local authority or authorities with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its functions,

(c) where the integration authority is a local authority, at least one person nominated by the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its functions,
(d) one person in respect of each of the groups mentioned in subsection (2), being a person who the integration authority considers to be representative of that group, and

(e) such other persons as the integration authority considers appropriate.

(2) The groups referred to in subsection (1)(d) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

(2A) The integration authority is to determine—

(a) the number of members of its strategic planning group,

(b) so far as not set out in this section, the processes for appointment, removal and replacement of members.

(2B) The integration authority may—

(a) appoint members of its strategic planning group from persons nominated under subsection (1),

(b) in such circumstances as the authority considers appropriate, remove persons appointed under paragraph (a) from membership of the group,

(c) appoint members in place of members who resign or are removed from membership of the group.

(2C) A constituent authority may—

(a) remove from its strategic planning group a member appointed to represent it,

(b) nominate under subsection (1) another person in place of a member of the group appointed to represent it.

(2D) A member of a strategic planning group may resign at any time.

(2E) During the period to which any strategic plan of an integration authority relates, its strategic planning group is also to comprise a person to represent the interests of each locality set out in the plan in pursuance of section 23(3)(a).

(2F) It is for the integration authority to—

(a) decide which persons are suitable to represent the interests of a locality, and

(b) select the representative.

(2G) An integration authority may under subsection (2F)(b) select a single person in respect of two or more localities.

(2H) The validity of anything done by an integration authority’s strategic planning group is not affected by any vacancy in its membership.

(3) The procedure of an integration authority’s strategic planning group is to be such as the authority determines.

(4) An integration authority may pay to members of its strategic planning group such expenses and allowances as the authority determines.

27 Preparation of strategic plan

(1) This section applies where an integration authority in relation to the area of a local authority is preparing a strategic plan.

(1A) The integration authority is to—
(a) prepare proposals for what the strategic plan should contain, and
(b) seek the views of its strategic planning group on the proposals.

(2) Taking account of any views expressed by virtue of subsection (1A)(b), the integration
authority is then to—

(a) prepare a first draft of the strategic plan, and
(b) seek the views of its strategic planning group on the draft.

(3) Taking account of any views expressed by virtue of subsection (2)(b), the integration
authority is then to—

(a) prepare a second draft of the strategic plan,
(b) send a copy to—
   (i) the persons mentioned in subsection (4), and
   (ii) such other persons as it considers appropriate, and
(c) invite the recipients to express views (within such period as the integration
   authority considers appropriate) on the draft.

(4) The persons referred to in subsection (3)(b)(i) are—

(a) where the integration authority is an integration joint board, each constituent
   authority,
(b) where the integration authority is a local authority, the Health Board with which
   the local authority prepared the integration scheme in pursuance of which the
   integration authority acquired its delegated functions,
(c) where the integration authority is a Health Board, the local authority with which
   the Health Board prepared the integration scheme in pursuance of which the
   integration authority acquired its delegated functions, and
(d) persons who the integration authority considers to be representative of each of the
   groups mentioned in subsection (5).

(5) The groups referred to in subsection (4)(d) are such groups of persons appearing to the
Scottish Ministers to have an interest as may be prescribed.

(6) In finalising the strategic plan, the integration authority must take account of any views
expressed by virtue of subsection (3)(c).

27A Provision of information for purpose of preparing strategic plan

(1) A constituent authority must provide an integration authority which is an integration
joint board with such information as the authority may reasonably require for the
purpose of preparing a strategic plan.

(2) The person mentioned in subsection (3) must provide an integration authority which is a
Health Board or a local authority with such information as the integration authority may
reasonably require for the purpose of preparing a strategic plan.

(3) That person is the local authority or the Health Board with which the integration
authority prepared the integration scheme in pursuance of which the integration
authority acquired its delegated functions.
29 **Publication of strategic plans**

(1) As soon as practicable after the finalisation of the plan under section 27, an integration authority must publish its strategic plan.

(3) At the same time as publishing a strategic plan, an integration authority must also publish a statement of the action which it took in pursuance of section 27.

30 **Significant decisions outside strategic plan: public involvement**

(1) This section applies where the integration authority for the area of a local authority—

   (a) proposes to take a significant decision about the arrangements for the carrying out of the integration functions for the area of the authority, and

   (b) intends the decision to take effect other than by virtue of revising its strategic plan under section 30A.

(2) In subsection (1)(a), “significant decision” means a decision which the integration authority considers might significantly affect the provision of a service provided in pursuance of the integration functions in the area of the local authority.

(3) The integration authority must—

   (a) seek and have regard to the views of its strategic planning group, and

   (b) take such action as it thinks fit with a view to securing that persons mentioned in subsection (4) are involved in and consulted on the decision.

(4) Those persons are users of the service which is being or may be provided.

30A **Review of strategic plan**

(1) An integration authority—

   (a) must before the expiry of the relevant period review the effectiveness of its strategic plan,

   (b) may from time to time carry out such a review.

(2) In carrying out a review under subsection (1), the integration authority must—

   (a) have regard to—

      (i) the integration delivery principles, and

      (ii) the national health and wellbeing outcomes, and

   (b) seek and have regard to the views of its strategic planning group on—

      (i) the effectiveness of the arrangements for the carrying out of the integration functions in the area of the local authority, and

      (ii) whether the integration authority should prepare a replacement strategic plan.

(3) Following a review under subsection (1), an integration authority may prepare a replacement strategic plan.

(4) Subject to subsection (2), the process of such a review is to be such as the integration authority determines.
(5) A constituent authority must provide an integration authority which is an integration joint board with such information as the integration authority may reasonably require for the purpose of carrying out a review under subsection (1).

(6) The person mentioned in subsection (7) must provide an integration authority which is a Health Board or a local authority with such information as the integration authority may reasonably require for the purpose of carrying out a review under subsection (1).

(7) That person is the local authority or the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions.

(8) A strategic plan prepared in pursuance of this section must specify a day on which the period of the plan is to begin.

(9) In subsection (1), “relevant period”, in relation to an integration authority, means—

(a) the period of 3 years beginning with the integration start day (as defined in section 23(4)), and

(b) each subsequent period of 3 years beginning with—

(i) where a replacement strategic plan is prepared following a review under subsection (1), the day specified under subsection (8),

(ii) where no replacement strategic plan is prepared following such a review, the day on which the integration authority decides not to prepare a revised strategic plan.

30B Requirement to prepare replacement strategic plan

(1) This section applies where the integration authority in relation to the area of a local authority is an integration joint board.

(2) If it appears to a constituent authority that the strategic plan is preventing, or is likely to prevent, the constituent authority from carrying out any of its functions appropriately or in a way which is consistent with the integration delivery principles and the national health and wellbeing outcomes, the constituent authorities acting jointly may direct the integration authority to prepare a replacement strategic plan.

(3) A direction under subsection (2) must—

(a) be in writing,

(b) include a statement summarising the reasons for giving it.

(4) A direction under subsection (2) must specify—

(a) a day by which the replacement strategic plan must be prepared, and

(b) a day on which the period of the plan is to begin.

(5) The constituent authorities acting jointly may by direction substitute a different day for a day specified under subsection (4).

(6) An integration authority must comply with a direction given to it under subsection (2).

30C Strategic plan: annual financial statement

(1) Each integration authority must publish an annual financial statement—

(a) when it publishes its first strategic plan, and
(b) each year after that.

(2) An annual financial statement must set out in relation to the strategic plan to which it relates the amount that the integration authority intends to spend in implementation of the plan.

### Carrying out of integration functions

#### 31 Carrying out of integration functions: general

In carrying out an integration function for the area of a local authority, a person must have regard to—

(a) the integration delivery principles (see section 25), and

(b) the national health and wellbeing outcomes (see section 5).

#### 32 Carrying out of integration functions: localities

(1) This section applies where—

(a) an integration authority carrying out an integration function for the area of a local authority proposes to take a decision which the authority considers might significantly affect the provision in a locality of the area of a service provided in pursuance of the function, or

(b) a person carrying out an integration function for the area of a local authority proposes to take a decision which the person considers might significantly affect the provision in a locality of the area of a service provided in pursuance of the function.

(2) In subsection (1), “locality” means a locality of an area as set out in the strategic plan in pursuance of section 23(3)(a).

(3) The integration authority or, as the case may be, person must take such action as the authority or person thinks fit with a view to securing that the groups mentioned in subsection (4) are involved in and consulted on the decision.

(4) The groups referred to in subsection (3) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

(5) The integration authority may pay to members of groups consulted under subsection (3) such expenses and allowances as the authority determines.

#### 33 Integration authority: performance report

(1) Each integration authority must prepare a performance report for the reporting year.

(2) A performance report is a report setting out an assessment of performance during the reporting year to which it relates in carrying out the integration functions for the area of the local authority.

(3) The Scottish Ministers may by regulations prescribe the form and content of performance reports.

(3A) An integration authority must—

(a) publish each performance report before the expiry of the period of 4 months beginning with the end of the reporting year, and
(b) provide a copy of it to the persons mentioned in subsection (3B).

(3B) Those persons are—

(a) where the integration authority is an integration joint board, each constituent authority,
(b) where the integration authority is a local authority and a Health Board acting jointly, the integration joint monitoring committee,
(c) where the integration authority is a Health Board or a local authority—
   (i) the integration joint monitoring committee, and
   (ii) the other authority.

(3C) A constituent authority must provide an integration authority which is an integration joint board with such information as the authority may reasonably require for the purpose of preparing a performance report.

(3D) The other authority must provide an integration authority which is a Health Board or a local authority with such information as the integration authority may reasonably require for the purpose of preparing a performance report.

(4) In this section—

“other authority” means the local authority or the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions,

“reporting year”, in relation to an integration authority, means—

(a) the period beginning with the date prescribed under section 9(3) or, as the case may be, 14(1A) and ending on the first anniversary of that date, and
(b) each subsequent period of a year.

Reports by integration joint monitoring committee

(33A) Reports

(1) An integration joint monitoring committee may give reports to the integration authority on any aspect of the carrying out of the integration functions for the area of the local authority for which the integration joint monitoring committee is established.

(2) A report may include recommendations as to how those integration functions should be carried out in future.

(3) Where a report is given to an integration authority under subsection (1), the integration authority must—

(a) have regard to the report and any recommendations included in it,
(b) take such action as the authority considers necessary, and
(c) if the report includes recommendations, give the integration joint monitoring committee a response to them in writing as soon as is reasonably practicable after the authority is given the report.

(4) An integration joint monitoring committee may publish—

(a) reports given under subsection (1),
(b) responses given under subsection (3)(c).
(5) The local authority and the Health Board which prepared the integration scheme by virtue of which the integration joint monitoring committee is established must provide the committee with such reports, information or other assistance as the committee may reasonably require for the purpose of preparing a report under subsection (1).

### Review of integration scheme

#### 33B Review of integration scheme

(1) This section applies where an integration scheme has been approved by the Scottish Ministers under section 7.

(2) The local authority and the Health Board must carry out a review of the scheme before the expiry of the relevant period for the purpose of identifying whether any changes to the scheme are necessary or desirable.

(3) Sections 3 and 6 apply to a review of an integration scheme under subsection (2) as they apply to the preparation of an integration scheme (but as if the words “Before submitting the integration scheme for approval under section 7,” in section 6(2) were omitted).

(4) After taking account of any views of persons consulted under section 6 (as applied by subsection (3)), the local authority and the Health Board must decide whether any changes to the scheme are necessary or desirable.

(5) In subsection (2), the “relevant period” means—

(a) the period of 5 years beginning with the day on which the scheme was approved under section 7, and

(b) each subsequent period of 5 years beginning with—

(i) where the local authority and the Health Board vary the scheme under section 34, the day specified under subsection (5) of that section,

(ii) where the local authority and the Health Board decide no changes to the scheme are necessary or desirable, the day on which that decision is made.

#### 33C Requirement to review integration scheme

(1) This section applies where an integration scheme has been approved by the Scottish Ministers under section 7.

(2) On the request of the local authority or the Health Board, the local authority and the Health Board must jointly carry out a review of the scheme for the purpose of identifying whether any changes to the scheme are necessary or desirable.

(3) Where matters are prescribed under section 1(3)(e), the Scottish Ministers may require the local authority and the Health Board jointly to carry out a review of the integration scheme for the purpose of identifying whether any changes to the scheme are necessary or desirable.

(4) Sections 3 and 6 apply to a review of an integration scheme under subsection (2) or (3) as they apply to the preparation of an integration scheme (but as if the words “Before submitting the integration scheme for approval under section 7,” in section 6(2) were omitted).

(5) After taking account of any views of persons consulted under section 6 (as applied by subsection (3)), the local authority and the Health Board must decide whether any changes to the scheme are necessary or desirable.
34 Revised integration scheme

(1) This section applies where a local authority and a Health Board decide under section 33B or 33C that changes to an integration scheme are necessary or desirable.

(2) The local authority and the Health Board may vary the scheme by jointly preparing a revised integration scheme.

(3) A revised integration scheme may—
   (a) set out additional functions that are to be delegated under the scheme as mentioned in section 1(3)(b),
   (b) set out functions that are delegated by virtue of the integration scheme approved under section 7 that are no longer to be delegated,
   (c) if the integration scheme delegates functions in accordance with the integration model mentioned in section 1(4)(b), (c) or (d), set out functions that are to be carried out in conjunction with the delegated functions,
   (d) if the integration scheme delegates functions in accordance with the integration model mentioned in section 1(4)(b), (c) or (d), set out functions that are no longer to be carried out in conjunction with the delegated functions,
   (da) change the method of determining amounts to be made available as mentioned in section 1(3)(ca),
   (e) change the method of determining payments as mentioned in section 1(3)(d),
   (f) change or remove any information included in the plan by virtue of section 1(3)(e).

(3A) Before complying with subsection (4) or (as the case may be) (4A), the local authority and the Health Board must jointly consult—
   (a) such persons or groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed, and
   (b) such other persons as the local authority and the Health Board think fit.

(3B) In finalising the revised integration scheme, the local authority and the Health Board must take account of any views expressed by virtue of subsection (3A).

(4) If a revised integration scheme includes provision of the type mentioned in any of paragraphs (a) to (e) of subsection (3), the local authority and the Health Board must jointly submit the revised scheme to the Scottish Ministers for approval under section 7.

(4A) If a revised integration scheme includes provision of the type mentioned in paragraph (f) of subsection (3), the local authority and the Health Board must jointly give notice of the change to the Scottish Ministers.

(5) A revised integration scheme takes effect on such day as may be specified by the Scottish Ministers.

(6) As soon as practicable after a revised integration scheme takes effect, the local authority and the Health Board must publish it.

35 New integration scheme

(1) This section applies where a local authority and a Health Board decide under section 33B or 33C that changes to an integration scheme are necessary or desirable.
(2) If the local authority and the Health Board wish to change any of the matters mentioned in subsection (3) they must prepare a new integration scheme under section 1 or (as the case may be) 2(2).

(3) The matters are—

(a) the local authority which prepared the integration scheme,

(b) the integration model.

(4) This Act applies in relation to a new integration scheme prepared by virtue of subsection (2) as it applies in relation to an integration scheme which requires to be prepared by section 1 or (as the case may be) 2(2).

### 36 Power to make provision in consequence of new integration scheme

(1) This section applies where the Scottish Ministers approve an integration scheme which has been prepared by virtue of section 35.

(2) In consequence of the replacement of an integration scheme by a new integration scheme, the Scottish Ministers may by order provide for the winding-up of an integration joint board.

(3) In consequence of the replacement of an integration scheme by a new integration scheme, the Scottish Ministers may by scheme make such provision about the transfer of staff, property, rights, liabilities or obligations of an integration joint board, a local authority or a Health Board as they consider necessary.

(4) Before making a scheme under subsection (3), the Scottish Ministers must consult—

(a) the person from whom it is proposed to transfer staff, and

(b) the person to whom it is proposed that the staff be transferred.

### Supplementary

### 37 Information-sharing

(1) Where a local authority and a Health Board are jointly preparing an integration scheme, each of them may disclose information to the other for or in relation to the purpose of preparing the scheme.

(2) Where two or more local authorities and a Health Board are jointly preparing an integration scheme, each of them may disclose information to any of the others for or in relation to the purpose of preparing the scheme.

(3) A person mentioned in subsection (4) may disclose information to any other person mentioned in that subsection for or in relation to any of the purposes mentioned in subsection (5).

(4) The persons are—

(a) a local authority,

(b) a Health Board,

(c) an integration joint board.

(5) The purposes are—

(a) functions that are delegated by virtue of an integration scheme approved under section 7,
functions that are to be carried out in conjunction with delegated functions,
(c) the preparation of a strategic plan.

(6) Subsections (1) to (3) apply despite any duty of confidentiality owed to any person in respect of the information by the person disclosing the information.

38 Grants to local authorities

(1) The Scottish Ministers may make a grant to a local authority in respect of costs incurred by the authority by virtue of this Part.

(2) The payment of a grant under subsection (1) may be made subject to such conditions (including conditions as to repayment) as the Scottish Ministers may determine.

39 Default power of Scottish Ministers

(1) Subsection (2) applies where a local authority and a Health Board fail before the day prescribed for the purposes of section 7, or the day specified under subsection (4)(c) of that section, to submit an integration scheme for the approval of the Scottish Ministers under that section.

(2) The Scottish Ministers may—
(a) specify functions of the local authority and the Health Board which are to be delegated to an integration joint board,
(b) by order establish the integration joint board to which the functions are to be delegated,
(c) require the local authority and the Health Board to delegate the specified functions to the integration joint board before the prescribed day,
(d) require the local authority and the Health Board to make such payments to the integration joint board as the Scottish Ministers may specify, and
(e) require the local authority and the Health Board to comply with such other requirements in relation to the functions as the Scottish Ministers may specify.

40 Directions

(1) The Scottish Ministers may give directions to a local authority in relation to the carrying out of—
(a) functions conferred on it by this Act,
(b) functions delegated to it in pursuance of an integration scheme,
(c) functions specified in the scheme that are to be carried out in conjunction with those functions.

(2) The Scottish Ministers may give directions to a Health Board in relation to the carrying out of—
(a) functions conferred on it by this Act,
(b) functions delegated to it in pursuance of an integration scheme,
(c) functions specified in the scheme that are to be carried out in conjunction with those functions.
(3) The Scottish Ministers may give directions to an integration joint board in relation to the carrying out of—
   (a) functions conferred on it by this Act,
   (b) functions delegated to it in pursuance of an integration scheme.

(4) A local authority, a Health Board or an integration joint board must comply with a direction given to it under this section.

(5) Directions under this section—
   (a) may vary or revoke earlier directions under this section,
   (b) must be in writing.

(6) The Scottish Ministers may not under subsection (1) or (2) give a direction requiring a local authority or Health Board to make a written application of the type mentioned in section 22A.

41 Guidance

(1) A person mentioned in subsection (2) must have regard to any guidance issued by the Scottish Ministers about its functions under or in relation to this Act.

(2) Those persons are—
   (a) a local authority,
   (b) a Health Board,
   (c) an integration joint board,
   (d) an integration joint monitoring committee.

41A Social Care and Social Work Improvement Scotland

In section 53 of the Public Services Reform (Scotland) Act 2010 (inspections by Social Care and Social Work Improvement Scotland)—

(a) in subsection (1), after paragraph (b), add—
   “(c) where social services, services provided under the health service or services provided by an independent health care service are provided in pursuance of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 (“the 2014 Act”), the co-ordination of those services.”,

(b) in subsection (2), after paragraph (e), add—
   “(f) where the inspection is carried out under subsection (1)(c)—
      (i) reviewing and evaluating the extent to which the social service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,
      (ii) reviewing and evaluating the extent to which the co-ordination of social services, services provided under the health service and services provided by an independent health care service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,
(iii) reviewing and evaluating the effectiveness of a strategic plan prepared under section 23 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(iv) encouraging improvement in the extent to which implementation of a strategic plan prepared under section 23 of the 2014 Act complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, and

(v) enabling consideration as to the need for any recommendations to be prepared as to any such improvement to be included in the report prepared under section 57.”, and

(c) after subsection (6), add—

“(7) In this section—

“independent health care service” has the meaning given by section 10F(1) of the National Health Service (Scotland) Act 1978;

“integration delivery principles” has the meaning given by section 25 of the 2014 Act.”.

41B Healthcare Improvement Scotland

(1) The National Health Service (Scotland) Act 1978 is amended as follows.

(2) In section 10I (Healthcare Improvement Scotland: inspection of services provided under the health service)—

(a) after subsection (1), insert—

“(1A) Where a service provided under the health service is provided by virtue of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 ("the 2014 Act"), HIS may inspect the service for any of the purposes mentioned in subsection (1B).

(1B) The purposes are—

(a) reviewing and evaluating the extent to which the service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(b) reviewing and evaluating the extent to which the co-ordination of services provided under the health service and social services is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(c) reviewing and evaluating the effectiveness of a strategic plan prepared under section 23 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(d) encouraging improvement in the extent to which implementation of a strategic plan prepared under section 23 of the 2014 Act complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, and
(e) enabling consideration as to the need for any recommendations to be prepared as to any such improvement to be included in the report prepared under section 10N.”.

(b) after subsection (2), insert—

“(3) In this section—

“integration delivery principles” has the meaning given by section 25 of the 2014 Act;

“social services” has the meaning given by section 46 of the Public Services Reform (Scotland) Act 2010.”.

(3) In section 10J (inspections of independent health care services)—

(a) in subsection (1), after paragraph (b), add—

“(c) where services provided by an independent health care service and social services are provided in pursuance of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 (“the 2014 Act”), the co-ordination of those services.”,

(b) in subsection (2), after paragraph (e), add—

“(f) where the inspection is carried out under subsection (1)(c)—

(i) reviewing and evaluating the extent to which the independent health care service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(ii) reviewing and evaluating the extent to which the co-ordination of services provided by an independent health care service and social services is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(iii) reviewing and evaluating the effectiveness of a strategic plan prepared under section 23 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(iv) encouraging improvement in the extent to which implementation of a strategic plan prepared under section 23 of the 2014 Act complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, and

(v) enabling consideration as to the need for any recommendations to be prepared as to any such improvement to be included in the report prepared under section 10N.”.

(c) after subsection (7), add—

“(8) In this section—

“integration delivery principles” has the meaning given by section 25 of the Public Bodies (Joint Working) (Scotland) Act 2014;

“social services” has the meaning given by section 46 of the Public Services Reform (Scotland) Act 2010.”.
41C Joint inspections of health services and social services

(1) The Public Services Reform (Scotland) Act 2010 is amended as follows.

(2) In section 115(11) (meaning of “confidential information”), for “section”, where it second occurs, substitute “sections 116A(4) and”.

(3) After section 116, insert—

“116A Joint inspections of social services and health services

(1) Social Care and Social Work Improvement Scotland (“SCSWIS”) and Healthcare Improvement Scotland (“HIS”) may jointly conduct an inspection in relation to—

(a) any social services, services provided under the health service or services provided by an independent health care service which are provided in pursuance of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 (“the 2014 Act”), or

(b) a local authority, Health Board or integration joint board (as defined in section 1(4)(a) of the 2014 Act) which is required by section 23 of the 2014 Act to prepare a strategic plan.

(2) The purposes of an inspection under this section may be any of those mentioned in section 10I(1) or (1B) or 10J(2) of the National Health Service (Scotland) Act 1978 or section 53(2) of this Act.

(3) In conducting an inspection under this section, SCSWIS and HIS must have regard to any code of practice or practice note issued by the Scottish Ministers for the purpose of—

(a) giving practical and general guidance on matters relating to such an inspection (including, without prejudice to that generality, such matters as access to confidential information and the holding, sharing and destruction of such information),

(b) promoting what appear to them to be desirable practices with regard to such matters.

(4) After conducting an inspection under this section, SCSWIS and HIS must—

(a) prepare a report, and

(b) give any person to whom the report relates an opportunity to comment on the report.

(5) SCSWIS and HIS must—

(a) give the report to the Scottish Ministers,

(b) give copies of the report to any person to whom the report relates, and

(c) make copies of the report available at their offices for inspection by any person at any reasonable time.

(6) In this section—

“independent health care service” has the meaning given by section 10F of the National Health Service (Scotland) Act 1978;

“social services” has the meaning given by section 46.”.
(4) In section 117 (regulations relating to joint inspections), after subsection 5, add—

“(6) In this section, “joint inspection” means an inspection conducted under section 115 or 116A.”.

41D Amendments of section 56 of Local Government (Scotland) Act 1973

In section 56 of the Local Government (Scotland) Act 1973 (arrangements for discharge of functions by local authorities)—

(a) after subsection (7), insert—

“(7A) A local authority is not to make arrangements under this section for the discharge of any of its functions under the Public Bodies (Joint Working) (Scotland) Act 2014 by any other local authority.”, and

(b) after subsection (15), add—

“(16) In this section, “Act” includes an Act of the Scottish Parliament.”.

42 Meaning of “integration authority”

For the purposes of this Part, the “integration authority” for the area of a local authority is—

(a) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(a), the integration joint board established in pursuance of the scheme,

(b) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(b), the Health Board to which the functions are delegated,

(c) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(c), the local authority to which the functions are delegated,

(d) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(d), the local authority and the Health Board to which the functions are delegated, acting jointly.

43 Meaning of “integration functions”

(1) For the purposes of this Part, the “integration functions” for the area of a local authority are—

(a) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(a), the functions delegated to the integration joint board in pursuance of the scheme,

(b) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(b)—

(i) the functions delegated to the Health Board in pursuance of the scheme, and

(ii) the functions to be carried out in conjunction with those functions,
(c) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(c)—

(i) the functions delegated to the local authority in pursuance of the scheme,

(ii) the functions to be carried out in conjunction with those functions,

(d) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(d)—

(i) the functions delegated to each of the Health Board and the local authority in pursuance of the scheme, and

(ii) the functions to be carried out in conjunction with those functions.

(2) In subsection (1), the references to the functions which are to be carried out in conjunction with delegated functions are to the functions set out in the integration scheme in pursuance of section 1(3)(c).

43A Meaning of “constituent authority”

For the purposes of this Part, each local authority and the Health Board which prepared the integration scheme in pursuance of which an integration joint board was, or is to be, established is a “constituent authority” in relation to that board.

PART 2

SHARED SERVICES

44 Shared services

(1) The Common Services Agency for the Scottish Health Service (the “Agency”) may, with the consent of the Scottish Ministers, enter into arrangements with a person mentioned in subsection (2) under which the Agency provides, or secures the provision of, any goods or services for the person.

(2) The persons are—

(a) the Scottish Ministers,

(b) any other office-holder in the Scottish Administration,

(c) any Scottish public authority,

(d) any Scottish public authority with mixed functions or no reserved functions,

(e) any government department,

(f) any cross-border public authority,

(g) any body corporate formed by a Health Board or by the Agency, or in the formation of which a Health Board or the Agency participated, by virtue of a delegation of the power in section 84B(1) of the National Health Service (Scotland) Act 1978 (joint ventures).

(3) Services which may be provided under subsection (1) include in particular—

(a) administrative services,

(b) technical services,
(c) legal services,
(d) other professional services,
(e) accommodation services.

(4) The power to make arrangements under subsection (1) is without prejudice to any other power of the Agency to provide goods or services to other persons.

(4A) The Scottish Ministers may by order amend subsection (2) so as to add or remove a person, or a description of a person, for the time being mentioned in or falling within that subsection.

(5) In this section—

“cross-border public authority” has the meaning given by section 88(5) of the Scotland Act 1998 (c.46),
“government department” has the meaning given by section 126(1) of that Act,
“office-holder in the Scottish Administration” is to be construed in accordance with section 126(7) of that Act,
“Scottish public authority” has the meaning given by section 126(1) of that Act except that it does not include—
(a) a Health Board,
(b) a Special Health Board (constituted under section 2(1)(b) of the National Health Service (Scotland) Act 1978), or
(c) Healthcare Improvement Scotland,
“Scottish public authority with mixed functions or no reserved functions” means persons, bodies and office-holders (other than the Agency) listed in schedule 5 to the Public Services Reform (Scotland) Act 2010 (improvement of public functions: listed bodies) under the heading “Scottish public authorities with mixed functions or no reserved functions”.

44A Section 44: consequential provision

(1) The National Health Service (Scotland) Act 1978 is amended in accordance with subsections (2) and (3).

(2) In section 10 (Common Services Agency)—

(a) in subsection (1), the words from “which” to the end are repealed, and

(b) after that subsection, insert—

“(1A) The Agency has the functions conferred on it by—

(a) this Act, and

(b) section 44 of the Public Bodies (Joint Working) (Scotland) Act 2014.”

(3) In section 15 (supply of goods and services to local authorities etc.)—

(a) in subsection (1)—

(i) for “, a Health Board or the Agency”, in the first two places where it occurs, substitute “or a Health Board”, and

(ii) in paragraph (e), the words “or the Agency” are repealed,
(b) after that subsection, insert—

“(1ZA) Paragraph (a) of subsection (1) applies to the Agency as it applies to a Health Board.”,

(c) in subsection (2), after “including” insert “paragraph (a) as applied by subsection (1ZA) and”, and

(d) subsections (2A) to (2D) are repealed.

(4) In section 17(2) of the Patient Rights (Scotland) Act 2011, for “that Act” substitute “the 1978 Act”.

**44B Common Services Agency for the Scottish Health Service: residual liabilities**

In section 2(1) of the National Health Service (Residual Liabilities) Act 1996 (certain Scottish health bodies: duty to transfer residual liabilities on ceasing to exist), for “or a Special Health Board” substitute “, a Special Health Board or the Common Services Agency for the Scottish Health Service”.

**45 Extension of schemes for meeting losses and liabilities of health service bodies**

(1) Section 85B of the National Health Service (Scotland) Act 1978 (schemes for meeting losses and liabilities of health service bodies) is amended as follows.

(2) In subsection (2)—

(a) the word “and” immediately after paragraph (ea) is repealed,

(b) after paragraph (f) add—

“(g) local authorities; and

(h) integration joint boards established by order under section 9(2) of the 2014 Act,”.

(3) After subsection (2A) insert—

“(2B) The reference—

(a) in paragraph (a) of subsection (1) to property of a local authority is to be construed as a reference to property held by a local authority in connection with the exercise of its relevant functions;

(b) in paragraph (b) of that subsection to the functions of a local authority is to be construed as a reference to the relevant functions of a local authority.

(2C) In subsection (2B), “relevant functions” means—

(a) integration functions; and

(b) such other functions as the Scottish Ministers may by order specify.

(2D) In subsection (2C)(a), “integration functions” means functions which in pursuance of an integration scheme under the 2014 Act are—

(a) delegated to the authority;

(b) to be carried out in conjunction with functions delegated to the authority (that is, functions set out in the integration scheme in pursuance of section 1(3)(c) of that Act); or
(c) to be carried out by the authority by virtue of a direction under section 22 of the 2014 Act.”.

(4) After subsection (4) insert—

“(4A) Subsection (4)(a) does not apply in relation to a local authority.”.

(5) After subsection (5) insert—

“(6) In this section, “the 2014 Act” means the Public Bodies (Joint Working) (Scotland) Act 2014.”.

PART 3

HEALTH SERVICE: FUNCTIONS

46 Scottish Ministers: power to form companies etc.

In section 84B of the National Health Service (Scotland) Act 1978 (joint ventures)—

(a) in subsection (1), for “companies”, wherever it occurs, substitute “bodies corporate”;

(b) in subsection (2), for “company” substitute “body corporate”, and

(c) in subsection (3), the definition of “companies” is repealed.

47 Health Boards: carrying out of functions

After section 12J of the National Health Service (Scotland) Act 1978, insert—

“12K Power of Health Board to carry out other Health Board’s functions

A Health Board may, with the agreement of another Health Board and the Scottish Ministers, carry out on behalf of that other Health Board any function of that other Health Board.”.

PART 4

GENERAL

48 Interpretation

(1) In this Act—

“Health Board” has the meaning given by section 1(7),

“health care” has the same meaning as in section 10A(1)(b) of the National Health Service (Scotland) Act 1978,

“health professionals” means persons of such description engaged in the provision of health care as may be prescribed,

“integration joint board” has the meaning given by section 1(4)(a),

“integration joint monitoring committee” has the meaning given by section 14(2)(a),

“integration scheme” has the meaning given by section 1(3),

“prescribed” means prescribed by the Scottish Ministers by regulations,
“social care” means—

(a) social services (having the same meaning as in Part 5 of the Public Services Reform (Scotland) Act 2010), and

(b) such functions of local authorities relating to the provision of accommodation for persons who are homeless as may be prescribed,

“social care professionals” means persons of such description engaged in the provision of social care as may be prescribed,

“strategic plan” has the meaning given by section 23(2).

(2) For the purposes of this Act, a provider of a service is a “commercial” provider if the aim of the person in providing the service is or includes making a profit.

(3) References in this Act (other than sections 2(3), 37(1) and 43A)—

(a) to a local authority include, in the case where the integration scheme is being or has been jointly prepared under section 2(4), references to both or all the authorities which are preparing or have prepared the scheme, acting jointly,

(b) to the area of a local authority mean, in a case where the integration scheme is being or has been jointly prepared under section 2(4), the combined area of the local authorities which are preparing or have prepared the scheme.

(4) References in this Act to a function include references to a function so far as exercisable in relation to persons or matters of a particular class or description.

49 Subordinate legislation

(1) Regulations and orders under this Act may—

(a) make different provision for different purposes,

(aa) make different provision for different cases or classes of case,

(b) include such supplementary, incidental, consequential, transitional or transitory provision, or savings, as the Scottish Ministers consider appropriate.

(2) Regulations under sections 1(4H) and 5(1) are subject to the affirmative procedure.

(2A) An order under section 44(4A) is subject to the affirmative procedure.

(3) An order under section 50 containing provision which adds to, replaces or omits any part of the text of an Act is subject to the affirmative procedure.

(4) Otherwise, regulations and orders under this Act are subject to the negative procedure.

(5) This section does not apply to an order under section 52(2).

50 Ancillary provision

(1) The Scottish Ministers may by order—

(a) make such supplementary, incidental or consequential provision as they consider appropriate for the purposes of, in consequence of, or for giving full effect to, any provision of this Act,

(b) make such transitional or transitory provision or savings as they consider appropriate for the purposes of, or in connection with, the coming into force of any provision of this Act.
(2) An order under this section may modify any enactment (including this Act).

51 Repeals and revocation

(A1) Section 5A of the Social Work (Scotland) Act 1968 (which makes provision about local authority plans for community care services) is repealed.

(1) Sections 4A and 4B of the National Health Service (Scotland) Act 1978 (c.29) (which make provision about community health partnerships) are repealed.

(2) Sections 15 to 17 of the Community Care and Health (Scotland) Act 2002 (asp 5) (which make provision about joint working among local authorities and certain health bodies) are repealed.

(3) Section 2 of the National Health Service Reform (Scotland) Act 2004 (asp 7) (which inserts sections 4A and 4B into the National Health Service (Scotland) Act 1978) is repealed.

(3A) Section 17(1) of the Patient Rights (Scotland) Act 2011 is repealed.

(4) Section 20 of the Social Care (Self-directed Support) (Scotland) Act 2013 (asp 1) (which amends section 15(4) of the Community Care and Health (Scotland) Act 2002) is repealed.

(5) The Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013 (S.S.I. 2013/220) is revoked.

52 Commencement

(1) Sections 1(3) to (7), 5, 37 and 41 and this Part (other than section 51) come into force on the day after Royal Assent.

(2) The other provisions of this Act come into force on such day as the Scottish Ministers may by order appoint.

(3) An order under subsection (2) may contain transitory or transitional provision or savings.

53 Short title

The short title of this Act is the Public Bodies (Joint Working) (Scotland) Act 2014.
SCHEDULE
(introduced by section 1(4A))

Enactments conferring on local authorities functions which may be delegated

Sections 22, 26, 45 and 48 of the National Assistance Act 1948.


Sections 1, 4, 5, 6B, 8, 10, 12, 12A, 12AZA, 12AA, 12AB, 13 to 14, 27, 27ZA, 28, 29, 59, 78A, 80, 81, 83, 86 and 87 of the Social Work (Scotland) Act 1968.

Sections 34, 39, 40 and 50 of the Children Act 1975.

Section 24 of the Local Government and Planning (Scotland) Act 1982.

Sections 21, 22 and 23 of the Health and Social Services and Social Security Adjudications Act 1983.

Sections 3, 5, 6, 8, 9 and 10 of the Foster Children (Scotland) Act 1984.

Sections 2, 3, 7 and 8 of the Disabled Persons (Services, Consultation and Representation) Act 1986.

Sections 4, 5 and 5A and Part II of the Housing (Scotland) Act 1987.

Sections 17, 19 to 27, 29 to 32, 36 and 38 of the Children (Scotland) Act 1995.


Sections 10, 12, 37 and 39 to 45 of the Adults with Incapacity (Scotland) Act 2000.

Sections 1, 2, 5, 6, 8 and 92 of the Housing (Scotland) Act 2001.

Sections 5, 6 and 14 of the Community Care and Health (Scotland) Act 2002.

Sections 17, 25 to 27, 33, 34, 228 and 259 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Sections 10 and 11 of the Management of Offenders etc. (Scotland) Act 2005.

Section 71 of the Housing (Scotland) Act 2006.

Sections 1, 4, 5, 6, 9, 10, 11, 12, 19, 26, 45, 47, 48, 49, 51, 80, 90, 99 and 105 of the Adoption and Children (Scotland) Act 2007.

Sections 4 to 11, 14, 16, 18, 22, 40, 42 and 43 of the Adult Support and Protection (Scotland) Act 2007.

Sections 35, 37, 42, 44, 48, 49, 60, 131, 145, 166 and 167 of the Children’s Hearings (Scotland) Act 2011.

Sections 3, 5 to 13, 16 and 19 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Public Bodies (Joint Working) (Scotland) Bill
[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

Introduced by: Alex Neil
Supported by: Derek Mackay
On: 28 May 2013
Bill type: Government Bill
INTRODUCTION

1. As required under Rule 9.7.8A of the Parliament’s Standing Orders, these Revised Explanatory Notes are published to accompany the Public Bodies (Joint Working) (Scotland) Bill (introduced in the Scottish Parliament on 28 May 2013) as amended at Stage 2. Text has been added or deleted as necessary to reflect the amendments made to the Bill at Stage 2 and these changes are indicated by sidelining in the right margin.

2. These Explanatory Notes have been prepared by the Scottish Government in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

THE BILL

4. The Bill provides the framework which will support the improvement of the quality and consistency of health and social care services in Scotland. This framework permits the integration of local authority services with health services. In addition, the Bill provides for the Common Services Agency commonly known as NHS National Services Scotland to provide goods and services to public bodies including local authorities; for the Scottish Ministers to form a wider range of joint venture structures than at present in order to make the most effective use of resources; and to extend the Clinical Negligence and Other Risks Scheme (CNORIS) indemnity scheme run by the Scottish Ministers.

Outline of the Bill

5. In summary the Bill:
   • Provides for national outcomes for health and wellbeing, and for delivery of which Health Boards and local authorities will be accountable to the Scottish Ministers and the public (note that the provisions of the Bill apply to area Health Boards and not Special Health Boards).
• Sets out principles for planning and delivery of integrated functions, which local authorities, Health Boards and joint integration boards will be required to have regard to. They set out that the main purpose of integrated services is to improve the wellbeing of recipients, as well as an expectation that planning and delivery will take account of key principles relating to integrated delivery; the requirement to balance the needs of individuals with the overall needs of the population; anticipation and prevention of need; and effective use of resources.

• Establishes integration joint boards and integration joint monitoring committees as the partnership arrangements for the governance and oversight of health and social care services. The Bill will remove Community Health Partnerships from statute.

• Requires Health Board and local authority partners to enter into arrangements (the integration scheme) to delegate functions and appropriate resources to ensure the effective delivery of those functions. The Bill provides two options for integrating budgets and functions. First, delegation to an integration joint board established as a body corporate - in this case the Health Board and the local authority agree the amount of resources to be committed by each partner for the delivery of services to support the functions delegated. Second, delegation between partners. In this case the Health Board and/or local authority delegates functions and the corresponding amount of resource, to the other partner.

• Requires integration joint boards to appoint a chief officer, who will through the board be jointly accountable to the constituent Health Board and local authorities, responsible for the management of the integrated budget and the delivery of services for the area of the integration scheme. The chief officer will also lead the development and delivery of the strategic plan for the joint board.

• Requires integration joint boards, and Health Boards or local authorities to whom functions are delegated acting in the capacity of “integration authority” to prepare a strategic plan for the area, which sets out arrangements for delivery of integration functions and how it will meet the national health and wellbeing outcomes. The integration authority will be required to involve a range of partners in the development of the plan and consult widely. In addition, locality planning duties will require the integration authority to make suitable arrangements to consult and plan locally for the needs of its population.

• Delivers opportunities for more effective use of public services and resources by allowing for Health Boards to be able to contract on behalf of other Health Boards for contracts which involve providing facilities, and by allowing the Scottish Ministers to form a wider range joint ventures structures to collaborate effectively with local authorities and enable a joint approach to asset management and disposal.

• Provides for the extension of the Common Services Agency’s ability to deliver shared services to public bodies including local authorities.

• Enables the Scottish Ministers to extend the range of bodies able to participate in the CNORIS scheme for meeting losses and liabilities of certain health service bodies. The scheme is established for relevant bodies to meet expenses arising from any loss or damage to their property; and liabilities to third parties for loss, damage or injury arising from the carrying out of the functions of the scheme members. The Bill amends the bodies able to participate in the scheme to include local authorities and integration joint boards.
COMMENTARY ON SECTIONS

PART 1

FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

Integration schemes

Section 1 – Integration schemes: same local authority and Health Board area

6. Section 1 makes provision about integration schemes and sets out the four models of integration from which local authorities and Health Boards are to choose for the purposes of integration planning and integrated delivery of services in accordance with the Bill.

7. Integration planning is predicated on the delegation of local authority and/or Health Board functions using one of the four models of delegation set out in subsection (4): (a) the local authority and the Health Board delegate functions to an integration joint board established as a body corporate by order by the Scottish Ministers; (b) the local authority delegates functions to the Health Board; (c) the Health Board delegates functions to a local authority, and (d) the local authority delegates functions to the Health Board and the Health Board delegates functions to the local authority.

8. By virtue of subsections (1) and (2), where the area of a local authority is the same as the area of a Health Board i.e. there is a single local authority within the Health Board area, the local authority and the Health Board are required to jointly prepare an integration scheme for the area of the local authority.

9. Subsection (3) sets out what the integration scheme must include. The required information is: (a) which model of integration is to be used, (b) the functions which are to be delegated in the way identified, (c) where functions are delegated to a Health Board, local authority or both, the functions of that body which are to be carried out in conjunction with the delegated functions, (the functions which may be set out in this part of the scheme are described in subsection (5)), (ca) (where subsection (5A) applies) a method of determining amounts to be made available by the Health Board with respect to the delegated functions, (d) (where subsection (5A) does not apply, or where it applies but the Health Board deems it not to apply) a method of determining payments which are to be made with respect to the delegated functions, and (e) any additional information that may be required by the Scottish Ministers by regulations.

10. Subsection (4A) provides for local authorities to delegate only those of their functions that are conferred by the enactments listed in the schedule. Subsection (4B) provides for Health Boards to delegate such of their functions as are prescribed by the Scottish Ministers. Subsection (4C) provides that the Scottish Ministers may by regulations prescribe functions conferred by the enactments listed in the schedule that local authorities must delegate (where the integration model mentioned in subsection (4)(a) or (b) applies) in so far as those functions relate to persons aged 18 years or over. Subsection (4D) provides for the Scottish Ministers to prescribe certain functions of a Health Board that must be delegated where the integration model mentioned in subsection (4)(a) or (c) applies and the functions relate to persons aged 18 years or over. Subsection (4E) sets out the requirements which apply where the integration model provided for in subsection (4)(d), in which functions may be delegated to both the Health Board and local authority, is chosen. The provision sets out that local authorities and Health Boards must delegate functions prescribed under
subsections (4C) and (4D) respectively so far as the functions relate to persons aged 18 years or over. By virtue of subsections (4F) and (4G), the Scottish Ministers may prescribe functions of Health Boards that must be delegated other than in prescribed circumstances or and prescribe functions of Health Boards and local authorities that may not be delegated in prescribed circumstances. By virtue of subsection (4H) the Scottish Ministers may remove enactments from the schedule.

11. Subsection (5A) applies where Health Board functions which are to be delegated are carried out in a hospital which serves two or more local authority areas. Subsection (7), read with section 48(1)(Interpretation) defines what is meant by “Health Board” for the purposes of the Bill. Its effect is that the provisions of the Bill do not apply to Special Health Boards.

Section 2 - Integration schemes: two or more local authorities in Health Board area

12. Section 2 sets out integration planning requirements where more than one local authority sits within the boundary of a single Health Board area (in contrast to the requirements in section 1(2) which apply where there is a single local authority in a Health Board area).

13. By virtue of subsection (2), each local authority and the Health Board are to agree which of the alternative duties in subsections (3) and (4) they will comply with in respect of the local authority area (compliance with one or the other is mandatory). The options are for a local authority to jointly prepare an integration scheme with that Health Board, for its own area only (subsection (3)), or for the local authority to join together with one or more other local authorities to, with the Health Board, jointly prepare an integration scheme for the areas of those local authorities (subsection (4)). The result is that within a single Health Board area, which houses more than one local authority, there may be any number of single local authority plans and/or multiple local authority plans. For example, in an area with 3 local authorities there may be a plan for a single area plus a plan covering the other two areas; or in an area with 6 local authorities there could be a plan covering three areas, plus a plan covering two areas, plus a plan for a single area. The effect is to provide flexibility so that planning decisions can be taken on the basis of what is appropriate for the areas in question i.e. multiple local authorities, within the area of the same Health Board, can plan together where appropriate, or they may choose to plan separately.

14. Subsection (4A) sets out that where the two or more local authorities and a Health Board decide that the integration model mentioned in section 1(4)(c) or (d) is to apply, (a) functions can be delegated to only one of the local authorities, (b) the integration scheme must set out which local authority the functions are to be delegated to, known as the “lead authority”, (c) functions may also be delegated by the Health Board to the lead authority and (d) functions may be delegated by local authorities to the Health Board and by the Health Board and other local authorities to the lead authority.

15. Subsection (5) sets out that when preparing an integration scheme, whether between an individual local authority and Health Board, or multiple local authorities and a Health Board, a local authority must (a) take into account any other integration scheme that is currently or has been prepared for the same Health Board area, and (b) the potential impact on the Health Board of any plans prepared in relation to that Health Board. This provision establishes the importance of different integration schemes within a single Health Board area having regard to their combined effect, and inter-operability, in relation, in particular, to the effective running of the Health Board.
Section 3 – Considerations in preparing integration scheme

16. Section 3 requires the local authority and Health Board to consider the integration principles and the national health and wellbeing outcomes when preparing their integration scheme. This provides the link with the national outcomes for health and wellbeing from the outset and underpins the purpose of integrating services, to ensure integration arrangements which embed a preventative, anticipatory and person-centred approach to the planning and delivery of services. Section 4 provides further information on integration principles and section 5 provides further information on national health and wellbeing outcomes.

Section 4 – Integration planning principles

17. Section 4 establishes the integration planning principles that must be taken into account when preparing an integration scheme.

18. The effect of subsection (1)(a) is to ensure that decisions about integration of functions take account of the principle that services, for the purposes of carrying out functions that must or may be delegated, are to improve the wellbeing of users of that service.

19. Subsection (1)(b) supplements this by setting out principles for delivery which must also be taken into account in taking decisions about how functions will be integrated. The effect is to ensure a focus on integrated delivery including consideration of the needs of different service users and different areas, the dignity of service users, the participation by service users in the community in which they live, protecting and improving the safety of service users, improving the quality of services, local planning and leadership, the anticipation of needs and prevention of needs arising, and the effective use of resources.

Section 5 – Power to prescribe national outcomes

20. This section provides for the Scottish Ministers to set out in regulations, national outcomes that relate to health and wellbeing. The national outcomes will provide for improved experience of services and outcomes that services achieve. The intention is for the national outcomes on health and wellbeing to be reflected in the Single Outcome Agreements, which the national outcomes expressed within the National Performance Framework.

21. Before doing so, the Scottish Ministers are required to consult persons set out in subsections (3) and (4). The effect of the provision is to involve the groups identified in the development of the national outcomes on health and wellbeing.

Section 6 – Consultation

22. Section 6 sets out consultation requirements in relation to the preparation of integration schemes.

23. The local authority and Health Board, before submitting the integration scheme for approval, are required to consult (a) those persons or groups of person, set out by the Scottish Ministers, by regulations, and (b) any other persons as the local authority and Health Board think fit. The consultation must be carried out jointly by the local authority and the Health Board. The
local authority and Health Board are required to take account of views expressed as part of the consultation, when finalising the integration scheme.

Section 7 - Approval of integration scheme

24. This section requires a local authority and Health Board to jointly submit the integration scheme to the Scottish Ministers for approval, before a date that will be set by the Scottish Ministers by regulations.

25. Subsection (4) requires the Scottish Ministers to, (a) provide the Health Board and the local authority with the reasons for refusing to approve an integration scheme, (b) explain how the scheme should be modified and (c) set a date by which the modified scheme must be submitted for approval.

26. Following submission of a modified integration scheme under subsection (4), the Scottish Ministers can, (a) approve the modified integration scheme or (b) refuse to approve the modified scheme. Where the Scottish Ministers refuse to approve a modified scheme, the local authority and the Health Board will be treated as if they have failed to submit an integration scheme and the default powers of the Scottish Ministers in section 39 will then apply.

27. Subsection (5) gives Ministers a discretionary power to grant an extension for submission of a plan for approval. The Scottish Ministers may grant an extension on their own initiative or on the request of the local authority and the Health Board. Where the request comes from the local authority and the Health Board it must be made jointly and reasons must be given. The effect is to enable a plan to be accepted after the statutory deadline for submission, where there is good reason.

28. The Scottish Ministers may decide either to approve an integration scheme submitted to them, or to refuse to approve it. Although any information that may be included by virtue of section 1(3)(e) does not form part of the information to be approved, it may be taken into account by Ministers in coming to their decision.

Section 8 – Publication of integration scheme

29. Section 8 requires the local authority and Health Board to publish the approved integration scheme, as soon as practicable after it has been approved.

Implementation of integration scheme

Section 9 – Functions delegated to integration joint board

30. This section provides that, where the Scottish Ministers approve an integration scheme which sets out that functions will be delegated to an integration joint board under section 1(4)(a), Ministers may by order establish the integration joint boards, which will have the functions specified in the integration scheme delegated to it.

31. Subsection (3) provides for the functions in the integration scheme to be delegated on a day set by the Scottish Ministers, unless the functions have been delegated on an earlier date under section 23(3A).
Section 10 – Chief officer of integration joint board

32. Section 10 requires the integration joint board to appoint a member of staff to be its chief officer. The integration joint board will not necessarily be given powers to employ its own staff. Subsections (2), (3) and (4) provide that the chief officer is to be seconded to it from one of its constituent local authorities or Health Board. In the event that there is a wish in future for the chief officer to be employed directly by the joint integration board, the Scottish Ministers have powers to make an order under subsection (5) to enable this.

33. Subsection (4) provides that where the person to be appointed is not an existing member of staff of a local authority or Health Board by which the integration joint board was established, the person is first to be appointed to the local authority or the Health Board and then seconded to the integration joint board.

34. Subsection (6) requires the integration joint board to consult the Health Board and each local authority, before appointing the chief officer of the integration joint board.

35. Subsection (7) provides for the Scottish Ministers to approve the responsibilities of the chief officer.

Section 11 – Other staff of integration joint board

36. This section provides for the Scottish Ministers, by order, to give integration joint boards the ability to appoint staff other than a chief officer and to make further provision in relation to the staffing of integration joint boards (generally or making different provision in relation to different joint boards) as the Scottish Ministers think fit, including: (a) the appointment of staff; (b) the numbers of staff; and (c) the terms and conditions of staff. The Scottish Ministers may make provision for these matters to be subject to the determination, direction or agreement of any person. This allows the Scottish Ministers to permit other persons, such as integration joint boards, to decide these matters.

37. Subsection (4)(a) provides for flexibility in the use of the power in subsection (1), so an order made under section 11 can be made which can apply only to a single, or some, integration joint boards as well as to all integration joint boards. Subsection (4)(b) provides for further flexibility for the Scottish Ministers to make different provision in relation to different integration joint boards.

38. Subsection (5) places a requirement on the Scottish Ministers to consult with Health Boards, local authorities and integration joint boards before exercising the power to make an order under subsection (1).

Section 12 – Integration joint boards: further provision

39. This section enables the Scottish Ministers to make further provision about integration joint boards.

40. Subsection (1) gives the Scottish Ministers powers to make provision by order (either generally or making different provision about different joint boards) about the membership,
proceedings and general powers of integration joint boards; the supply of services or facilities to integration joint boards by a local authority or Health Board; the establishment of committees by integration joint boards; the operation of committees of integration joint boards, the delegation of functions conferred upon integration joint boards by an integration scheme to the chief officer, any member of its staff or any committee member; and any other matter as the Scottish Ministers think fit in relation to the establishment or operation of integration joint boards.

41. Subsection (2) provides for flexibility in the use of the power in subsection (1). By virtue of subsection (2)(a) an order may be made under section 12 which applies only to a single, or some, integration joint boards as well as to all integration joint boards. By virtue of (2)(b) an order made under section 12 may make different provision in relation to different integration joint boards.

42. Subsection (2A) requires the Scottish Ministers to consult with the Health Board, local authority and integration joint board, before making an order under subsection (1).

43. Subsection (3) provides for the Scottish Ministers to make schemes for the transfer to an integration joint board of staff, property, rights, liabilities, or obligations of their constituent authorities. This power may be exercised to support the delivery of delegated functions by the integration joint board, where that is considered appropriate. Subsection (3A) requires the Scottish Ministers to consult with the relevant integration joint board, relevant Health Board and local authority before making a scheme under subsection (3).

44. Subsections (4) and (5) require the Scottish Ministers, before making such a scheme under subsection (3), to consult with health professionals, social care professionals and other groups of persons prescribed by regulations whom the Scottish Ministers consider to have an interest.

Section 12A – Integration joint boards: finance and audit

45. Section 12A(1) provides that the chief officer of an integration joint board is responsible for the financial affairs of the integration joint board.

46. Subsection (2)(a) amends section 106 of the Local Government (Scotland) Act 1973 so that the provisions of Part 7 of that Act will apply to integration joint boards, requiring them to appoint a proper officer for the financial administration of the financial affairs of the integration joint board, keep accounts and have these accounts audited by the Accounts Commission for Scotland. The proper officer may be the Chief Officer if the integration joint board deems that to be appropriate. The Chief Officer is the accountable officer for all matters, but the integration joint board is able to appoint another officer to be the proper officer for matters of financial administration. Such an arrangement is not obligatory, but will allow for the integration joint board to place financial accountability in the hands of a finance professional, if it is agreed locally that that is appropriate.

47. Subsection (2)(b) provides that certain sections of the Local Government (Scotland) Act 1973, in respect of social security and benefit administration, will not apply to integration joint boards as they are outside of the scope of their functions.
Section 13 - Payments to integration joint boards in respect of delegated functions

48. Section 13 provides for the allocation of resources by the local authority and Health Board in relation to functions delegated by them to an integration joint board, to support the effective carrying out of the functions.

49. Subsection (2) requires payments to be made by the local authority, in respect of such of their functions as are delegated under the integration scheme, of the amount determined in accordance with the method set out in the integration scheme.

50. Subsection (2A) places a requirement on Health Boards to set aside an amount, to be determined in accordance with the method set out in the integration scheme, for functions which are delegated that relate to services provided in large hospitals, namely a hospital that carries out functions in relation to two or more local authority areas. Subsection (3) places a requirement on Health Boards to make payments, either to an integration joint board or a local authority acting as the integration authority, for delegated functions where no “large hospital” functions are delegated (or where they are and the Health Board has deemed them not to apply). It has the effect that the amount to be paid by a Health Board will not include an amount set aside under subsection (2A).

Section 14 – Functions delegated to local authority or Health Board

51. Section 14 applies where the Scottish Ministers approve an integration scheme under section 7 and that plan contains provision about the delegation of functions by a local authority to a Health Board or functions delegated by a Health Board to a local authority, or both, as the case may be, under section 1(4)(b), (c) or (d).

52. Subsection (1A) enables the Scottish Ministers to prescribe a day by which functions must be delegated, if they are not delegated on an earlier date specified under section 23(3A).

53. Subsection (2) requires, before the functions are delegated, that the local authority and Health Board set up an integration joint monitoring committee to monitor the operational delivery of the functions set out in the integration scheme.

Section 15 – Transfer of staff where functions delegated to a local authority or Health Board

54. Section 15 provides that the Scottish Ministers may make provision by scheme about the transfer or secondment of staff from the body responsible for delegating the functions in the integration scheme as set out in section 1(4)(b), (c) or (d), to the body the functions are delegated to. This provision therefore relates to transfers to local authorities or Health Boards, as opposed to transfers to integration joint boards, which are dealt with by section 12(3).

55. Before making such a scheme under section 15, subsections (1A) and (1B) require the Scottish Ministers to consult with health professionals, social care professionals and other groups of persons who are prescribed in regulations whom the Scottish Ministers consider to have an interest, and subsection (3) requires the Scottish Ministers to consult the Health Board and local authority.
Section 16 – Integration joint monitoring committees: further provision

56. Section 16 confers a power on the Scottish Ministers to make provision by order about the establishment, membership and proceedings of integration joint monitoring committees (either generally or making different provision about different committees), as well as any other matter relating to their operation as the Scottish Ministers think fit.

Section 17 – Payments to Health Boards in respect of delegated functions

57. Section 17 requires that where a local authority delegates a function to the Health Board, in accordance with an approved integration scheme, the local authority must make payment to the Health Board of an amount determined in accordance with the method set out in the integration scheme.

Section 18 – Payments to local authorities in respect of delegated functions

58. Subsection (1A) requires that, where a Health Board delegates a function to a local authority, the Health Board is under a duty in subsection (1) to set aside an amount for use by the local authority which has been determined according to the method set out in the integration scheme in respect of services provided in large hospitals. Subsection (2) provides that where no delegated functions relate to services delivered in large hospitals, or where the Health Board chooses to make payments to the local authority in respect of those functions, the Health Board must make payments of amounts to the local authority for all of the delegated functions including those which relate to services delivered in large hospitals in accordance with the method set out in the integration scheme.

59. Subsection (3) requires that, in arrangements in which a local authority is the integration authority and where more than one local authority is covered by the same integration scheme, each delegating local authority is under a duty to make a payment to the local authority which is the lead authority for each delegated function.

Section 18A – Health funding: further provision

60. Section 18A deals with how budgets for services provided in large hospitals are to be used in planning for the delivery of services using the totality of health and social care resources to best meet the needs of the population. Health Boards are required to identify and make available to the integration authority an amount which relates to services provided in large hospitals which are included in the delegated functions, where such amounts are not included in the payments to the integration authority. Subsection (2) gives the integration authority the power to direct the use of this amount by the Health Board in line with the strategic plan.

61. Subsections (3) and (4) deal with situations where there is a variance between actual costs and those set out in the strategic plan.

62. Where the amount spent in relation to services delivered in a large hospital is less than the amount set out in the strategic plan, subsection (3) allows the integration authority to require that the Health Board make payment to it for the difference.
63. Where the amount spent in relation to services delivered in a large hospital is greater than had been determined in the strategic plan, subsection (4) allows the Health Board to require that the integration authority make payment to it for the difference.

64. Subsections (5) and (6) require that the Health Board provides the integration authority with information relating to the amounts set aside.

Section 19 – Transfer of staff: effect on contract of employment

65. Section 19 makes provision about the effect on an individual’s contract of employment on the transfer (or proposed transfer in the case of subsection (2)) of that individual’s employment by scheme under section 12 or 15.

66. Subsection (2) provides that where, before the day of transfer, a person who is to be transferred informs their original employer that they do not wish to transfer employment, the person’s contract of employment is terminated on the day before the day of transfer. The effect of this is that a person who does not wish to transfer does not have to do so but instead his or her contract will end immediately before the transfer would have taken place.

67. Subsection (3) sets out the effects of a transfer on an employee’s contract. In effect, the contract continues as it was before the transfer, except that the new employer takes the place of the previous employer. This means that the rights, powers, duties and liabilities of the original employer under or in connection with the contract of employment are transferred to the new employer and anything done by or in relation to the original employer in respect of the contract of employment is treated as having been done by or in relation to the new employer.

68. Subsection (3A) clarifies that, in relation to pension obligations, in circumstances where staff transfer between employer, whether between a local authority and Health Board or to an integration joint board, there will be no transfer of any liability for any deficit, or right to a share in any surplus, in respect of the transferred employee’s membership of a pension scheme relating to their employment prior to the transfer.

69. Subsection (4) makes provision to put beyond doubt that a person is not to be treated as being dismissed as a result of any provision of this section.

70. Subsection (5) protects any right that a person may have under general employment law to terminate their contract where there is a substantial detrimental change to his or her working conditions.

71. Subsection (6) makes clear that the change in employer as a result of the transfer of a person under this section does not constitute a substantial detrimental change to a person’s working conditions. This has the effect that the transfer of a person by scheme under section 12 or 15 cannot be considered a substantial detrimental change such as to give rise to any right protected by subsection (5).
Section 20 - Co-operation

72. Section 20 operates where two or more local authorities have joined together to prepare an integration scheme under section 2(4), or there is otherwise more than one integration scheme in relation to the same Health Board area. It puts a duty on the local authorities involved and the Health Board to cooperate with each other in relation to the efficient and effective use of their resources (including in particular buildings, staff and equipment) relevant to the scheme or schemes.

Section 20A - Carrying out of functions conferred on officers of local authorities

73. Section 20A provides that functions that are conferred by enactment on an officer of a local authority, which relate to a function delegated as part of the integration scheme, are deemed to be conferred on officers of the other bodies (a Health Board and any other local authorities) which prepared the same integration scheme.

Section 20B - Carrying out of functions conferred on officers of Health Boards

74. Section 20B provides that functions that are conferred by enactment on an officer of a Health Board, which relate to a function delegated as part of the integration scheme, are deemed to be conferred on officers of the local authority or local authorities which prepared the same integration scheme.

Carrying out of delegated functions

Section 21 – Effect of delegation of functions

75. Section 21 sets out the effect of the delegation of functions in pursuance of an integration scheme.

76. Subsection (2) requires that the integration authority to which a function is delegated is to carry out that function. Subsection (3) provides that the integration authority has all of the powers and duties that apply in connection with carrying out the function. Subsection (4) provides that the delegation of the function does not prevent the function being carried out by the person who delegated it. Subsection (5) confers a power on the Scottish Ministers, by order, to require that an integration authority which is an integration joint board must or must not exercise a power which otherwise applies in connection with the carrying out of the function specified in the order.

Section 22 – Directions by integration authority

77. Subsection (1) provides that, where the integration authority is an integration joint board, it must provide directions to the Health Board and local authority for the carrying out of the delegated functions.

78. Subsection (2) applies where the integration authority is not an integration joint board, i.e. it is a local authority or a Health Board. This enables the integration authority to give directions to the other bodies who prepared the integration scheme for the carrying out of any delegated functions. The giving of directions is not mandatory under this subsection. This enables an integration authority to choose to carry out functions itself, or to issue a direction in respect of the carrying out
of the function. Where an integration plan was prepared by more than one local authority, this subsection allows the integration authority to direct one of the local authorities to carry out a function for the entire area covered by the integration scheme.

79. Subsection (3) provides that the person to whom a direction may be given under subsection (1) or (2) must provide such information to the integration authority as is necessary to enable the integration authority to decide whether or not to give a direction and the content of any direction. This seeks to ensure that such information as is necessary for effective strategic planning is shared between the integration authority, the Health Board and the local authority.

80. Subsections (4) and (5) provide that a direction can be given to more than one person, i.e. an integration joint board can give a direction to both the Health Board and the local authority, and that such a direction can require each party to carry out the functions jointly or in part or in relation to a specified area or to do particular things in relation to the function.

Section 22A - Section 22: supplementary

81. This section makes supplementary provision in relation to the issuing of directions under section 22.

82. Subsection (1) provides that directions issued under section 22 must set out payments (or the method of determining payments) to be made by the integration authority to the person to whom the function is delegated. Directions may regulate the way in which the function is to be carried out and may make ancillary provision.

83. Subsection (2) sets out particular matters which may be provided for in directions issued under section 22. This provides that integration authorities may use directions to require the provision of information to the integration authority, to take action to enable the integration authority to comply with any court order made against it in connection with a delegated function or reimburse the integration authority in relation to any liabilities incurred in connection with a delegated function.

84. Subsection (3) requires that the integration authority make such payments to the Health Board and local authority as are set out in directions given by it.

85. Subsection (4) provides that a person to whom a direction under section 22 is given must comply with the direction.

86. Subsection (5) clarifies that a direction may vary or revoke an earlier direction and that the direction must be given in writing.

87. Subsections (6), (7) and (8) provide for the situation in which a Health Board and local authority agree that an integration joint board should be enabled to deliver functions directly by itself. Subsection (6) provides that the Scottish Ministers may make an order to allow an integration joint board to decide not to give directions in respect of a specified delegated function. Subsection (7) sets out the conditions that apply to the exercise of this power. An order under (6) may be made only if an application is received from the Health Board and local authority, and if the Scottish
Ministers consider that the order should be made to improve compliance with the national health and wellbeing outcomes. Subsection (8) allows the Scottish Ministers to exclude a particular function (or functions) from an order made under subsection (6) if they do not consider that the making of an order in respect of that function would improve compliance with the national health and wellbeing outcomes.

**Strategic planning etc.**

**Section 23 – Requirement to prepare strategic plans**

88. Section 23 requires the integration authority for the area of each local authority to prepare a strategic plan. This section sets out what a strategic plan is and the period the plan relates to. Section 39 sets out who is the integration authority for a local authority area, depending on the integration model adopted in the integration scheme.

89. The integration authority can include such material as it thinks fit in the strategic plan, however there are two mandatory elements:

- A strategic plan must set out the arrangements for carrying out the integration functions (defined in section 40) in the local authority area over the period of the plan (subsection (2)(a)). The area must be divided into localities for this purpose, and the arrangements for each locality must be set out separately (subsection (3)).

- A strategic plan must also set out the way in which the arrangements for carrying out the functions are intended to achieve or contribute towards achieving the national health and wellbeing outcomes.

90. Subsection (3A) provides that the Health Board and local authority may choose to delegate the functions on a day that is earlier than the day prescribed by the Scottish Ministers under sections 9(3) or 14(1A). Where this occurs, the integration authority must make clear in its first strategic plan the date when functions are to be delegated.

91. The first strategic plan of an integration authority must be prepared before the integration start date (subsection (4)), which is defined in subsection (6) as meaning either the date of delegation of functions set out in the strategic plan or the day prescribed by the Scottish Ministers under section 9(3) or 14(2).

**Section 24 – Considerations in preparing strategic plan**

92. Section 24(2) requires the integration authority to take into account the integration delivery principles (set out in section 25) and the national health and wellbeing outcomes (prescribed under section 5) in preparing a strategic plan. Section 24(2) seeks to ensure the principles and national outcomes are at the heart of planning for the population and embeds a person centred approach, alongside anticipatory and preventative care planning.

93. Subsections (3) and (4) provide that each integration authority, when preparing a strategic plan, must take account of any other strategic plan that has been, or is being, prepared where that plan sets out, or proposes to set out, arrangements for the use of services, facilities or resources used by another integration authority.
Section 25 – Integration delivery principles

94. Section 25 sets out the integration delivery principles that must be taken into account in preparation of the strategic plan and in the actual carrying out of functions delegated under an integration scheme (as required by section 31).

95. The effect of subsection (1)(a) is to ensure that in making arrangements for the carrying out of integration functions, the integration authority takes account of the main purpose of the services provided in pursuance of those functions is to improve the wellbeing of users of the service.

96. Subsection (1)(b) supplements this by setting out principles for delivery which must also be taken into account in making arrangements for delivery of integration functions. The effect is to ensure a focus on integrated delivery - including consideration of the needs of different service users and different areas, the dignity of service users, the participation by service users in the community in which they live, protecting and improving the safety of service users, improving the quality of services, local planning and leadership, the anticipation and prevention of need, and the effective use of resources.

Section 26 – Establishment of strategic planning group

97. Section 26 puts an obligation on integration authorities to establish a strategic planning group for each local authority area, for the purposes of preparing the strategic plan for that area.

98. Depending on the model of integration chosen, the group must involve members nominated by the local authority or the Health Board, or both, as set out in subsection (1)(a), (b) and (c). In effect, this provides for the partners who prepared the integration scheme and are party to the integrated arrangements to be involved in the development of the strategic plan. In addition, the integration authority will be required by subsection (1)(d) and (e) to involve a range of relevant stakeholders.

99. The group must also include representatives of groups prescribed by the Scottish Ministers by regulations under subsection (2) as having an interest, and other persons as the integration authority considers appropriate.

100. Subsection (2A) provides for the integration authority to determine the number of members in its strategic planning group and the process for the appointment, replacement and removal of members. Subsection (2B) provides for the integration authority to appoint members of the strategic planning group from persons nominated under subsection (1), to remove persons from membership of the group and to appoint members in place of members who resign or are removed from membership of the group. Subsection (2C) provides for a constituent authority to remove from its strategic planning group a member appointed to represent it and to nominate (under subsection (1)) another person in place of a member of the group appointed to represent it. Subsection (2D) provides for a member of the strategic planning group to resign at any time. Subsections (2E) to (2G) provide for the views of localities to be taken into account by requiring the integration authority to identify the most appropriate person to represent each locality on the strategic planning group. This also provides for local flexibility, so that an individual can represent more than one locality. Subsection (2H) provides that the integration authority’s ability to make decisions is not undermined by any vacancy in its membership.
101. The integration authority is to determine the procedure of the group, and may pay members of the group expenses and allowances.

**Section 27 – Preparation of strategic plan**

102. Section 27 applies where an integration authority in relation to the area of a local authority is preparing a strategic plan. The section sets out the process for the involvement of the strategic planning group in the development of the strategic plan, ensuring the group’s engagement in the process from the start.

103. The integration authority is required to prepare proposals about matters the strategic plan should contain, and consult the strategic planning group on the proposals (subsection (1A)) and then to prepare a first draft of the strategic plan, taking into account the views of the group expressed during the consultation. The integration authority must then consult the group on the draft (subsection (2)).

104. Taking account of the views in response to the consultation on the first draft, the integration authority is required to prepare a second draft of the strategic plan and send a copy of it for comment to persons mentioned in subsection (4), and any other persons the integration authority considers appropriate (subsection (3)).

105. The persons mentioned in subsection (4) include the local authority and the Health Board or both (depending on the model of integration chosen) as well as representatives of any groups prescribed by the Scottish Ministers under subsection (5). The effect of this is to ensure that any others with an interest will have an opportunity to comment on the draft plan.

106. Subsection (6) requires the integration authority to take into account the views obtained through consultation on the second draft of the strategic plan when finalising the strategic plan.

**Section 27A – Provision of information for purpose of preparing strategic plan**

107. Section 27A places a duty on Health Boards and local authorities to share information for the purpose of preparing the strategic plan. Subsection (1) requires the provision of information by constituent authorities to an integration joint board. Subsections (2) and (3) apply to the provision of information to an integration authority which is a local authority or a Health Board. In both cases, information must be shared if it is information which may be reasonably required for the purpose of preparing a strategic plan.

**Section 29 – Publication of strategic plans**

108. Section 29 places a duty on integration authorities to publish strategic plans.

109. Subsection (1) requires integration authorities to publish their strategic plans as soon as practicable after the plan has been finalised under section 27.

110. Subsection (3) requires an integration authority to publish a statement at the same time it publishes its strategic plan, which describes the consultation it undertook under section 27.
Section 30 – Significant decisions outside strategic plan: public involvement

111. Section 30 makes provision for where an integration authority plans on making a decision that would have a significant effect on the arrangements for provision of a service in pursuance of integrated functions outwith the context of the strategic planning cycle.

112. The integration authority is required to take appropriate action in order to involve and consult its strategic planning group, along with users or potential users of the service which is being or may be provided in relation to the decision.

Section 30A – Review of strategic plan

113. Section 30A sets out the review process that applies to a strategic plan. Subsections (1) and (9) require that an integration authority review its strategic plan at least every three years, and may carry out additional reviews from time to time. Subsection (2) provides that in carrying out a review of the strategic plan, integration authorities must have regard to the national health and wellbeing outcomes, the integration delivery principles and the views of the strategic planning group. Subsection (3) provides that the carrying out of a review under subsection (1) may result in the integration authority making any necessary changes by replacing its strategic plan. Subsection (4) provides flexibility for integration authorities to determine the details of the review process they use, subject to subsection (2).

114. Under subsections (5) to (7), the Health Board and local authority are required to provide the integration authority with the information that is reasonably required to carry out the review of the strategic plan. Subsection (8) provides that a strategic plan which is prepared following a review must specify the date on which it takes effect.

Section 30B – Requirement to prepare replacement strategic plan

115. Section 30B applies only in relation to integration joint boards. It provides for the local authority and the Health Board, acting jointly, to direct the integration joint board to prepare a replacement strategic plan where they, jointly, feel the strategic plan prohibits them from carrying out any of their functions. Subsections (3) and (4) set out specific requirements for a direction to prepare a replacement strategic plan. Under subsection (6), a direction requiring the replacement of the strategic plan is binding on the integration authority.

Section 30C – Strategic plan: annual financial statement

116. Section 30C requires the integration authority to publish an annual financial statement upon publication of its first strategic plan, and every year after that (subsection (1)). The financial statement must set out the total resources that the integration authority intends to allocate under the provisions of the strategic plan (subsection (2)).

Carrying out of integration functions

Section 31 – Carrying out of integration functions: general

117. Section 31 obliges integration joint boards, local authorities and Health Boards to have regard to the national health and wellbeing outcomes and the integration delivery principles set out
in section 25, when carrying out an integration function. The effect is to embed the principles in delivery as well as in planning to ensure a shift towards preventative and anticipatory care and that the services delivered meet the different needs of different individuals and are ‘person centred’.

**Section 32 – Carrying out of integration functions: localities**

118. Section 32 requires person carrying out an integration function for the area of a local authority (which may be the local authority, the Health Board or the integration joint board depending on the integration model adopted and any directions made under section 22) to involve and consult interested persons prescribed by the Scottish Ministers by regulations where it proposes to take a decision that it considers might significantly affect the service provision in a locality of the area of the local authority.

119. Subsection (5) gives the integration authority the ability to pay the members of the groups consulted such expenses and allowances as the integration authority determines.

**Section 33 - Integration authority: performance report**

120. This section requires each integration authority to prepare a performance report for each reporting year.

121. The report must set out an assessment of performance in carrying out the integrated functions during the reporting year.

122. Subsection (3) enables the Scottish Ministers to make regulations that set out the form and content of performance reports. Subsections (3A) and (3B) require the integration authority to publish the performance report within four months of the end of the reporting year and to provide a copy to the Health Board, the local authority and/or the integration joint monitoring committee, as appropriate to the model of integration chosen.

123. Subsections (3C) and (3D) require that the Health Board and the local authority must provide such information as the integration authority might reasonably require for the purposes of preparing a performance report to the integration joint board or the authority (being a local authority or Health Board), as appropriate to the model of integration chosen.

124. Subsection (4) provides that the “reporting year” is a period of one year starting on the date that the integration functions were delegated or the prescribed date set by the Scottish Ministers that delegation of functions must occur, and each subsequent period of a year.

*Reports by integration joint monitoring committee*

**Section 33A - Reports**

125. Section 33A sets out that an integration joint monitoring committee may give reports to the integration authority on the carrying out of any aspect of the integration functions.

126. Under subsection (2), reports under this section may include recommendations as to how the integration functions should be carried out in future.
127. Subsection (3) obliges the integration authority to have regard to the report and any recommendations contained within it. It requires the integration authority to take such action as it considers necessary and, where a report contains recommendations, respond to the integration joint monitoring committee. Subsection (4) makes provision for the publication of reports under this section.

128. Subsection (5) obliges the local authority and the Health Board to provide the integration joint monitoring committee with such reports, information and other assistance that it may reasonably require for the purpose of preparing a report under (1).

Section 33B - Review of integration scheme

129. Section 33B obliges the local authority and the Health Board to carry out a review of their integration scheme at least every five years. Subsection (3) requires that the Health Board and the local authority have regard to the integration planning principles and the national health and wellbeing outcomes, as set out in section 3, and that they undertake the consultation process as set out in section 6.

130. Subsection (4) requires the local authority and the Health Board to take account of the persons consulted and to decide whether changes to the integration scheme are necessary or desirable.

Section 33C - Requirement to review integration scheme

131. Section 33C gives the Health Board or the local authority the power to require that a joint review of the integration scheme is undertaken to identify if any changes to the integration scheme are necessary or desirable. Subsection (3) gives the Scottish Ministers the ability to require that the local authority and the Health Board undertake a review of the integration scheme where matters are prescribed under section 1(3)(e).

132. Subsections (4) and (5) require that the Health Board and the local authority undertake this review having regard to the integration planning principles and the national health and wellbeing outcomes, as set out in section 3, and that they undertake the consultation process as set out in section 6. Subsection (5) requires the local authority and the Health Board to take account of those persons consulted and decide whether changes to the integration scheme are necessary or desirable.

Section 34 – Revised integration scheme

133. This section sets out the process for varying the integration scheme after the local authority and Health Board decide, following a review, that changes to the scheme are desirable.

134. Any variation must be made jointly by the local authority and the Health Board and is to be achieved by the preparation of a revised integration scheme.

135. Subsection (3) establishes the scope of variation that may apply to the integration scheme. A revised integration scheme may include further functions that are to be delegated, set out functions that are no longer to be delegated, amend the functions that are to be carried out in conjunction with the delegated functions when delegating to a Health Board only or a local authority only or to both,
make adjustments to the method of determining payments as mentioned in section 1(3)(ca) and/or 1(3)(d) and change or remove any information included within the integration scheme by virtue of section 1(3)(e).

136. Subsections (3A) and (3B) oblige the Health Board and the local authority to consult with persons or groups of persons the Scottish Ministers may prescribe and other persons as they think fit, and take account of their views.

137. If the revised integration scheme includes changes of the type mentioned in subsection (3)(a) to (e) then it must be submitted for approval by the Scottish Ministers.

138. If the revised integration scheme includes changes of the type mentioned in subsection (3)(f), the Scottish Ministers must be notified of the change.

139. Subsection (5) obliges the Scottish Ministers to set a date that a revised integration scheme takes effect. Subsection (6) requires the Health Board and the local authority to publish a revised scheme as soon as is practicable after the date on which it takes effect.

Section 35 – New integration scheme

140. Section 35 applies where a local authority and Health Board decide under section 33B or 33C that changes to an integration scheme are necessary or desirable. Section 35 sets out that a local authority and Health Board must prepare a new integration scheme under section 1 where they wish to change the local authorities that are party to the scheme or the integration model. The new scheme is subject to all the same requirements, including consultation and the requirement for Ministerial approval, as the original integration scheme. Subsection (4) clarifies that the Bill applies to a new integration scheme created under section 35 as it applies to a scheme prepared under section 1 or section 2(2).

Section 36 – Power to make provision in consequence of new integration scheme

141. This section confers powers on the Scottish Ministers to take steps in consequence of a new integration scheme approved under section 35. They are empowered to provide by order for the winding-up of any integration joint board that was established in pursuance of the original plan. They can also provide by scheme for the transfer of staff, property, rights, liabilities or obligations of an integration joint board, local authority or Health Board as may be necessary in light of the new scheme.

142. Subsection (4) requires the Scottish Ministers to consult the local authority and the Health Board before putting in place a scheme for the transfer of staff as a consequence of a new integration scheme.

Supplementary

Section 37 – Information-sharing

143. Section 37 allows for the disclosure of information between local authorities, Health Boards and integration joint boards for the purpose of preparing an integration scheme, carrying out the
functions that are delegated, the functions that are to be carried out in conjunction with delegated functions and the preparation of a strategic plan. The sharing of information for these purposes can take place without breaching any duty of confidentiality that may be owed by a Health Board or local authority to any person.

Section 38 – Grants to local authorities

144. Section 38 provides for the Scottish Ministers to make grant payments to local authorities in respect of costs incurred by virtue of Part 1 of the Bill, and to set conditions in relation to grants made.

Section 39 – Default power of Scottish Ministers

145. Section 39 provides for the Scottish Ministers to take action where a local authority and Health Board have failed to submit an integration scheme to them for approval by the deadline set under section 7, or the day specified under section 7(4)(c).

146. In such circumstances the Scottish Ministers may require the local authority and Health Board to adopt the integration joint board model of integration and may decide the functions to be delegated to it. They may also establish the integration joint board by order, set a deadline by which the local authority and Health Board must delegate the specified functions to the integration joint board, specify payments to be made by the local authority and Health Board to the integration joint board and impose other requirements in relation to the delegated functions.

Section 40 – Directions

147. Section 40 confers a power on the Scottish Ministers to give directions to integration joint boards, Health Boards and local authorities.

148. Directions given to a local authority or Health Board under this section may relate to the functions conferred on them by this Bill, the carrying out of functions delegated to them in pursuance of an integration scheme, and the functions to be carried out in conjunction with the delegated functions (subsections (1) and (2)).

149. Directions to an integration joint board may relate to the functions conferred on it by this Bill and the carrying out of functions delegated to it in pursuance of an integration scheme (subsection (3)).

150. Integration joint boards, Health Boards and local authorities are required to comply with a direction given to them by the Scottish Ministers under this section.

151. Subsection (5) provides that directions made under this section may vary or revoke earlier directions made under this section and are to be made in writing.

152. Subsection (6) places a limit on the use of the power in this section to prevent the Scottish Ministers from issuing a direction to require a local authority and Health Board to submit an application under section 22A(7). The Scottish Ministers cannot make an order under section
22A(6) without the prior written application of the Health Board and local authority. Section 40(6) ensures that the Scottish Ministers cannot direct the Health Board and local authority to make such a written application.

Section 41 – Guidance

153. Section 41 requires persons mentioned in subsection (2) to take account of any guidance issued by the Scottish Ministers about their functions, under or in relation to the Bill. The persons are a local authority, a Health Board, an integration joint board and an integration joint monitoring committee.

Section 41A – Social Care and Social Work Improvement Scotland

154. Section 41A makes amendments to the Public Services Reform (Scotland) Act 2010 to provide for Social Care and Social Work Improvement Scotland (SCSWIS) to inspect services which are delivered under integration functions in pursuance of an integration scheme, regardless of the person carrying out the function.

Section 41B – Healthcare Improvement Scotland

155. Section 41B makes amendments to the National Health Service (Scotland) Act 1978 to provide for Healthcare Improvement Scotland (HIS) to inspect services which are delivered under integration functions in pursuance of an integration scheme, regardless of the person carrying out the function.

Section 41C – Joint inspections of health and social services

156. Section 41C makes amendments to the Public Services Reform (Scotland) Act 2010 to provide for SCSWIS and HIS to jointly inspect health and social care services provided under integration functions in pursuance of an integration scheme.

157. In carrying out joint inspections, SCSWIS and HIS are to adhere to current codes of practice issued by the Scottish Ministers and may carry out joint inspections for any of the purposes provided for by section 10I(1) or (1B) or 10J(2) of the National Health Service (Scotland) Act 1978, or section 53(2) of the Public Services Reform (Scotland) Act 2010.

Section 41D – Amendments of section 56 of Local Government (Scotland) Act 1973

158. Section 41D amends the Local Government (Scotland) Act 1973 to ensure that the functions which are conferred on local authorities by the Bill must be carried out by that local authority, and may not be delegated to another local authority. For example, a local authority could not delegate the function of preparing a strategic plan under section 1 or 2 to another local authority.

Section 42 –Meaning of “integration authority”

159. Section 42 sets out who is the integration authority for a local authority area for the purposes of Part 1 of the Bill. This depends on the model of integration adopted, so that the integration authority is: the integration joint board, where the integration scheme provides for functions to be
delegated to an integration joint board; the Health Board, where in accordance with the integration scheme functions are delegated to the Health Board only; the local authority where, in accordance with the integration scheme, functions are delegated to the local authority only; or both the local authority and the Health Board acting jointly where, in accordance with the integration scheme, functions are delegated to both the local authority and the Health Board.

Section 43 – Meaning of “integration functions”

160. Section 43 sets out what the integration functions for the area of a local authority are for the purposes of Part 1 of the Bill. Where the integration scheme provides for functions to be delegated to an integration joint board, the integration functions are those delegated to the board in pursuance of the scheme. Where the integration scheme provides for functions to be delegated to either a local authority or to a Health Board or to both a local authority and a Health Board, the integration functions are those delegated in pursuance of the scheme, as well as the functions specified in the scheme as ones which are to be exercised in conjunction with the delegated functions.

Section 43A – Meaning of “constituent authority”

161. Section 43A provides a definition of the term “constituent authority” for the purposes of Part 1 of the Bill. This term refers to the local authority, or local authorities, and the Health Board which prepared an integration scheme in pursuance of which an integration joint board has been established.

PART 2

SHARED SERVICES

Section 44 - Shared services

162. Section 44(1) provides for the Common Services Agency for the Scottish Health Service to provide, or arrange the provision of, goods and services to the bodies listed in subsection (2). The Common Services Agency may only provide, or arrange the provision of, goods and services to those bodies with the consent of the Scottish Ministers.

163. Subsection (3) provides an illustrative list of the services which may be provided. The list comprises administrative, technical, legal, other professional and accommodation services.

164. The Common Services Agency also has powers under the National Health Service (Scotland) Act 1978 (“the 1978 Act”) to provide goods and services to certain persons. For example, under section 15 of the 1978 Act, the Common Services Agency may provide goods to doctors, dentists and ophthalmologists who are providing primary medical services under a contract with a Health Board. Subsection (4) sets out that the power of the Common Services Agency to provide goods and services under subsection (1) of this section sits alongside and does not prejudice any other power of the Common Services Agency to provide goods or services to other persons.

165. Subsection (4A) provides for the Scottish Ministers by order to amend the list of persons, or description of person, to whom the Common Services Agency may provide goods or services.
Section 44A – Section 44: consequential provision

166. Section 44A amends sections 10 and 15 of the 1978 Act and section 17(2) of the Patient Rights (Scotland) Act 2011 to make changes which are necessary in consequence of section 44 and 51. Subsection (2) adjusts section 10 of the 1978 Act to reflect that the functions of the Common Services Agency are conferred on it by Section 44 of the Bill as well as by the 1978 Act. Subsection (3)(a) removes references to the Common Services Agency from section 15 of the 1978 Act. The functions formerly conferred on the Agency by that section are replaced by functions conferred on the Agency by section 44 of the Bill. Subsection (3)(b) and (c) have the effect that section 15(1)(a) of the 1978 Act continues to apply to the Common Services Agency despite the change made by subsection (2). Subsection (3)(d) repeals sections 15(2A)-(2D) of the 1978 Act. Subsection (4) makes a change to section 17(2) of the Patient Rights (Scotland) Act 2011 to insert a reference to “the 1978 Act”. Section 17(1) of the 2011 Act, which includes a similar reference to the 1978 Act, is repealed by 51(3A) of the Bill.

Section 44B – Common Services Agency for the Scottish Health Service: residual liabilities

167. Section 44B amends section 2(1) of the National Health Service (Residual Liabilities) Act 1996 to ensure that those bodies entering into contracts with the Common Services Agency are offered the same protection which is provided when contracting with other NHS bodies. This change is made to take account of the fact that the Common Services Agency may, since the enactment of section 14 of the Public Services Reform (Scotland) Act 2010, be dissolved by order under that Act. In the event that such an order is made, any residual liabilities of the Common Services Agency will transfer to the Scottish Ministers or another health body.

Section 45 – Extension of schemes for meeting losses and liabilities of health service bodies

168. Section 45 amends section 85B of the National Health Service (Scotland) Act 1978 (the “1978 Act”) to permit local authorities and integration joint boards to participate in the scheme established under that section for the purposes of meeting losses and liabilities incurred in the exercise of relevant functions.

169. Subsection (3) inserts references into the 1978 Act, which have the effect of restricting the functions of local authorities that can be covered by a scheme made under section 85B of the 1978 Act. It restricts the functions to integration functions and to functions that a local authority carries out in accordance with a direction from a integration joint board. The Scottish Ministers are given the power to specify by order other functions of local authorities that can be covered by a scheme under section 85B of the 1978 Act. “Integration functions” are defined for the purposes of this section in relation to local authorities as functions which are: delegated to the authority under an integration scheme; to be carried out in conjunction with delegated functions; or to be carried out by the local authority in pursuance of a direction by a Health Board or integration joint board under section 22.

170. Subsection (4) amends the existing power in the 1978 Act so that the Scottish Ministers are not able to direct local authorities to participate in a scheme made under section 85B of the 1978 Act.
PART 3

HEALTH SERVICE: FUNCTIONS

Section 46 – Scottish Ministers: power to form companies etc.

171. Section 46 provides for amendments to section 84B (Joint ventures) of the 1978 Act. Currently, the Scottish Ministers may only form or participate in companies as defined by section 1(1) of the Companies Act 2006. The amendment permits the Scottish Ministers to form and participate in any type of body corporate. This includes limited liability partnerships and Scottish Charitable Incorporated Organisations.

Section 47 – Health Boards: carrying out of functions

172. Section 47 amends the 1978 Act to permit Health Boards to exercise any function of another Health Board where the other Health Board and the Scottish Ministers give their consent.

PART 4

GENERAL

Section 48 – Interpretation

173. Section 48 provides various definitions that apply to this Act.

Section 49 - Subordinate legislation

174. The Bill contains various powers for the Scottish Ministers to make regulations and orders. This section makes further provision about regulations and orders under the Bill in particular enabling them to make different provision for different purposes, make different provisions for different classes of cases, and to include supplementary, incidental, consequential, transitional or transitory provision. It also provides that regulations under sections 1(4H) and 5(1) and any order under section 44(4A), along with any order under section 50 which amends the text of another Act, is subject to the affirmative procedure. Other regulations and orders under the Bill are subject to the negative procedure.

Section 50 - Ancillary provision

175. This section provides powers for the Scottish Ministers to make supplementary, incidental or consequential provision by order, as they consider appropriate for the purposes of, or in connection with, or for the purposes of giving full effect to, any provision made by, or by virtue of, this Act. Such an order may also make such transitional, transitory or savings provision as the Scottish Ministers consider appropriate for the purposes of, or in connection with, the coming into force of any provision.

Section 51 – Repeals and revocation

176. Subsection (A1) repeals section 5A of the Social Work (Scotland) Act 1968, which makes provisions about local authority plans for community care services.
177. Subsection (1) and (3) repeal sections 4A and 4B of the National Health Service (Scotland) Act 1978 and section 2 of the National Health Service Reform (Scotland) Act 2004, thereby removing Community Health Partnerships from statute.

178. Subsection (2) repeals sections 15 to 17 of the Community Care and Health (Scotland) Act 2002 which provide the current mechanism for Health Boards and local authorities to delegate functions and make payments in relation to those functions, and for the transfer of staff in relation to the delegated functions.

179. Subsection (3A) repeals section 17(1) of the Patient Rights (Scotland) Act 2011 which makes an amendment to the National Health Service (Scotland) Act 1978 which is superseded by section 44(1) of the Bill.

180. Subsection (4) repeals section 20 of the Social Care (Self-directed Support) (Scotland) Act 2013 which amends section 15 of the Community Care and Health (Scotland) Act 2002 (which is itself repealed by subsection (2)).

181. Subsection (5) revokes the Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013. The provisions of that Order are substantially replicated in sections 44 and 44A of the Bill.

Section 52 – Commencement

182. Section 52 establishes that sections 1(3) to (7), 5, 37, 41 and Part 4 (other than section 51) of the Bill come into force on the day after Royal Assent. Powers are conferred on the Scottish Ministers to commence the other provisions of the Act on dates appointed by order and to make transitory, transitional or savings provisions in connection with commencement.

Section 53 – Short title

183. Section 53 states that the short title of this Act is the Public Bodies (Joint Working) (Scotland) Act 2014.

Schedule

184. The schedule to the Bill is introduced by section 1(4A). The schedule sets out a list of functions conferred on local authorities that, by virtue of section 1(4A), may be delegated under an integration scheme prepared under section 1 or 2 of the Bill. Broadly, the listed enactments confer functions on local authorities which relate to the provision of social care services.
SUPPLEMENTARY DELEGATED POWERS MEMORANDUM

Purpose

1. This Memorandum has been prepared by the Scottish Government to assist the Delegated Powers and Law Reform Committee in its consideration of the Public Bodies (Joint Working) (Scotland) Bill. This Memorandum describes the provisions in the Bill conferring power to make subordinate legislation which are either introduced or amended at Stage 2. This Memorandum supplements the Delegated Powers Memorandum on the Bill as introduced.

PROVISIONS CONFERRING POWER TO MAKE SUBORDINATE LEGISLATION INTRODUCED OR AMENDED AT STAGE 2

PART 1 – FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

Integration schemes

Section 1(4B)-(4D), (4F) and (4G) – Integration schemes: same local authority and Health Board area

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>the Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>regulations made by statutory instrument</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>negative</td>
</tr>
<tr>
<td>Amended or new power:</td>
<td>new powers and amended powers</td>
</tr>
</tbody>
</table>

Provision

2. Subsection (3) provides that an integration scheme is a scheme setting out certain matters including, in accordance with subsection (3)(b), the functions that are to be delegated in accordance with a model provided for in subsection (4).

3. Subsection (4B) provides for the Scottish Ministers to prescribe by regulations the functions that a Health Board may delegate by virtue of an integration scheme. Subsection (4C) provides for the Scottish Ministers to prescribe by regulations the functions conferred by enactments listed in the schedule to the Bill that local authorities must delegate but only in so far as they are exercised in relation to persons aged at least 18 years where the local authority (and Health Board) are delegating functions to an integration joint board or the local authority is delegating functions to a Health Board. Subsection (4D) provides for the Scottish Ministers to
prescribe the functions of a Health Board that must be delegated but only in so far as they are exercisable in relation to persons aged at least 18 years where the Health Board (and local authority) are delegating functions to an integration joint board or the Health Board is delegating functions to a local authority. Subsection (4F) provides for the Scottish Ministers to prescribe the functions of a Health Board that: (a) must be delegated other than in prescribed circumstances or (b) may not be delegated in certain prescribed circumstances. Subsection (4G) provides for the Scottish Ministers to prescribe the functions of a local authority, being functions conferred by an enactment listed in the schedule, which may not be delegated in certain prescribed circumstances.

4. By virtue of section 48(1), “prescribed” means prescribed by the Scottish Ministers by regulations.

Reason for taking the power

5. The powers provide appropriate flexibility for the Scottish Ministers in setting out the functions of a local authority and a Health Board that may, must and may not be delegated under an integration scheme. It also allows the Scottish Ministers to make provision as to the delegation of functions in certain circumstances.

Stage 2 amendment

6. The Bill as introduced contained no limits on the functions that were to be available for delegation, but permitted the Scottish Ministers to make regulations under section 1(6) setting out the functions of health boards or local authorities that must, may or may not be delegated.

7. It was noted in evidence to the Health and Sport Committee by Local Government stakeholders and the Convention of Scottish Local Authorities (COSLA) that the Bill provided for a broader range of local authority functions to be available for delegation than the policy intention set out in the Policy Memorandum.

8. The Bill has been amended at Stage 2 to restrict the range of functions available for delegation to meet the policy intention of integrating adult health and social care services. Section 1(6) as introduced has been replaced with new, more restricted powers. Under section 1(4B), the Scottish Ministers may, by regulations, prescribe functions of Health Boards which are to be delegated. No functions of Health Boards which are not so prescribed will be able to be delegated under an integration scheme. Under section 1(4C), regulations may be made to require the delegation of local authority functions only if the function is conferred by an enactment listed in the schedule to the Bill and only in so far as the function is exercisable in relation to persons at least 18 years of age. Under section 1(4D), regulations may be made to require the delegation of functions of Health Boards only in so far as the functions are exercisable in relation to persons at least 18 years of age.

9. These amendments, along with the schedule, therefore provide for the functions conferred on Health Boards and local authorities that may be delegated under integration schemes and provide appropriate Ministerial control on the delegation of functions. The powers allow the Scottish Ministers to set the framework within which Health Boards and local authorities will determine the functions to be delegated when implementing an integration scheme.
Choice of procedure

10. Regulations made under these provisions are subject to the negative procedure. This is considered appropriate given the restrictions on the exercise of these powers by the Scottish Ministers that are contained within the provisions themselves. Subsection (4B) and (4C) only allow functions to be prescribed in so far as they relate to adults. Subsection (4C) is further limited as it only permits functions to be prescribed which are included in the schedule to the Act. The effect of these restrictions is that these powers cannot be used to permit or require the delegation of functions other than those which relate to adult health and social care services.

Section 1(4H) – Integration schemes: same local authority and Health Board area

Power conferred on: the Scottish Ministers
Power exercisable by: regulations made by statutory instrument
Parliamentary procedure: affirmative
Amended or new power: new power

Provision

11. Section 1(4H) provides for the Scottish Ministers to, by regulations, remove an enactment from the schedule to the Bill. The Schedule provides the list of enactments that confer functions on a local authority that may be delegated. The schedule was added by amendment at stage 2 and sets out the enactments which confer functions which a local authority may delegate under an integration scheme.

Reason for taking the power

12. The power ensures that the Scottish Ministers are able to update the list of enactments in the schedule to remove any function which, in future, may become unsuitable for delegation without requiring primary legislation. Primary legislation would, however, be required to broaden the scope of local authority functions that may be delegated under an integration scheme by adding additional enactments to the list in the schedule. Where a new function is conferred on a local authority by primary legislation, it would be possible for the schedule to be amended by the enactment creating or conferring the new function, to enable the delegation of that function by the local authority.

Choice of procedure

13. Regulations made under this provision are subject to the affirmative procedure. Notwithstanding that the use of the power is limited to the removal of enactments from the schedule, given that this power enables the Scottish Ministers to amend primary legislation by way of regulations it is considered appropriate that the exercise of the power is subject to a higher degree of Parliamentary scrutiny.
Section 9(3) – Functions delegated to an integration joint board

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure
Amended or new power: new power

Provision

14. Subsection (3) provides that the Scottish Ministers may prescribe the day on which functions are to be delegated if they are not delegated by virtue of section 23(3A).

15. By virtue of section 48(1), “prescribe” means prescribed by the Scottish Ministers by regulations.

Reason for taking this power

16. This provision is required to provide for the Scottish Ministers to set an appropriate date by functions must be delegated. This is to ensure that the policy of integration of adult health and social care functions is achieved within a consistent and clear timescale across Scotland.

Stage 2 amendment

17. As introduced, section 9 provided that, where the integration model in 1(4)(a) was to apply, the Scottish Ministers were to prescribe a single day on which functions were to be delegated. An amendment has been made to section 23(3A) to allow integration authorities to choose to delegate functions on an earlier day, where that day is specified in their strategic plan. The amendment to section 9(3) ensures that where no such date is specified, functions will be delegated, at the latest, on the day prescribed by Ministers. This will provide for clarity as to the final date by which integration of adult health and social care functions must be implemented.

Choice of procedure

18. Regulations under section 9 remain subject to negative procedure for the reasons set out in paragraph 28 of the Delegated Powers Memorandum. The amendments make no change to the choice of procedure in relation to this power.

Section 11 – Other staff of integration joint board

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish Statutory Instrument
Parliamentary procedure: negative procedure
Amended or new power: amended power

Provision

19. Subsection (1) provides that the Scottish Ministers may by order make provision enabling integration joint boards to appoint staff other than a chief officer.
**Reason for taking this power**

20. The reasons for taking this power are set out in paragraph 33 of the Delegated Powers Memorandum.

**Stage 2 amendment**

21. The Bill was amended at Stage 2 to clarify that the power in 11(1) allows the Scottish Ministers to make provision in relation to only one integration joint board or some integration joint boards. Subsection (4)(a) now provides for flexibility so that an order under 11(1) will be able to take account of local circumstances.

22. Also, stakeholders raised concerns at Stage 1 that the power of the Scottish Ministers to enable, by order, integration joint boards to appoint staff other than a chief officer was broad and far reaching with the potential to significantly change the delivery of health and social functions. Section 11(5) was inserted at Stage 2 and requires that before making an order, the Scottish Ministers must consult with local authorities, Health Boards and integration joint boards where the order relates to integration joint boards generally, or relevant constituent authorities and the relevant integration joint board(s) where the order relates to one or some integration joint boards.

**Choice of procedure**

23. An order made under section 11 remains subject to negative procedure which is considered appropriate for the reasons set out in paragraph 34 of the Delegated Powers Memorandum. The amendments do not alter the choice of procedure.

**Section 12 – Integration joint boards: further provision**

<table>
<thead>
<tr>
<th>Power conferred on:</th>
<th>Scottish Ministers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power exercisable by:</td>
<td>order/regulations made by Scottish statutory instrument</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>negative procedure</td>
</tr>
<tr>
<td>Amended or new power:</td>
<td>new and amended power</td>
</tr>
</tbody>
</table>

**Provision**

24. On introduction, subsection (1) provided that the Scottish Ministers may by order make provision about: (a) the membership of integration joint boards; (b) their proceedings; (c) giving integration joint boards general powers (such as powers to contract, acquire or dispose of property or rights or borrow money or incur other liabilities) in connection with the carrying out of their functions; (d) the supply of services or facilities to integration joint boards by a local authority or Health Board; and (e) about any other matter relating to the establishment or operation of integration joint boards that the Scottish Ministers think fit.

**Reason for taking this power**

25. The reasons for taking this power are set out in paragraph 36 of the Delegated Powers Memorandum.
Stage 2 amendment

26. On reflection, the Scottish Ministers consider that integration joint boards should have the ability to establish committees should this be required to ensure the effective carrying out of its functions. In particular, integration joint boards may consider this appropriate where a greater number of functions were delegated that relate to different population groups. Given that this would be a significant change to the operation of integration joint boards and the carrying out of their functions, it is considered appropriate that integration joint boards should not be permitted to establish committees or delegate functions to those committees without the Scottish Ministers making an Order to permit this.

27. The Bill was amended at Stage 2 to provide a power for the Scottish Ministers to make an Order enabling an integration joint board to establish committees for any purpose and to permit an integration joint board to delegate any functions delegated to it in pursuance of an integration scheme to its chief officer, any other member of staff or to any such committee.

28. To ensure that there is appropriate flexibility available in the exercise of these powers, the Bill was amended at Stage 2 to insert section 12(2), which provides that the Scottish Ministers may make provision in an Order under 12(1) in relation to only one integration joint board, or some integration joint boards. This will allow the use of these powers to take into account different local circumstance.

29. COSLA raised concerns regarding the breadth of the power of the Scottish Ministers to make an order in relation to integration joint boards, in particular conferring powers to contract, borrow money and supply services. Given that the exercise of this power may result in significant change to the delivery of health and social care services the Scottish Ministers consider it appropriate to amend the Bill to provide for consultation before the exercise of the powers in section 12(1). By virtue of section 12(2A), before making such an Order the Scottish Ministers are required to consult integration joint boards, local authorities and Health Boards where the order relation integration joint boards generally or the relevant constituent authorities where the Order relates to one or some integration joint boards.

30. An amendment at stage 2 inserted a power at 12(5) to provide for the Scottish Ministers to prescribe other groups of persons, in addition to health and social care professionals, who must be consulted before making a scheme in relation to the transfer of staff under 12(4). This amendment was proposed by Rhoda Grant MSP and supported by the Royal College of Nursing. The Scottish Government considered it appropriate that before Ministers make any scheme under 12(4) relevant parties must be consulted. Where a new function is conferred on a local authority by primary legislation, it would be possible for the schedule to be amended by the enactment creating or conferring the new function, to enable the delegation of that function by the local authority.

Choice of procedure

31. An order under section 12(1) remains subject to negative procedure for the reasons set out in paragraph 37 of the Delegated Powers Memorandum. The amendments make no change to the choice of procedure in relation to these powers.
32. Regulations under section 12(5) are subject to negative procedure. This is considered appropriate given the regulations will deal with matters of detail in relation to the persons to be consulted before making any transfer scheme rather than any broad principle.

Section 14 – Functions delegated to local authority or Health Board

**Power conferred on:** Scottish Ministers  
**Power exercisable by:** regulations made by Scottish statutory instrument  
**Parliamentary procedure:** negative procedure  
**Amended or new power:** amended power

**Provision**

33. Subsection (1A) provides that the Scottish Ministers may prescribe the day on which functions are to be delegated if they are not delegated by virtue of section 23(3A).

By virtue of section 48(1), “prescribed” means prescribed by the Scottish Ministers by regulations.

**Reason for taking this power**

34. This provision is required to provide for the Scottish Ministers to set an appropriate date by which functions must be delegated. This is to ensure that the policy of integration of adult health and social care functions is achieved within a consistent and clear timescale across Scotland.

**Stage 2 amendment**

35. As introduced, section 14 provided that, where the integration model in 1(4)(b)-(d) was chosen, the Scottish Ministers were to prescribe a single day on which functions were to be delegated. An amendment has been made to section 23(3A) to allow integration authorities to choose to delegate functions on an earlier day, where that day is specified in their strategic plan. The amendment inserting section 14(1A) ensures that where no such date is specified, functions will be delegated, at the latest, on the day prescribed by Ministers. This will provide for clarity as to the final date by which integration of adult health and social care functions must be implemented.

**Choice of procedure**

36. Regulations under section 14 remain subject to negative procedure for the reasons set out in paragraph 40 of the Delegated Powers Memorandum. The amendments make no change to the choice of procedure in relation to this power.
Section 15 – Transfer of staff where functions delegated to local authority or Health Board

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure
Amended or new power: new power

Provision

37. On introduction subsection (1) provided for the Scottish Ministers to make, by scheme, provision about the transfer of staff. Subsection (1B)(c) provides for the Scottish Ministers to prescribe other groups of persons, in addition to health and social care professionals, who must be consulted before making a scheme in relation to the transfer of staff under subsection (1).

38. By virtue of section 48(1), “prescribed” means prescribed by the Scottish Ministers by regulations.

Reason for taking this power

39. This power is required to ensure that relevant parties, as well as health and social care professionals, are consulted on any scheme the Scottish Ministers may make in relation to the transfer of staff from a local authority to a Health Board.

Stage 2 Amendment

40. This power was inserted at stage 2 and proposed by Rhoda Grant MSP and supported by the Royal College of Nursing. The Scottish Government considered it appropriate that before Ministers make any scheme under 15(1) relevant parties must be consulted.

Choice of procedure

41. Regulations under section 12(5) is subject to negative procedure. This is considered appropriate given the regulations will deal with matters of detail in relation to the persons to be consulted before making any transfer scheme rather than any broad principle.

Section 22A – Section 22: supplementary

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: negative procedure
Amended or new power: amended power

Provision

42. Subsection (6) allows the Scottish Ministers to provide by order, where the conditions in subsection (7) are met, that an integration authority which is an integration joint board (a) may decide not to give a direction under section 22 in relation to carrying out a function specified in the order or, (b) may give a direction despite the making of that order.
Reason for taking this power

43. The Bill as introduced provided in section 22(8) that the Scottish Ministers could make an order to provide that an integration joint board must or must not make a direction under section 22. The reasons for taking this power are set out at paragraph 48 of the Delegated Powers Memorandum.

Stage 2 amendment

44. The Bill has been amended at Stage 2 so that section 22(1) now provides that an integration joint board must give a direction to one of its constituent authorities in relation to the carrying out of its functions. This reflects the intention that integration joint boards will primarily be responsible for the strategic planning and direction of integration functions, rather than for service delivery. However, the Scottish Government has been clear that, in time, it may be possible for integration joint boards to take on responsibility for delivery of integrated services. The power in subsection 22A(6) allows the Scottish Ministers, on receipt of a written application from the constituent authorities and provided that the Scottish Ministers consider that making an order in relation to some or all of the functions would improve compliance with the national health and wellbeing outcomes, to remove the requirement for an integration joint board to issue directions under section 22(1) and so provide for an integration joint board to deliver the functions delegated by virtue of an integration scheme. This provides for flexibility in the future.

45. The Bill was amended to provide for the policy intention that integration joint boards would not directly deliver integrated functions as the default position, and to require an order under 22A(6) for any integration joint board to be excepted from this default position. Further, COSLA raised concerns regarding the powers of the Scottish Ministers to permit an integration joint board to directly deliver integrated functions and the wide ranging implications for delivery of health and social care services. The provision has therefore been adjusted so that an application from the relevant constituent authorities is a precondition on the exercise of this power by the Scottish Ministers.

Choice of procedure

46. An order made under these provisions is subject to negative procedure, as was the previous version of the power provided in section 22(8) of the Bill as introduced. This remains appropriate given it merely allows the Scottish Ministers to enable a particular delivery mechanism and taking into account the requirements placed on the Scottish Ministers before being able to exercise the power.
Section 34 – Revised integration scheme

Power conferred on: Scottish Ministers
Power exercisable by: regulations made by Scottish statutory instrument
Parliamentary procedure: negative procedure
Amended or new power: new power

Provision

47. Subsection (3A) provides that, where a local authority and a Health Board are preparing a revised integration scheme, they must jointly consult certain persons before the revised integration scheme is submitted to the Scottish Ministers for approval. Subsection (3A)(a) provides that the persons to be consulted include such persons appearing to the Scottish Ministers to have an interest as may be prescribed.

48. By virtue of section 48(1), “prescribed” means prescribed by the Scottish Ministers by regulations.

Reason for taking this power

49. This power enable the Scottish Ministers to prescribe the relevant parties that must be included in any consultation on a revised integration scheme. It will enable the Scottish Ministers to ensure that the consultation on such a scheme is carried out uniformly between different areas and to a suitable standard given the significant effect on the provision of health and social care services that may result from changes to an integration scheme.

Stage 2 amendment

50. This power was inserted by amendment at stage 2 to provide for the Scottish Ministers to ensure that the relevant parties are consulted where a revised integration scheme is prepared. It ensures that a revised integration scheme will be subject to the same degree of consultation as the initial integration scheme that is prepared under section 1.

Choice of procedure

51. Regulations under section 34(3A)(a) are subject to negative procedure. This is considered appropriate given the regulations will deal with matters of detail relation to consultation requirement rather than broad principle.
PART 2 –SHARED SERVICES

Section 44(4A) – Shared services

Power conferred on: Scottish Ministers
Power exercisable by: order made by Scottish statutory instrument
Parliamentary procedure: affirmative procedure
Amended or new power: new power

Provision

52. Subsection (4A) provides a power for the Scottish Ministers to amend by order subsection (2) to add or remove a person or a description of a person, for the time being mentioned in or falling within that subsection.

Reason for taking this power

53. Section 44 of the Bill expands certain powers of the Common Services Agency, which are at present set out in section 15(2A) of the National Health Service (Scotland) Act 1978 (as that Act was amended by SSI 2013/220). At present section 15(2A) of that Act provides that the Common Services Agency may carry out certain activities or services for, or on behalf of certain persons. Those persons include the Scottish Ministers, government departments, local authorities and such public bodies or classes of public body as may be determined by the Scottish Ministers. As introduced, section 44(2) contained a list of Scottish public bodies that the Common Services Agency may, with the consent of the Scottish Ministers, enter into arrangements with for the provision of good or services. Those persons are: the Scottish Ministers; any other officer-holder in the Scottish Administration; any Scottish public authority; any Scottish public authority with mixed functions or no reserved functions; any government department; and any cross-border public authority. The new power inserted at stage two allows this list to be amended by the Scottish Ministers by Order. This power is taken to reflect the current provision in section 15(2A) that the Scottish Ministers may determine additional persons to or for whom the Common Services Agency may provide services.

Stage 2 amendment

54. It was considered appropriate to amend section 44 at Stage 2 to enable and provide for future flexibility and changing circumstance should the Scottish Ministers consider it appropriate to amend the list of persons or groups of persons in subsection (2), for example in the event that a new statutory body is created and it is appropriate to include it in section 44(2). The new power in subsection (4A) enables the Scottish Ministers to add or remove persons or groups from that list. This will allow section 44(2) to be kept up to date without requiring further primary legislation, as it can be amended by Order to take into account any changes to the public sector landscape or the powers of the Common Services Agency which may occur in future. It affords a similar level of flexibility as currently provided for in the powers of the Common Services Agency under, for example section 15(2A)(b)-(f).

Choice of procedure
55. An order under this provision is subject to affirmative procedure. Although the exercise of the power is restricted to the addition or removal of persons listed in 44(2), it allows the Scottish Ministers to amend primary legislation by Order. It is therefore appropriate that the use of this power should be subject to the higher degree of Parliamentary scrutiny that affirmative procedure allows.
Delegated Powers and Law Reform Committee

16th Report, 2014 (Session 4)

Public Bodies (Joint Working) (Scotland) Bill as amended at stage 2

Published by the Scottish Parliament on 19 February 2014
Delegated Powers and Law Reform Committee

Remit and membership

Remit:

1. The remit of the Delegated Powers and Law Reform Committee is to consider and report on—
   (a) any—
   (i) subordinate legislation laid before the Parliament or requiring the consent of the Parliament under section 9 of the Public Bodies Act 2011;
   (ii) [deleted]
   (iii) pension or grants motion as described in Rule 8.11A.1; and, in particular, to determine whether the attention of the Parliament should be drawn to any of the matters mentioned in Rule 10.3.1;
   (b) proposed powers to make subordinate legislation in particular Bills or other proposed legislation;
   (c) general questions relating to powers to make subordinate legislation;
   (d) whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation;
   (e) any failure to lay an instrument in accordance with section 28(2), 30(2) or 31 of the 2010 Act; and
   (f) proposed changes to the procedure to which subordinate legislation laid before the Parliament is subject.
   (g) any Scottish Law Commission Bill as defined in Rule 9.17A.1; and
   (h) any draft proposal for a Scottish Law Commission Bill as defined in that Rule.

Membership:

Richard Baker
Nigel Don (Convener)
Mike MacKenzie
Margaret McCulloch
Stuart McMillan (Deputy Convener)
John Scott
Stewart Stevenson
Committee Clerking Team:

Clerk to the Committee
Euan Donald

Assistant Clerk
Elizabeth White

Support Manager
Daren Pratt
The Committee reports to the Parliament as follows—

**INTRODUCTION**

1. At its meeting on 18 February 2014, the Delegated Powers and Law Reform Committee considered the delegated powers provisions in the Public Bodies (Joint Working) (Scotland) Bill as amended at Stage 2 ("the Bill")\(^1\). The Committee submits this report to the Parliament under Rule 9.7.9 of Standing Orders.

2. In broad outline, the Bill provides a framework with a view to the improvement of the quality and consistency of health and social care services, through the integration of health and social care services in Scotland. Four “models of integration” between local authority and Health Board functions may be used, by agreement subject to the approval of the Scottish Ministers. On default if an integration scheme is not submitted to Ministers, they may specify functions to be delegated to an integration joint board (Part 1).

3. The Bill also provides for the Common Services Agency (also known as NHS National Services Scotland) to provide goods and services to public bodies including local authorities (Part 2, section 44). It also provides for the Scottish Ministers to form a wider range of joint venture structures in relation to persons providing functions and services under the National Health Service (Scotland) Act 1978, to seek to make the most effective use of resources (Part 3, section 46). There is new provision that a Health Board may, with the agreement of another Health Board and the Scottish Ministers, carry out on behalf of that other Board any function of the other Board (Part 3, section 47).

4. The Bill also extends the scheme for meeting losses and liabilities of health service bodies which is run by NHS Scotland on behalf of the Scottish Ministers, to

---

\(^1\) Public Bodies (Joint Working) (Scotland) Bill as amended at Stage 2 available at: [http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Bill/b32as4-stage2-amend.pdf](http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Bill/b32as4-stage2-amend.pdf)
local authorities and “integration joint boards” established under Part 1 (Part 2, section 45).

5. The Scottish Government has provided the Parliament with a supplementary memorandum on the delegated powers provisions in the Bill, in advance of Stage 3 of the Bill (the SDPM\(^2\)).

6. The Committee reported on certain matters in relation to the delegated powers provisions in the Bill at Stage 1 in its 48th report of 2013.

**DELEGATED POWERS PROVISIONS**

7. The Committee considered each of the new or substantially amended delegated powers provisions in the Bill after Stage 2.

8. **After Stage 2, the Committee reports that it does not need to draw the attention of the Parliament to the new or substantially amended delegated powers provisions listed below and that it is content with the Parliamentary procedure to which they are subject:**

   - Section 1(4H) – Integration schemes: same local authority and Health Board area
   - Section 9(3) – Functions delegated to an integration joint board
   - Section 11(4) and (5) – Other staff of integration joint board
   - Section 12 – Integration joint boards: further provision
   - Section 14(1A) – Functions delegated to local authority or Health Board
   - Section 15 – Transfer of staff where functions delegated to local authority or Health Board
   - Section 18A – Health funding: further provision
   - Sections 22 and 22A – Directions by integration authority; Section 22: supplementary
   - Section 22A(6) – Section 22: supplementary
   - Section 30B – Requirement to prepare replacement strategic plan
   - Section 33(3) – Integration authority: performance report
   - Section 34(3A) – Revised integration scheme

\(^2\) Public Bodies (Joint Working) (Scotland) Bill Supplementary Delegated Powers Memorandum available at: [http://www.scottish.parliament.uk/S4_Bills/Public_Bodies_SDPM.pdf](http://www.scottish.parliament.uk/S4_Bills/Public_Bodies_SDPM.pdf)
• Section 36 – Power to make provision in consequence of new integration scheme

• Section 41C(3) – Joint inspections of health services and social services

• Section 44(4A) – Shared services (Common Services Agency)

9. The Scottish Government has written to the Committee to advise that it intends to bring forward an amendment at stage 3 which would make the powers at section 1(4C) and (4D) subject to the affirmative procedure. The correspondence from the Government is reproduced at the Annex.

10. The Committee reports that it finds the powers in section 1(4B) to (4D), (4F) and (4G) are acceptable in principle.

11. The Committee also notes the Scottish Government’s intention to bring forward an amendment at Stage 3 to provide that the powers conferred by section 1(4C) and (4D) would be subject to the affirmative procedure. The Committee is content with that proposal, and that the powers in section 1(4B), (4F) and (4G) are subject to the negative procedure.

12. The Committee therefore reports that it is content with the provisions in the Bill which have been amended at Stage 2 to insert or substantially alter provisions conferring powers to make subordinate legislation.
ANNEX

Correspondence from the Scottish Government, dated 14 February 2014.

I draw your attention to the Scottish Government’s intention to lay a Stage 3 amendment in relation to section 1(4C) and (4D), which will amend the choice of procedure that these powers will be subject to. On reflection, given the significance of the powers at 1(4C) and (4D), the Scottish Government consider it more appropriate that these powers be subject to affirmative procedure.
1. The Committee reported on the delegated powers in the Public Bodies (Scotland) Bill as amended at stage 2 on 19 February 2014 in its [16th Report of 2014](#).

2. Further to this, the Scottish Government has written to the Committee advising it of amendments it has lodged at stage 3 which relate to delegated powers and explaining the purpose of these amendments.

3. The Government initially wrote on 19 February advising the Committee of the amendments it was lodging at stage 3. This letter is attached at Annex A. Subsequently, on 21 February, the Government wrote again to the Committee in order to explain the purpose and effect of the amendments. This letter is attached at Annex B.

4. **Members are invited to note the Scottish Government’s response and to make any comments they wish.**
Correspondence from the Scottish Government – 19 February 2014

Further to my letter of 14 February and the Supplementary Delegated Powers Memorandum for the Public Bodies (Joint Working) (Scotland) Bill as amended at Stage 2, this letter sets out amendments at Stage 3 that confer delegated powers on the Scottish Ministers.

Section 1 – Integration schemes: same local authority and Health Board area

An amendment provides that regulations made under subsection 1(3)(e) may include provision about certain specific matters. Regulations under section 1(3)(e) are to be subject to the affirmative procedure.

After section 18 - Power of Scottish Ministers to make provision giving effect to integration scheme

An amendment provides for a new power for the Scottish Ministers make such provision by regulation as they think appropriate for the purpose of giving effect to any matters included in integration schemes by virtue of being prescribed in regulations made under section 1(3)(e). Regulations under this section are to be subject to the affirmative procedure.

Section 36 – Power to make provision in consequence of new integration scheme

An amendment provides a new power for the Scottish Ministers, when preparing a scheme in relation to the transfer of staff as a consequence of a new integration scheme, to prescribe persons appearing to the Scottish Ministers to have an interest for the purposes of consultation before a scheme is made under section 36. This amendment is similar to amendments made at stage 2 to sections 12 and 15, and reflects an undertaking given by the Cabinet Secretary to the Health and Sport Committee at Stage 2 to bring forward such an amendment in respect of section 36. Regulations under section 36 are to be subject to the negative procedure.

Section 46 – Scottish Ministers: power to form companies etc.

An amendment to section 46 provides for the Scottish Ministers to prescribe additional purposes for which the Scottish Ministers may form or participate in forming bodies corporate and participate in bodies corporate that are formed. The Scottish Ministers may only prescribe purposes which relate to their functions under the National Health Service (Scotland) Act 1978. Regulations under section 46 are to be subject to the negative procedure.

Section 49 – Subordinate legislation

An amendment to section 49 adds sections 1(3)(e), (4C), (4D) and the new section to be added in after section 18 (Power of Scottish Ministers to make provision giving effect to integration scheme) to the provisions which will be subject to the affirmative procedure.
Correspondence from the Scottish Government – 21 February 2014

This letter provides some additional information in relation to Stage 3 amendments lodged by the Scottish Government which, if agreed to, will amend existing powers to make subordinate legislation and insert new powers to make subordinate legislation.

Section 1(3)(e) – Integration schemes: same local authority and Health Board area (amended power)

An amendment has been lodged relating to the existing power in section 1(3)(e) of the Bill. Section 1(3)(e) enables the Scottish Ministers to make regulations to prescribe certain information about certain additional prescribed matters that must be included in an integration scheme prepared under section 1(2) of the Bill. The amendment provides some indicative examples of the provision that may be made in these regulations. This additional provision is made to indicate the type of provision in any regulations made under section 1(3)(e).

An amendment has also been lodged to provide that the power will be subject to the affirmative procedure, recognising that the power to prescribe the information (and the matters on which such information is to be provided) to be set out in an integration scheme is important as integration schemes are central to establishing effective integrated arrangements. The higher level of parliamentary scrutiny is therefore considered appropriate.

After section 18 - Power of Scottish Ministers to make provision giving effect to integration scheme (new power)

This new section, if agreed to, will confer a new power on the Scottish Ministers to make such provision by regulations as they think appropriate for the purpose of giving effect to any matters included in integration schemes by virtue of being prescribed in regulations made under section 1(3)(e).

The matters to be included in the integration scheme under sections 1(3)(a)-(d), such as the model of integration and the functions to be delegated, are subject to additional detail in later provisions of the Bill as to how the detail included in the integration scheme is to be given effect to. As section 1(3)(e) allows for additional matters to be prescribed which must be included in the integration scheme, it is necessary that the Scottish Ministers are also able to make provision to set out the means by which these aspects of the integration scheme will take effect. As the information to be included in the plan under section 1(3)(e) is not set out on the face of the Bill, it is not possible to make provision giving effect to such information in the Bill and regulations are therefore necessary.

Regulations under this section are to subject to the affirmative procedure. This higher level of parliamentary scrutiny is considered appropriate given the matters that may be prescribed to be addressed in integration scheme are central to establishing effective integrated arrangements.
Section 20A – Carrying out of functions conferred on officers of local authorities.

The power in section 20A provides for the Scottish Ministers to set out in regulations a list of existing statutory functions, conferred on an officer of a local authority, that may be deemed to be conferred on an officer of the Health Board or of any other local authorities that prepared the same integration scheme.

The power enables the Scottish Ministers to make clear which functions section 20A applies to, and the conditions which must be satisfied before a function is deemed to be conferred on a person other than the person on whom it was directly conferred by statute.

Regulations under this section are subject to the negative procedure. This is considered appropriate given that regulations do not provide for any new statutory functions but will set out limited circumstances in which a statutory function may apply to another person for the purposes of integration.

Section 20B - Carrying out of functions conferred on officers of Health Boards

The power in section 20B provides for the Scottish Ministers to set out in regulations a list of existing statutory functions, conferred on an officer of a Health Board, that may be deemed to be conferred on an officer of the local authority or any other local authority that prepared the same integration scheme.

The power enables the Scottish Ministers to make clear which functions section 20B applies to, and the conditions which must be satisfied before a function is deemed to be conferred on a person other than the person on whom it was directly conferred by statute.

Regulations under this section are subject to the negative procedure. This is considered appropriate given that regulations do not provide for any new statutory functions but will set out limited circumstances in which a statutory function may apply to another person for the purposes of integration.

Section 36 – Power to make provision in consequence of new integration scheme (amended power)

Section 36(6)(c), if the relevant amendment is agreed to, will confer a new power on the Scottish Ministers, when preparing a scheme in relation to the transfer of staff etc. as a consequence of a new integration scheme, to prescribe additional groups of persons appearing to the Scottish Ministers to have an interest who must be consulted before the Scottish Ministers make a transfer scheme under section 36(3).

This amendment is similar to amendments made at Stage 2 to sections 12 and 15, and reflects an undertaking given by the Cabinet Secretary to the Health and Sport Committee at Stage 2, to bring forward such an amendment in respect of section 36.

Regulations under section 36(6)(c) will be subject to the negative procedure. This is considered appropriate given the regulations will deal with matters of detail in relation to the persons to be consulted before making any transfer scheme rather than any broad principle.
Section 46 – Scottish Ministers: power to form companies etc. (new power)

If agreed to, the amendment to section 46 of the Bill (which inserts a new section 84B(2A) and (2B) into the National Health Service (Scotland) Act 1978) will confer a power on the Scottish Ministers to prescribe additional purposes for which the Scottish Ministers may: (a) form or participate in forming bodies corporate; and (b) participate in bodies corporate that are formed. The Scottish Ministers may only prescribe purposes which relate to their functions under the National Health Service (Scotland) Act 1978.

Section 46 of the Bill is intended to allow Scottish Ministers, (and any health service body such as a Health Board to whom Ministers delegate their functions under the National Health Service (Scotland) Act 1978), to participate in all types of body corporate, and for a broad range of purposes. This will allow them to enter into joint venture agreements with other bodies, including in particular with local authorities. Local authorities’ powers in this area are broad and not subject to specific statutory constraints. By contrast, the powers of the Scottish Ministers and Health Bodies are limited by the provisions of section 84B of the 1978 Act. This amendment aims to ensure that the purposes for which Scottish Ministers and Health Bodies may form or participate in bodies corporate may be adjusted in future without the need for further primary legislation but the power is limited as the purposes must relate to the functions conferred by the National Health Service (Scotland) Act 1978. The Scottish Ministers will require to make regulations to prescribe any such additional purposes. This will ensure that health bodies and other public sector bodies are able to jointly participate in bodies corporate for a broad range of purposes, subject to the approval and control of the Scottish Ministers.

Regulations under section 46 are to be subject to the negative procedure. This is considered the appropriate level of scrutiny given the regulation will deal with matters of detail rather than any broad purpose.
Present:
Bruce Crawford (Committee Substitute)  Nigel Don (Convener)
Mike MacKenzie  Margaret McCulloch
John Scott  Stewart Stevenson

Apologies were received from Richard Baker, Stuart McMillan (Deputy Convener).

Public Bodies (Joint Working) (Scotland) Bill: The Committee considered further the delegated powers provisions in this Bill and noted correspondence from the Scottish Government regarding amendments, which relate to delegated powers, lodged by them at Stage 3. The Convener agreed, on behalf of the Committee, to highlight a concern relating to the delegated power in amendment 86 during the Stage 3 debate.
Public Bodies (Joint Working) (Scotland) Bill: After Stage 2

10:37

The Convener: As members will recall, the committee agreed its report on the Public Bodies (Joint Working) (Scotland) Bill as amended at stage 2 at last week’s meeting. Further to that, the Scottish Government has written to the committee advising it of amendments that it has lodged at stage 3 that relate to delegated powers and explaining the purpose of those amendments.

Members have seen the correspondence from the Scottish Government and we have just had a briefing. I invite them to comment on what is before us.

Stewart Stevenson: There is a simple shortcoming in the information that is before the committee in relation to section 46 and the amendment that allows the Scottish ministers to form companies and bodies corporate. Such an amendment being lodged at stage 3 clearly suggests that something has arisen in the ministers’ consideration of the bill that has caused them to introduce the measure, but there is nothing before us that helps me to understand the reason behind that.

It is a power to cover future events as yet unknown, so I can understand the general point, but it would be helpful to the Parliament if we understood the specific reason that the minister had for lodging the amendment. We can see its effect and the process by which the measure would be implemented. I have no concerns about either of those points but, without knowing the reason why the amendment was lodged, there is a shortcoming in our ability to understand it properly.

John Scott: I agree utterly with what Stewart Stevenson says on this occasion. I am concerned that the measure is being introduced at stage 3 without the normal parliamentary scrutiny that one would expect. I appreciate that there may be policy issues here, but nonetheless the power is far reaching, as I understand it, and we should have had more information than we currently have to enable us to evaluate the intent.

Bruce Crawford: I agree that we should have more information, although I am not sure that the power is as far reaching as members might imagine. I remember having the same discussion when the bill that formed Scottish Water was considered. At that time, I challenged the then Labour and Liberal Executive on whether the use of the term “body corporate” was necessarily about the formation of companies. Allan Wilson, who was then the minister, quite rightly told me that it can be about forming joint ventures with other public bodies and not just outside organisations. The step that the Government is taking is not unusual, although I agree that the committee should have had more information about the intent and purpose.

John Scott: I appreciate that. I remember that Bruce Crawford and I sat on that bill committee together, and I note that there is a precedent, as he reminded us. However, stage 3 of the Public Bodies (Joint Working) (Scotland) Bill will take place this afternoon. It is simply not good enough that we have not had more of an explanation.

Convener, perhaps you will wish to take part in this afternoon’s debate, to elicit the information from the Government minister. I do not know; it is, of course, a matter for you.

The Convener: Clearly, it is a matter for the committee, and if the committee is concerned, it is probably appropriate that the convener takes part and expresses the committee’s concerns. However, I would like to hear all members’ views. I am conscious that Mike MacKenzie may want to say something.

Mike MacKenzie (Highlands and Islands) (SNP): I have a general point to make about the timing. The power might be entirely benign or even beneficial—it might be something that we would welcome—but the timeframe does not allow us to explore it. In general terms, we ought to try to devise a means of avoiding this situation.

The Convener: Yes. Of course, we have mentioned the issue several times in the past few weeks. We still have the convener of the appropriate committee listening in, and I am sure that he will explore that.

I am in the committee’s hands as to what we should do this afternoon. The obvious thought is that I, on your behalf, should raise the issue at the appropriate point, when amendment 86 is called. I would simply ask the Government whether it can say any more about the purpose for which the power is there and note that, if there is a serious policy behind it, we might have expected that the negative procedure would not be used.

Stewart Stevenson: Just for clarity, convener, I agree that you should use the phrase “on behalf of the committee”. It is important that we agree that you will be speaking not as an individual but on behalf of the committee.

The Convener: Yes. That would reflect this morning’s discussion.

Stewart Stevenson: That is fine. I just wanted us to be clear about that.

John Scott: I have every confidence in you, convener.
The Convener: I do not want to over-egg this, but is there anything else that we need to say, or has everything that is appropriate been said? I think that it has.

John Scott: We are perhaps the least important part of the process, but I note that the committee that is responsible for the bill, those who gave evidence on it and others who scrutinised it during the consultation are not aware of the power. We are at the end of the chain, but many others who might have wished to comment have not been able to do so.

The Convener: Right. I think that I know what I have to do. Thank you for that.

10:43

Meeting continued in private until 10:52.
Public Bodies (Joint Working) (Scotland) Bill

Marshalled List of Amendments selected for Stage 3

The Bill will be considered in the following order—

Sections 1 to 53  Schedule

Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 1

Alex Neil

1 In section 1, page 1, line 20, leave out <where subsection (5A) applies> and insert <in relation to any functions to which subsection (5A) applies that are to be delegated>.

Alex Neil

2 In section 1, page 1, line 21, leave out from <in> to end of line 22 and insert <for use by the person to whom the functions are delegated in respect of those functions,>.

Alex Neil

3 In section 1, page 1, line 23, leave out from beginning to <it> in line 24 and insert <in relation to any functions other than those mentioned in paragraph (ca) that are to be delegated (including any functions mentioned in that paragraph but in relation to which the Health Board deems subsection (5A)>.

Alex Neil

4 In section 1, page 1, line 25, leave out from <a> to <is> in line 26 and insert <the delegated functions by the person delegating the functions to the person to whom the functions are>.

Nanette Milne

95 In section 1, page 1, line 26, at end insert—

<( ) arrangements for a single point of entry to complaints systems for all services provided in pursuance of functions delegated under paragraph (b) or (c).>.

Malcolm Chisholm

96 In section 1, page 1, line 26, at end insert—

<(da) arrangements for seeking the advice of the persons mentioned in subsection (3A) with regard to the quality, safety and standards of services provided in pursuance of functions delegated under paragraph (b) or (c).>
Malcolm Chisholm

97 In section 1, page 1, line 27, at end insert—

<\(3A\) The persons mentioned in subsection (3)(da) are—

(a) the medical director of the Health Board,
(b) the director of nursing of the Health Board,
(c) the chief social work officer of the local authority.>

Alex Neil

5 In section 1, page 2, line 9, after <in> insert <Part 1 of>

Alex Neil

6 In section 1, page 2, line 9, at end insert <, or

( ) by virtue of an enactment listed in Part 2 of the schedule.>

Alex Neil

98 In section 1, page 2, line 12, after second <by> insert <or by virtue of>

Alex Neil

99 In section 1, page 2, line 33, after second <by> insert <or by virtue of>

Alex Neil

7 In section 1, page 2, line 42, at end insert—

<\(\) Regulations under subsection (3)(e) may include provision—

(a) conferring discretion on local authorities and Health Boards,
(b) requiring local authorities and Health Boards to establish processes and procedures relating to prescribed matters,
(c) imposing requirements on local authorities and Health Boards about the disclosure of information,
(d) in relation to such other matters relating to integration schemes as the Scottish Ministers think fit.>

Section 2

Alex Neil

8 In section 2, page 3, line 24, after <authority> insert <and the Health Board>

Section 4

Alex Neil

9 In section 4, page 4, line 1, leave out <functions which are delegated under an integration scheme> and insert <integration functions>

Malcolm Chisholm

100 In section 4, page 4, line 2, after <wellbeing> insert <and independent living>
Nanette Milne

101 In section 4, page 4, line 7, after <needs> insert <, aspirations, abilities, characteristics and circumstances>

Nanette Milne

102 In section 4, page 4, line 7, at end insert <including the need for access to independent advocacy services,>

Alex Neil

10 In section 4, page 4, line 9, at end insert—

<( ) takes account of the particular characteristics and circumstances of different service-users,>

<( ) respects the rights of service-users,>

Malcolm Chisholm

103 In section 4, page 4, line 10, leave out <takes account of the> and insert <has regard to the right to>

Malcolm Chisholm

104 In section 4, page 4, line 10, at end insert—

<( ) enables service-users to exercise choice and control and to participate in decisions regarding their need for services and the provision of those services to them,>

Malcolm Chisholm

105 In section 4, page 4, leave out lines 11 and 12 and insert—

<( ) has regard to the right of service-users to participate in the life of the community in which they live,>

Section 5

Alex Neil

11 In section 5, page 4, line 24, after <wellbeing> insert <(the “national health and wellbeing outcomes”)>
Section 7

Alex Neil
14 In section 7, page 5, line 19, leave out subsection (2)

Section 11

Alex Neil
15 In section 11, page 6, line 37, leave out <appoint> and insert <employ>

Alex Neil
16 In section 11, page 7, line 6, leave out subsection (3)

Section 12A

Alex Neil
17 In section 12A, page 8, line 31, leave out subsection (1)

Alex Neil
18 In section 12A, page 9, line 1, leave out <95,>

After section 18

Alex Neil
19 After section 18, insert—

<Power of Scottish Ministers to make provision giving effect to integration scheme

The Scottish Ministers may by regulations make such provision as they think fit for the purpose of giving effect to provision included by virtue of section 1(3)(e) in integration schemes approved by them under section 7.>

Section 18A

Alex Neil
106 Move section 18A to after section 22A

Section 19

Alex Neil
20 In section 19, page 12, line 1, leave out <imposes on> and insert <transfers to>

Alex Neil
21 In section 19, page 12, line 5, leave out <confers any right on the new employer> and insert <transfers to the new employer any right>
Section 20A

Alex Neil

22 In section 20A, page 12, line 24, leave out <function conferred by> and insert <prescribed function conferred by or by virtue of>

Alex Neil

23 In section 20A, page 12, line 26, at end insert <, and>
     ( ) any prescribed conditions are satisfied.>

Alex Neil

24 In section 20A, page 12, line 27, after second <the> insert <prescribed>

Alex Neil

25 In section 20A, page 12, line 30, after <Board> insert <or (as the case may be) a local authority and Health Board acting jointly>

Alex Neil

26 In section 20A, page 12, line 30, after second <the> insert <prescribed>

Section 20B

Alex Neil

27 In section 20B, page 12, line 34, leave out <function conferred by> and insert <prescribed function conferred by or by virtue of>

Alex Neil

28 In section 20B, page 12, line 36, at end insert <, and>
     ( ) any prescribed conditions are satisfied.>

Alex Neil

29 In section 20B, page 12, line 37, after second <the> insert <prescribed>

Alex Neil

30 In section 20B, page 13, line 1, after <Board> insert <or (as the case may be) a local authority and Health Board acting jointly>

Alex Neil

31 In section 20B, page 13, line 1, after second <the> insert <prescribed>

Section 22

Alex Neil

32 In section 22, page 13, line 19, leave out <on its behalf>
Alex Neil

33 In section 22, page 13, line 23, leave out <on its behalf>

Section 22A

Alex Neil

34 In section 22A, page 13, line 39, at end insert—

<(  ) must, where provision of the type mentioned in section 1(3)(ca) is included in the integration scheme in relation to the function to which the direction relates, set out the amount which has been set aside by the Health Board for the use of the person who is to carry out the function,>}

Alex Neil

35 In section 22A, page 14, line 1, after <must> insert <, in any other case,>

Alex Neil

36 In section 22A, page 14, line 2, leave out <on its behalf>

Alex Neil

37 In section 22A, page 14, line 3, at end insert—

<(  ) must specify how such an amount or, as the case may be, such a payment is to be used,>}

Alex Neil

38 In section 22A, page 14, leave out lines 13 and 14

Alex Neil

39 In section 22A, page 14, line 15, leave out second <the> and insert <any>

Alex Neil

40 In section 22A, page 14, line 25, leave out from <or> to end of line 26

Alex Neil

41 In section 22A, page 14, line 32, leave out <national health and wellbeing outcomes> and insert <integration delivery principles and contribute to achieving the national health and wellbeing outcomes in relation to the carrying out of the functions>

Alex Neil

42 In section 22A, page 14, line 35, leave out <national health and wellbeing outcomes in relation to> and insert <integration delivery principles or contribute to achieving the national health and wellbeing outcomes in relation to the carrying out of>
Section 23

Rhoda Grant

43 In section 23, page 15, line 5, after <outcomes,> insert—

<( ) setting out arrangements between the integration authority and other such
authorities for ensuring that integration functions are carried out in a way that
takes account of the particular needs of service-users moving into the area of the
local authority from the area of another local authority.>

Alex Neil

44 In section 23, page 15, line 12, leave out <not to be delegated to the authority on> and insert <to
be delegated to the authority before>

Alex Neil

107 In section 23, page 15, line 23, leave out <14(2)> and insert <14(1A)>

Section 24

Alex Neil

45 In section 24, page 15, line 34, leave out <utilised by> and insert <used in relation to>

Alex Neil

46 In section 24, page 15, line 36, leave out <utilised by> and insert <used in relation to>

Section 25

Alex Neil

47 In section 25, page 16, line 3, leave out <functions which are delegated under an integration
scheme> and insert <integration functions>

Malcolm Chisholm

108* In section 25, page 16, line 4, after <wellbeing> insert <and independent living>

Nanette Milne

109 In section 25, page 16, line 9, after <needs> insert <, aspirations, abilities, characteristics and
circumstances>

Nanette Milne

110 In section 25, page 16, line 9, at end insert <including the need for access to independent
advocacy services,>

Alex Neil

48 In section 25, page 16, line 11, at end insert—

<( ) takes account of the particular characteristics and circumstances of
different service-users,

( ) respects the rights of service-users,>
Malcolm Chisholm
111 In section 25, page 16, line 12, leave out <takes account of the> and insert <has regard to the right to>

Malcolm Chisholm
112 In section 25, page 16, line 12, at end insert—

<( ) enables service-users to exercise choice and control and to participate in decisions regarding their need for services and the provision of those services to them,>

Malcolm Chisholm
113 In section 25, page 16, leave out lines 13 and 14 and insert—

<( ) has regard to the right of service-users to participate in the life of the community in which they live,>

Neil Findlay
49 In section 25, page 16, line 20, after <arising,> insert—

<( ) supports and rewards staff employed in the provision of those services in a way that will best protect the quality of the service,>

Section 26

Alex Neil
114 In section 26, page 16, line 31, leave out <it> and insert <the local authority>

Alex Neil
115 In section 26, page 16, line 33, after second <the> insert <local>

Rhoda Grant
116 In section 26, page 16, line 40, at end insert—

<( ) at least one person who the integration authority considers to be representative of service-users in the area to which the strategic plan relates,

( ) at least one person who the integration authority considers to be representative of carers in the area to which the strategic plan relates,>

Alex Neil
50 In section 26, page 17, line 19, leave out <its> and insert <a>

Section 27

Nanette Milne
117 In section 27, page 18, line 23, at end insert—

<( ) groups appearing to the integration authority to be representative of non-commercial organisations contributing to the health and wellbeing of service-users in the area covered by the strategic plan,>
Section 30A

51 In section 30A, page 20, line 9, at end insert—
<( ) Sections 24, 27, 27A and 29 apply in relation to a strategic plan prepared by virtue of
subsection (3) as those sections apply in relation to a strategic plan prepared by virtue of
section 23.>

Alex Neil

52 In section 30A, page 20, line 14, leave out <23(4)> and insert <23(6)>

Alex Neil

53 In section 30A, page 20, line 19, leave out <revised> and insert <replacement>

Section 30B

54 In section 30B, page 20, line 26, leave out <is consistent with the integration delivery principles
and> and insert <complies with the integration delivery principles and contributes to achieving>

Alex Neil

55 In section 30B, page 20, line 37, at end insert—
<( ) Sections 24, 27, 27A and 29 apply in relation to a strategic plan prepared by virtue of
subsection (2) as those sections apply in relation to a strategic plan prepared by virtue of
section 23.>

Section 31

118 In section 31, page 21, line 9, leave out <(see section 25)>.

Alex Neil

119 In section 31, page 21, line 10, leave out <(see section 5)>

Section 32

56 In section 32, page 21, line 14, after <the> insert <integration>

Section 33

Alex Neil

57 In section 33, page 21, line 33, after <in> insert <planning and>
Section 33B

Bob Doris

120 In section 33B, page 23, line 14, at end insert—

<(3A) When carrying out a review of the scheme under subsection (2), the local authority and the Health Board must jointly review the impact of the scheme on—

(a) the rights of children,
(b) the outcomes for children,
(c) the continuity of services provided to those persons moving from services generally provided to persons under 18 years of age to services generally provided to persons aged 18 years or over,
(d) such other matters as may be prescribed.

(3B) In subsection (3A)—

“children” means persons who have not attained the age of 18 years, “the rights of children” has the same meaning as in section 4(1) of the Children and Young People (Scotland) Act 2014.>

Bob Doris

121 In section 33B, page 23, line 16, after <(3)),> insert <and

( ) any impacts identified under subsection (3A),>
Bob Doris

123 In section 33C, page 23, line 41, after <(3),> insert <and

( ) any impacts identified under subsection (4A),>

Section 34

Alex Neil

59 In section 34, page 24, line 20, leave out <plan> and insert <scheme>

Alex Neil

60 In section 34, page 24, line 22, leave out <or (as the case may be) (4A)>>

Alex Neil

61 In section 34, page 24, line 29, leave out from beginning to <(3),> in line 30

Alex Neil

62 In section 34, page 24, line 32, leave out subsection (4A)

Section 35

Alex Neil

124 In section 35, page 25, line 1, leave out <any of the matters> and insert <a matter>

Section 36

Alex Neil

63 In section 36, page 25, line 22, at end insert—

<(5) Before making a scheme under subsection (3) in relation to staff, the Scottish Ministers must consult in respect of each group mentioned in subsection (6) such persons appearing to be representative of the group as the Scottish Ministers think fit.

(6) The groups mentioned in subsection (5) are—

(a) health professionals,

(b) social care professionals,

(c) such other groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.>}

Section 37

Alex Neil

64 In section 37, page 25, line 39, leave out from beginning to end of line 1 on page 26 and insert—

<( ) the carrying out of integration functions,>

Section 41A

Alex Neil

65 In section 41A, page 27, line 28, after second <the> insert <planning, organisation or>
66 In section 41A, page 27, line 30, after <(2)> insert—

<( ) for “this section” substitute “subsection (1)(a) or (b)”,

( )>  

67 In section 41A, page 27, leave out line 31  

68 In section 41A, page 27, line 35, after second <the> insert <planning, organisation or>  

69 In section 41A, page 28, line 11, after <57.”.> insert—

<( ) after subsection (2), insert—

“(2A) The purposes of an inspection under subsection (1)(c) may include any of those mentioned in subsection (2)(f) to (j).”,>  

70 In section 41A, page 28, line 17, at end insert—

<“national health and wellbeing outcomes” has the same meaning as in section 5(1) of the 2014 Act.”.>  

71 In section 41B, page 28, line 21, at end insert—

<( ) for subsection (1), substitute—

“(1) HIS may inspect any service provided under the health service—

(a) in pursuance of its general duty of furthering improvement in the quality of health care in Scotland, or

(b) for any of the purposes mentioned in subsection (1B).”,>  

72 In section 41B, page 28, line 23, leave out <is> and insert <and social services are>  

73 In section 41B, page 28, line 25, leave out <service> and insert <planning, organisation or coordination of those services>  

74 In section 41B, page 28, line 31, after second <the> insert <planning, organisation or>
Alex Neil
75 In section 41B, page 29, line 7, at end insert—
<“national health and wellbeing outcomes” has the same meaning as in section 5(1) of the 2014 Act;>

Alex Neil
76 In section 41B, page 29, line 15, after second <the> insert <planning, organisation or>

Alex Neil
77 In section 41B, page 29, line 16, after <(2)> insert—
<( ) for “this section” substitute “subsection (1)(a) or (b)”,
( )>

Alex Neil
78 In section 41B, page 29, leave out line 17

Alex Neil
79 In section 41B, page 29, line 22, after second <the> insert <planning, organisation or>

Alex Neil
80 In section 41B, page 29, line 37, after <10N.”,> insert—
<( ) after subsection (2), insert—
“(2A) The purposes of an inspection under subsection (1)(c) may include any of those mentioned in subsection (2)(f) to (j).”,>

Alex Neil
81 In section 41B, page 29, line 41, leave out <Public Bodies (Joint Working) (Scotland) Act 2014;> and insert <2014 Act;
“national health and wellbeing outcomes” has the same meaning as in section 5(1) of the 2014 Act;>

Section 41C

Alex Neil
82 In section 41C, page 30, line 19, at end insert—
<( ) On the request of SCSWIS and HIS, any other person or body mentioned in section 115(6) may conduct an inspection under subsection (1) jointly with SCSWIS and HIS.>

Section 41D

Alex Neil
83 In section 41D, page 31, line 9, leave out <of its functions under> and insert <functions conferred on it by>
After section 41D

Alex Neil

84 After section 41D, insert—

<Children’s services planning

In section 7(1) of the Children and Young People (Scotland) Act 2014 (which makes provision for introductory matters relating to children’s services planning), in the definition of “other service provider”, after paragraph (e), insert—

“(f) an integration joint board established by order under section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014.”.>

Section 46

Alex Neil

85 In section 46, page 35, line 13, at end insert—

<( ) after subsection (1), insert—

“(1A) The Scottish Ministers may do any (or all) of the following—

(a) form or participate in forming bodies corporate for any of the purposes mentioned in subsection (1B),

(b) participate in bodies corporate formed for any of those purposes,

(c) with a view to securing or facilitating any of the purposes for which such a body corporate is formed—

(i) transfer, or secure the transfer, to the body corporate of heritable or moveable property held by the Scottish Ministers, a Health Board, the Common Services Agency for the Scottish Health Service (“the Agency”) or Healthcare Improvement Scotland (“HIS”) under or by virtue of, or for the purposes of, this Act and any rights, liabilities or obligations relating to the property,

(ii) otherwise invest in the body corporate (whether by acquiring assets, securities or rights or otherwise),

(iii) provide loans and guarantees and make other kinds of financial provision to or in respect of the body corporate.

(1B) The purposes are—

(a) management or development of any heritable property held by the Scottish Ministers, a Health Board, the Agency or HIS under or by virtue of, or for the purposes of, this Act,

(b) management of any moveable property so held,

(c) disposal of any such heritable or moveable property.”.>

Alex Neil

86 In section 46, page 35, line 14, after <corporate”,> insert—

<( ) after subsection (2), insert—

“(2A) The Scottish Ministers may—
(a) form or participate in forming bodies corporate for a prescribed purpose,
(b) participate in bodies corporate formed for a prescribed purpose.

(2B) A purpose prescribed under subsection (2A) must relate to the functions conferred on the Scottish Ministers by or under this Act.”.

Section 48

Alex Neil

125 In section 48, page 35, line 30, at end insert—
<“integration delivery principles” has the meaning given by section 25,>

Alex Neil

87 In section 48, page 35, line 34, at end insert—
<“national health and wellbeing outcomes” has the same meaning as in section 5(1),>

Alex Neil

88 In section 48, page 36, line 11, after <2(3),> insert <11(5)(a)(i), 12(2A)(a)(i), 33C(2) (first occurrence only),>

Neil Findlay

89 In section 48, page 36, line 19, at end insert—
<( References in this Act to improving the quality of services include measures to ensure that services are provided to service-users for an amount of time that is appropriate to meet their needs.>

Section 49

Alex Neil

90* In section 49, page 36, line 26, leave out <1(4H) and 5(1)> and insert <1(3)(e), (4C), (4D) and (4H), 5(1) and (Power of Scottish Ministers to make provision giving effect to integration scheme)>

Schedule

Alex Neil

91 In the schedule, page 38, line 17, leave out <and 38> and insert <, 38 and 76>

Alex Neil

92 In the schedule, page 38, line 26, leave out <80, 90, 99> and insert <71, 80, 90, 99, 101>

Alex Neil

93 In the schedule, page 38, line 30, leave out <145, 166 and 167> and insert <144, 145, 166, 167, 180, 183 and 184>
In the schedule, page 38, line 33, at end insert—

<PART 2

FUNCTIONS CONFERRED BY VIRTUE OF ENACTMENTS

Section 4 of the Community Care and Health (Scotland) Act 2002.
Section 153 of the Children’s Hearings (Scotland) Act 2011.>
Groupings of Amendments for Stage 3

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted;
- the text of amendments to be debated on the day of Stage 3 consideration, set out in the order in which they will be debated. **THIS LIST DOES NOT REPLACE THE MARSHALLED LIST, WHICH SETS OUT THE AMENDMENTS IN THE ORDER IN WHICH THEY WILL BE DISPOSED OF.**

Groupings of amendments

Note: The time limits indicated are those set out in the timetabling motion to be considered by the Parliament before the Stage 3 proceedings begin. If that motion is agreed to, debate on the groups above each line must be concluded by the time indicated, although the amendments in those groups may still be moved formally and disposed of later in the proceedings.

**Group 1: Integration schemes: same local authority and health board area**
1, 2, 3, 4, 7, 14, 19, 63

**Group 2: Integration scheme: arrangements for complaints and advice**
95, 96, 97

**Group 3: Local authorities: functions which may be delegated**
5, 6, 98, 99, 91, 92, 93, 94

**Group 4: Minor and technical amendments**
8, 106, 20, 21, 56, 58, 59, 60, 61, 62, 124, 64, 83, 125, 88, 90

Debate to end no later than 40 minutes after proceedings begin

**Group 5: Principles**
9, 100, 101, 102, 10, 103, 104, 105, 47, 108, 109, 110, 48, 111, 112, 113, 49, 118, 89

**Group 6: National health and wellbeing outcomes**
11, 12, 13, 119, 87

**Group 7: Integration joint boards: staff and finance etc.**
15, 16, 17, 18
Group 8: Carrying out of functions conferred on officers of local authorities and health boards
22, 23, 24, 25, 26, 27, 28, 29, 30, 31

Debate to end no later than 1 hour 20 minutes after proceedings begin

Group 9: Directions by integration authority
32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42

Group 10: Integration authority: strategic planning
43, 44, 107, 45, 46, 114, 115, 116, 50, 117

Group 11: Review and replacement of strategic plan
51, 52, 53, 54, 55

Debate to end no later than 2 hours after proceedings begin

Group 12: Review of integration scheme: impact on children
120, 121, 122, 123

Group 13: Inspections by SCSWIS and HIS
65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82

Group 14: Children’s services planning
84

Group 15: Scottish Ministers: power to form companies
85, 86

Debate to end no later than 2 hours 30 minutes after proceedings begin
Note: (DT) signifies a decision taken at Decision Time.

Business Motion: Joe FitzPatrick, on behalf of the Parliamentary Bureau, moved S4M-09141—that the Parliament agrees that, during stage 3 of the Public Bodies (Joint Working) (Scotland) Bill, debate on groups of amendments shall, subject to Rule 9.8.4A, be brought to a conclusion by the time limit indicated, that time limit being calculated from when the stage begins and excluding any periods when other business is under consideration or when a meeting of the Parliament is suspended (other than a suspension following the first division in the stage being called) or otherwise not in progress:

- Groups 1 to 4: 40 minutes
- Groups 5 to 8: 1 hour 20 minutes
- Groups 9 to 11: 2 hours
- Groups 12 to 15: 2 hours 30 minutes.

The motion was agreed to.

Public Bodies (Joint Working) (Scotland) Bill - Stage 3: The Bill was considered at Stage 3.

The following amendments were agreed to (without division): 1, 2, 3, 4, 5, 6, 98, 99, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 106, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 107, 45, 46, 47, 48, 114, 115, 50, 51, 52, 53, 54, 55, 118, 119, 56, 57, 58, 59, 60, 61, 62, 124, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 125, 87, 88, 90, 91, 92, 93 and 94.

The following amendments were disagreed to (by division)—

- 95 (For 49, Against 61, Abstentions 0)
- 96 (For 53, Against 61, Abstentions 0)
- 100 (For 54, Against 62, Abstentions 0)
- 101 (For 54, Against 62, Abstentions 0)
- 102 (For 52, Against 64, Abstentions 0)
- 103 (For 53, Against 61, Abstentions 0)
- 104 (For 54, Against 62, Abstentions 0)
- 105 (For 54, Against 62, Abstentions 0)
- 43 (For 53, Against 62, Abstentions 0)
- 108 (For 54, Against 61, Abstentions 0)
- 111 (For 53, Against 62, Abstentions 0)
Amendment 120 was moved and, with the agreement of the Parliament, withdrawn.

The following amendments were not moved: 97, 109, 110, 121, 122 and 123.

**Public Bodies (Joint Working) (Scotland) Bill:** The Cabinet Secretary for Health and Wellbeing (Alex Neil) moved S4M-09115—That the Parliament agrees that the Public Bodies (Joint Working) (Scotland) Bill be passed.

After debate, the motion was agreed to (DT).
The Presiding Officer (Tricia Marwick): The next item of business is stage 3 proceedings on the Public Bodies (Joint Working) (Scotland) Bill. In dealing with the amendments, members should have copies of the bill as amended at stage 2, the marshalled list and the groupings of amendments. The division bell will sound and proceedings will be suspended for five minutes for the first division of the afternoon. The period of voting for the first division will be 30 seconds. Thereafter, we will allow a period of one minute for the first division after a debate.

Section 1—Integration schemes: same local authority and Health Board area

The Deputy Presiding Officer (Elaine Smith): Group 1 is on integration schemes: same local authority and health board area. Amendment 1, in the name of the cabinet secretary, is grouped with amendments 2 to 4, 7, 14, 19 and 63.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): The amendments in group 1 relate to integration schemes, which deal with the agreement between the health board and the local authority on local integrated arrangements. Amendments 1 to 4 seek to provide clarity regarding the details of financial calculations that must be included in the integration scheme, particularly in relation to large hospitals, such as Edinburgh royal infirmary and Glasgow Southern general, that serve the populations of more than one local authority.

Amendments 7 and 19 will ensure that Scottish ministers can require all necessary information to be included in integration schemes, and that they can ensure that health boards and local authorities are effectively bound into the agreements that they make in integration schemes.

Amendment 14 will ensure that ministers’ approval of all prescribed matters in an integration scheme is required. It will provide an important safeguard to ensure, for example, that ministers have the opportunity to approve suitably robust clinical and care governance arrangements under integration.

At the stage 2 Health and Sport Committee meeting on 21 January, I gave my support to Rhoda Grant’s amendments 216 and 218, which made changes to sections 12 and 15 of the bill to ensure that there would be consultation with professionals and other groups on matters relating to transfer of staff under those sections.

Neil Findlay (Lothian) (Lab): On amendment 63, will the appropriate trade unions be included in the consultation that will take place before a scheme is implemented?

Alex Neil: Yes. We have given a commitment to talk to the appropriate representatives of the staff side at all times.

At the same time, I gave an undertaking to the committee that the same provision would be inserted in section 36, which also makes provision for the transfer of staff. Amendment 63 seeks to insert that provision in section 36.

I move amendment 1.

Jim Hume (South Scotland) (LD): Local decision making and accountability are crucial if we want our health service to be integrated in a way that is suited to our local needs. Alex Neil’s amendment 14 seeks to take out—at quite a late stage—information in any integration scheme that would not need to be approved by a minister. To me, that means that, if amendment 14 is agreed to, ministerial approval would be needed for integration schemes to be approved.

I have similar concerns about amendments 7 and 19, as they provide for ministers to be able to alter integration schemes as they see fit. The Convention of Scottish Local Authorities has argued that the bill is too prescriptive and that there should be more flexibility at local level.

As amendments 14, 7 and 19 would result in the centre taking even more power and might allow for less flexibility, I seek assurances from the cabinet secretary on local accountability for integrated schemes before I decide whether to support the amendments.

Alex Neil: I assure the member—I think that, in committee, members of parties were united on this point—that we want to ensure that as much localism as possible is built into decisions at locality level and at partnership level, particularly in relation to the commissioning plan and the strategic plan for each integrated scheme, as well as the arrangements for the integrated scheme itself. That is fundamental to the success of the bill’s provisions as a whole.

I do not think that I need to say much more, as only one member had comments to make. I am happy to give Mr Hume the assurances that he sought.

Amendment 1 agreed to.

Amendments 2 to 4 moved—[Alex Neil]—and agreed to.
The Deputy Presiding Officer: Group 2 is on integration scheme: arrangements for complaints and advice. Amendment 95, in the name of Nanette Milne, is grouped with amendments 96 and 97.

Nanette Milne (North East Scotland) (Con): Complaints represent one of the ways in which people who are engaged at an individual level with services have their voices heard and access their rights. Everyone who makes a complaint about health and social care support and services in Scotland has the right to be listened to and have their concerns resolved as quickly and efficiently as possible. Most health boards and local authorities have developed clear and accessible complaints processes over a number of years to value the input of people who use support and services, and to ensure quality service provision that meets their needs. Listening to and learning from complaints can highlight where support or services need to be changed.

If integration is to produce seamless services for the people who use them, I agree with the Health and Social Care Alliance Scotland that health and social care partnerships must be required to provide a clear single route into complaints processes as that is one means of ensuring that the needs and experiences of service users can be listened to and learned from, and can help to drive improvement. Complaints processes are a key accountability mechanism to enable people to access their rights in relation to health and social care. Complaints handling arrangements have the potential to be further complicated through integration, but the bill makes no reference to the complaints process.

I decided not to move an amendment similar to amendment 95 at stage 2. I reserved my position after hearing the cabinet secretary say that a new social work complaints system is under development that "will be more accessible, allow complaints to be completed faster and produce a co-ordinated response for the complainant."—[Official Report, Health and Sport Committee, 21 January 2014; c 4754.]

However, the Health and Social Care Alliance Scotland, which raised the issue with me, still believes that the bill would be strengthened by the inclusion of a reference to ensuring effective access to a complaints system. As the development of the new system is still work in progress, I lodged amendment 95 for Parliament’s consideration at stage 3.

I support Malcolm Chisholm’s amendments 96 and 97, which aim to ensure that those in leadership positions with expertise in delivering care will have a clear route to share their expertise with integration authorities. The Government supported the involvement of medical and social work leads in its policy statements on secondary legislation at stage 2 and agreed to reconsider the place of senior nurses at stage 3. I would like to hear from the cabinet secretary that nurses, as well as doctors and social workers, should be similarly involved with integration authorities.

I move amendment 95.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I support Nanette Milne’s amendment 95. However, my amendments 96 and 97 relate to the quality, safety and standards of service, which I am sure we all agree must be absolutely central to the integration reforms. Moreover, I think that regulated professionals with accountability for providing high-quality care should also be central, with structures that support them to deliver their responsibilities meaningfully. In view of that, it is regrettable that there is little if anything about care governance arrangements in the bill. Quite rightly, there is a great deal about financial arrangements and arrangements for the delegation of functions, but I think that there is a gap in relation to care governance. I think that the fairly modest amendments 96 and 97 would help to fill that gap.

The cabinet secretary might say that his policy statement on section 12, which clearly is not in the bill itself, refers to the clinical director and chief social worker being non-voting members of the integration joint boards. That is all well and good as far as it goes, but I think that we need something more explicit about exactly the advice that will be sought from them and the arrangements for that. However, there is a glaring omission—Nanette Milne referred to this point—because there is no mention of the chief nursing officer in relation to the policy statement on section 12 or, as far as I can see, in relation to any other policy statements or words of the bill.

As someone who made sure—if I am allowed to say that—that the chief nursing officer was a member of every national health service board, I am particularly concerned about this issue, as members will appreciate. However, to be fair, the cabinet secretary was also concerned when I lodged an amendment at stage 2 that was similar but not identical to amendments 96 and 97. At the end of his winding-up speech, he said:

“Mr Chisholm’s one point that is worthy of further consideration—”

it was rather unworthy to say that I had only one point—

“is about whether the chief nursing officer in each board area should be included in the list that is in the bill. I am prepared to consider a stage 3 amendment to that effect. I accept his point, as 43 per cent of health service employees in Scotland are nurses and midwives.”—[Official
Perhaps the health secretary forgot his words, so very helpfully I have proposed amendments about arrangements for seeking the advice of professional leads who are experts in the delivery of quality care. Crucially, the professional leads referred to in the amendments include the chief nursing officer.

Many partnerships may well make arrangements that are similar to what I propose, but I believe that primary legislation should set out minimum mandatory expectations. My amendments provide a minimum guarantee that those who are able to make professional judgments on the quality of care can support innovation and development, improve decision making and raise concerns where appropriate.

If, by any chance, I am taken by surprise and the cabinet secretary does not support my amendments, I would at the very least urge him to insert the words “chief nursing officer” into the policy statement on section 12 because, by his own admission at committee, that was a glaring omission. Obviously, however, I would prefer him to support the amendments.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I support all three amendments in the group. The issue of complaints systems is important.

The cabinet secretary will remember that, during consideration of the Patient Rights (Scotland) Bill, we had an extensive debate about introducing a new system based on the four Cs—compliments, comments, concerns and complaints—as a modification of the system that had been introduced in the state hospital. There is a danger that, without Nanette Milne’s amendment 95, we will end up with an increased landscape and increased complexity rather than reduced complexity. Her amendment, which means that we would at least have

“a single point of entry to complaints systems for all services”,

is an initial step, but in the longer term we must simplify the overall system, because even with the amendment, there will still be multiple points of entry for complaints. A person has to decide whether they are a patient, someone who receives social care or someone who receives social work assessment, and those are just three examples of the different systems that exist at present.

I also support Malcolm Chisholm’s amendments 96 and 97, particularly in respect of nurses. The bill, if nothing else, is about the integration of community services, and in modern community services, nurses are often in the leadership positions. They need to be included, so I very much support amendment 97.

Alex Neil: First, I will deal with the complaints system. I recognise that the system for social work complaints is no longer up to date or adequate. That is why we are working to develop a new system that will be more accessible, better co-ordinated and quicker. I will use existing powers in relation to secondary legislation to make those changes, which is why we do not need any additional provisions in primary legislation. I already have the powers that I need to make the necessary changes.

I am confident that, when we make those changes, Nanette Milne and others will realise that the intention of her amendment 95 will be achieved under my existing powers. The bill is not the appropriate legislative vehicle in which to make changes to the complaints system, especially when we have not consulted on them as part of consideration of the bill. When I produce a final set of proposals, we will consult people before we implement them.

I agree with the spirit of Malcolm Chisholm’s amendments 96 and 97, as it is clearly fundamental that health boards and local authorities seek advice from health and social care professionals on all aspects of integrated service planning and delivery. However, I do not agree with the way in which the amendments seek to achieve that. I say again that we are on the same page. The only issue is how best to achieve our shared objective.

My first concern, which I described during the stage 2 sessions in committee, is that I do not believe that it is appropriate to name some health and social care professionals in the bill but not others, and thereby to make a distinction between those who are named and those who are not. It is equally important that, for example, the views of the director of public health, general practitioner representatives and allied health professionals, among others, are sought and considered. I will expect integration schemes to describe the engagement process for all professionals and not just a few, as Malcolm Chisholm suggests.

Furthermore, amendments 96 and 97 do not include non-statutory partners in health and social care. To my mind, users and carers have a lead role in describing what a quality service should be, and the third sector is a significant provider of care services.

Malcolm Chisholm: I hear what the cabinet secretary says, but the fact of the matter is that the policy statement on section 12 specifically names the clinical director, who will be a doctor, and the chief social work officer. There is no logic whatsoever in not also naming the chief nursing
Alex Neil: The logic is that a senior medic and a senior social worker in the role of chief social work officer had to be made clear in the bill, particularly in relation to the responsibilities of the chief social work officer, who has to attend partnership boards as part of their role. There is a distinction because the bill refers specifically to the statutory function of those two positions.

Integration schemes will be required to provide detail on the arrangements for engaging with those groups of stakeholders as well. I am prepared to specify, for example, the chief nursing officer in the guidance that we will issue after further consultation. As I said, if we start to name everyone in the bill, it will become very long and people who should be named will still be left out. It is therefore far better to specify those people in regulations and guidance than to name them in the bill.

Amendments 7 and 19 strengthen regulation-making powers with regard to the content and effect of the integration scheme, and I will ensure that we set out appropriate processes for the engagement of professionals and non-statutory stakeholders. We are on the same page. We are trying to achieve exactly the same objective, but it is better not to take those particular measures into the bill but to put them into guidance and regulations and, where appropriate, secondary legislation.

On that basis, I invite Nanette Milne to withdraw amendment 95 and ask Malcolm Chisholm not to move amendments 96 and 97.

Nanette Milne: This is beginning to sound a bit like a rerun of the Health and Sport Committee meeting at stage 2, when we were, “All on the same page, but—”

I hear what the cabinet secretary says about the complaints system; as we know, he said it at the committee as well. However, this is still a work in progress. We do not know what the new system will be, so I press amendment 95.

The Deputy Presiding Officer: The question is, that amendment 95 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division. As this is the first division of the afternoon, the Parliament is suspended for five minutes, after which there will be a 30-second vote.
Amendment 95 disagreed to.

Amendment 96 moved—[Malcolm Chisholm].

The Deputy Presiding Officer: The question is, that amendment 96 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.
Amendments 5, 6, 94, 98 and 99 make minor adjustments to section 1 and the schedule to include functions conferred by virtue of an enactment as well as functions conferred directly by an enactment.

Amendments 91 to 93 make minor additions to the list of enactments set out in the schedule to the bill that confer functions that may be delegated.

I move amendment 5.

Amendment 5 agreed to.

Amendments 6, 98, 99 and 7 moved—[Alex Neil]—and agreed to.

Section 2—Integration schemes: two or more local authorities in Health Board area

The Deputy Presiding Officer: Group 3 is on local authorities and functions that may be delegated. Amendment 5, in the name of the cabinet secretary, is grouped with amendments 6, 94, 98 and 99 to 94. Amendment 5 makes minor adjustments to section 1 and the schedule to include functions conferred by virtue of an enactment as well as functions conferred directly by an enactment. Amendment 91 to 93 make minor additions to the list of enactments set out in the schedule to the bill that confer functions that may be delegated.

I move amendment 5.

Amendment 5 agreed to.

Amendments 6, 98, 99 and 7 moved—[Alex Neil]—and agreed to.

Section 4—Integration planning principles

The Deputy Presiding Officer: Group 5 is on principles. Amendment 9, in the name of the cabinet secretary, is grouped with amendments 100 to 102, 10, 103 to 105, 47, 108 to 110, 48, 111 to 113, 49, 118 and 89. Amendment 9 makes minor adjustments to section 4 and the schedule to include functions conferred by virtue of an enactment as well as functions conferred directly by an enactment. Amendment 91 to 93 make minor additions to the list of enactments set out in the schedule to the bill that confer functions that may be delegated.

I move amendment 8.

Amendment 8 agreed to.
lodged a number of amendments at stage 2 to further strengthen the integration principles.

Amendments 10 and 48 in my name ensure that the rights of service users are taken into account and further embed a rights-based approach in the bill.

Nanette Milne’s amendments 101 and 109 are not necessary. Amendments 10 and 48 in my name, together with the requirement to consider the particular needs of different service users, already take into account the abilities and wishes of service users.

Health boards and local authorities are already subject to statutory requirements and guidance in relation to assessment. However, given the importance of considering individuals’ needs within an integrated approach to care, I intend to provide statutory guidance on this matter. The guidance will provide further support to health boards and local authorities to ensure that their understanding of “need” is appropriate.

In considering the use of the term “independent living” in amendments 100 and 108 in the name of Malcolm Chisholm, I accept and agree—as I noted at stage 2—that it is important to ensure that those principles and ideals are reflected in standards of planning, delivery and design of services. Terms such as “independent living” are, by their nature, potentially subject to changing or differing interpretation. The integration principles must apply equally to all users of health and social care services covered by the bill, not only vulnerable or disabled people. We will continue to embed the Scottish Government’s vision statement on independent living for disabled people in all the work that we do, including as we take forward integration.

Including the need for access to independent advocacy services has not been consulted on with stakeholders and has not been costed. It is not clear how, or by whom, those services would be delivered, nor is it clear whether there is capacity within advocacy services in Scotland at present to service such a commitment.

On individual choice, it is important to distinguish between the requirements that the Social Care (Self-directed Support) (Scotland) Act 2013 places on local authorities to provide choice and control over social care services and the purpose of the bill, which is to bring together the responsibilities, accountability, delivery and planning for health and social care services.

Choice and control cannot apply equally to all service users in all circumstances and to all health and social care services under the bill. What is important is that the integration planning and delivery principles require the health board, local authority and integration authority to consider the needs of service users and to plan for integration and to deliver services from the perspective of the service user. Therefore, I cannot support Malcolm Chisholm’s amendments 104 and 112.

It is important that the care that people receive is delivered in a person-centred way. That is, they should receive the right care, at the right time, in the right place. That will, naturally, be different for different individuals and in different circumstances. We cannot take a simplistic, one-size-fits-all approach. However, good professional practice will, of course, include appropriate recording of hours to meet the needs of individuals.

We also cannot recognise one set of individuals who provide care and support over any other group, be they unpaid carers or paid staff in the employment of health boards, local authorities, third sector organisations or independent contractors. It is, of course, important that everyone who makes a contribution to good-quality care is recognised for doing so.

I assure members that I continue to meet many of the stakeholders who have expressed support for the opposition amendments in the group. I am fully committed to continuing that dialogue and to examining ways that we can build those considerations into regulations and guidance, but the opposition amendments in the group do not achieve the aims that they seek.

I ask Malcolm Chisholm not to move amendments 100, 103 to 105, 108 and 111 to 113; Nanette Milne not to move amendments 101, 102, 109 and 110; and Neil Findlay not to move amendments 49 and 89.

I move amendment 9.

The Deputy Presiding Officer: Before I call the next five members who wish to speak on this group, I ask members to show courtesy to the cabinet secretary and all members who are participating in the debate and take their conversations outside the chamber.

Malcolm Chisholm: Thank you, Presiding Officer. I apologise to you and the cabinet secretary. I think that I heard most of his speech, but there was a good reason why I had to leave the chamber after my previous speech: I handed in to the official report my notes for this speech, which is not an error that I recommend to members.

The reason why I needed my notes back is that on them is a definition of independent living that, I am told, has been accepted by the cabinet secretary, COSLA, NHS Scotland and the Scottish independent living coalition. In particular, it has been accepted in a document called “Our Shared Vision for Independent Living in Scotland”.

A few moments ago, I heard Alex Neil say that there was no clear, indisputable definition of independent living. If I wanted to be unkind, which I never am, I could say that we spent a whole afternoon agreeing amendments about sustainable economic growth in a certain bill a few weeks ago, when it is generally agreed that there is no generally accepted definition of that concept. That did not stop the Scottish Government.

There is a more accepted definition of independent living that I will read out, because there is time. Independent living means “disabled people of all ages having the same freedom, choice, dignity and control”—

choice and control will come up later as well—

“as other citizens at home, at work, and in the community. It does not mean living by yourself, or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life.”

I think, therefore, that there is an accepted definition of independent living, and I think that it would be helpful if it were in the bill. There is certainly a great demand for that from many groups. In the committee, it might have been suggested that only certain people have independent living, but we all have it. Obviously, however, disabled people have had to fight for it. They, in particular, would welcome the inclusion of the definition in the bill.

15:00

The same applies to the word “rights”. Again, I welcome the cabinet secretary’s change of heart. When I moved a similar amendment in the committee, he argued that it was not necessary to add particular words about rights in the bill because, clearly, all Scottish Parliament legislation has to be consistent with the European convention on human rights. In fact, however, there is a particular, rights-based approach to health and social care that was recognised by the Government in the Social Care (Self-directed Support) (Scotland) Act 2013 and, in committee, we simply asked why we could not also have it in the bill. We should commend the cabinet secretary’s movement on the issue, which means that we will have words in the bill about respecting the rights of service users. I seek to build on that by echoing words from the 2013 act, which refers to service users’ “right to dignity”, and to their “right to participate in the life of the community in which they live. Those are just slight changes to the words that the cabinet secretary has put into the bill, in order to reflect the rights-based language of the 2013 act. As he has taken the first step on rights, I hope that he will take the next step and accept those amendments.

My other amendments are about choice and control, words that I have already quoted and that have met with the cabinet secretary’s approval in that context. The key words in amendment 104 concern the service users’ right to participate in decisions. I think that we all accept that that is crucial to a person-centred approach to health and social care. One of the big changes that has gradually been taking place over the course of the past few years is the move from the old, paternalistic models of health and social care to those in which patients or service users or whoever have the right to participate. That is generally accepted, but I think that the words “choice” and “control” are also important. The question of who is capable and who is incapable of exercising choice and control is part of a long-standing, well-researched and well-rehearsed debate. However, what is important to state is that it is vital not to roll back the years of progress in extending opportunities for choice and control. There is plenty of evidence that, with the right support, even people with profound difficulties and impairments, as well as, of course, frail, older people, can exercise choice in their lives. I therefore reject what the cabinet secretary said in committee and repeated today about it not being appropriate to place certain people in such a category.

I support the other amendments in this group, including, obviously, Neil Findlay’s, and also Nanette Milne’s. Issues about advocacy were raised in the committee, but I accept the wording that she has suggested in amendment 102, about taking account of “the need for access to independent advocacy”.

Nanette Milne: This group of amendments builds on a series of amendments at stage 2 that placed human rights principles more clearly at the heart of integration planning and delivery principles, giving respect to a person’s dignity and participation in the community, replacing the term “recipients of care” with “service users”, and amending the principles to ensure that service users, unpaid carers and those involved in health and social care from across the sectors are engaged in the planning and local delivery of services.

My amendments 101 and 109, by making explicit reference to people’s aspirations and abilities, as well as needs, and Malcolm Chisholm’s amendments 104 and 112, which refer to choice and control, more strongly reflect human rights and, particularly, a more person-centred approach, and strengthen amendments 10 and 48, in the name of the cabinet secretary, which I also support.

Also further embedding human rights in the legislation are Malcolm Chisholm’s amendment
108, referring to independent living, amendment 111, promoting service users’ right to dignity, and amendment 113, regarding the right of service users

"to participate in the life of the community in which they live".

My amendments 102 and 110 would ensure that consideration was given to supporting service users through access to independent advocacy. An independent advocate can help people to express their own needs and make informed decisions, and speak on behalf of people who are unable to speak for themselves or who choose not to do so. Ensuring that independent advocacy is included for those who wish to access it would support the bill’s aims and principles and help to ensure that the voices of individuals and communities are at the heart of the planning, design, delivery and review of services.

I await Neil Findlay’s contribution on his amendment 49 before I decide whether to support it.

Neil Findlay: Amendment 49 will address one of the fundamental problems with the current social care system: poverty pay. Social care in Scotland is rapidly becoming a minimum wage sector. Councils that are hamstrung by underfunding and cuts to budgets and without the ability to set their own taxes are forced into externalising services and cutting the costs of contracts to third sector and other organisations. Voluntary groups tell us that they simply cannot and will not provide the services that are needed, because they cannot fulfil contracts at current prices. Councils are trying to make savings, but they can cut from the same cloth only so often.

A number of voluntary organisations tell us that they want out of the care sector altogether. That move is driven not by the needs of their clients but by their need to survive. Many want to speak out on that issue, but will not do so for fear of what would happen to their local and national funding.

Meanwhile, more than 40,000 home care workers are trying to exist on poverty pay; 40,000 people are paid below the living wage. The esteem in which the job is held is at an all-time low. Staff are often not paid for travelling time, some have to pay for their own phone calls back to their base, and training budgets have been slashed. In a society in which we pay footballers £300,000 a week, young care staff are paid as little as £5.13 an hour to look after our mums and dads, grannies and granddads, and elderly friends and relatives. That is a national embarrassment and a scandal that must be brought to an end.

Staff need to be rewarded in a way that protects the services that they provide, and that should be done by introducing the living wage. If the Scottish Government does not implement the living wage for care staff across the country and fund local government appropriately to do so, Labour will.

Neil Findlay: If the living wage is good enough for NHS staff, it is good enough for staff who support the same patients and clients when they return to the community. Therefore, I ask members to support amendment 49.

Amendment 89 seeks to end the culture of strict time-limited care visits. Last week, Unison released its “Time to care” survey, in which it reported that 56 per cent of its members who were questioned were on time-limited care visits. Many members complained bitterly about the pressures that they are under and the impact on those for whom they care. I hope that the cabinet secretary has read that shocking report; if he has not, I will give him a copy.

In its briefing on amendment 89, the Coalition of Care and Support Providers in Scotland reported that its members have a policy of refusing to tender for work that is on a 15-minute schedule because

"it does not align with their approach to care and support; others believe that they would not be able to provide an acceptable quality of service within this time frame, especially to people with complex needs; and others again have based their decision on their experience of providing 30-minute visits (with one member commenting that in their view, 15 minutes would be too short even for ‘welfare’ visits)." 

It went on to say that 15-minute visits are

"increasingly a feature of care at home framework contracts."

Those comments come directly from the front line. We should listen to those concerns.

In a recent report, Age Scotland highlighted that care visits are now down to as little as seven minutes. I know that the cabinet secretary is a rather sprightly, fit young man, but I am sure that, even for an athlete such as he, washing, dressing, cooking, feeding and toileting would be a challenge in 15 minutes, never mind seven minutes. I urge people to think of the challenges that care workers face in trying to help people who have mobility problems or an illness such as cancer or dementia. Time and task visits run totally contrary to a person-centred approach. They run contrary to a human rights-based approach and common decency, dignity and respect.

If personalisation and human rights mean anything we have to change conveyor belt care, which is an affront to people’s dignity and the staff who want to provide a good service but have
some of the worst working conditions of any group of people working in the health and social care sector. The duration of a care visit must reflect the needs of the client, which is what amendment 89 seeks to ensure. I hope that the cabinet secretary accepts that important amendment, as this issue and poverty pay are two of the most important elements that undermine the quality of care that is provided in Scotland, and they are largely ignored by the bill.

**Gil Paterson (Clydebank and Milngavie) (SNP):** As a member of the Health and Sport Committee, I have been pleased to work on the bill in committee at stages 1 and 2. The guiding principle has been for the bill to be person centred, to ensure that service users are at the heart of service planning and delivery.

With people in Scotland living longer and the number of people with complex illnesses increasing, there is a huge challenge ahead for our health service. To meet that challenge there must be a joined-up approach, which is why it is vital to integrate health and social care services, which are indeed person centred. If we do not do that, there is a danger that those who need support at a vital time could be missed or passed from pillar to post, without receiving the best service.

During stage 2, members lodged a number of amendments. After lengthy discussions we believed that those amendments would not strengthen the bill and we rejected them. I am still of that opinion, which is why I urge members to vote against the non-Government amendments before them.

**Jim Hume:** Malcolm Chisholm’s amendment 100 and Nanette Milne’s amendment 101 are useful and important additions to the bill. They focus us and the legislation on the fact that person-centred care is what we all want to achieve.

For once, I disagree with the cabinet secretary about the term “independent living”, and I concur with Malcolm Chisholm. I add the United Nations to the list of organisations that recognise the term “independent living”. The UN Convention on the Rights of Persons with Disabilities refers to independent living and we could not argue with the UN. The convention states:

“Recognizing the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices.”

That is a strength of Malcolm Chisholm’s amendment 100.

Nanette Milne’s amendment 101 also recognises that person-centred care is a desired outcome of the bill. We know that beds are scarcer now and that most people wish to be treated at home.

We will support Malcolm Chisholm’s and Nanette Milne’s amendments and in doing so we will put into legislation person-centred care and independent living as the focus of delivery.

**Alex Neil:** I will deal with the points that have been raised as comprehensively as I can.

I fully accept the intention of Nanette Milne’s amendments, which are already reflected in the principles outlined at the start of the bill. To add to them at this stage would not be very helpful. A lot of the detail in her amendments would be more appropriately covered in regulations and guidance.

With regard to independent living, the bill’s principles must apply equally and appropriately to all users of health and social care services under the bill, not just vulnerable or disabled service users. They must also apply to children, able-bodied adults who suffer injury or disease, older people in residential homes and adult prisoners. Although the Scottish Government and COSLA have signed up to an independent living vision statement, as Malcolm Chisholm said, it is an entirely different matter to set out in primary legislation a static definition. It is worth noting that the UNCRPD describes “living independently”, so there are already different interpretations and definitions of “independent living”.

15:15

Furthermore, it is proposed that the national health and wellbeing outcomes, which will be prescribed in secondary legislation, will have an outcome on independent living. Secondary legislation provides for more flexibility when legislating on matters that may change over time.

I have no issue at all with the principle of what we are trying to achieve. We are all on the same page and we are all trying to achieve the same objective. However, if we build certain definitions into law, that can work against the people we are trying to help and we can end up in a legalistic fight when we want to get on with the job of ensuring that the services are properly designed, planned and delivered.

Neil Findlay’s amendments would not do what he said he wants to do. I will explain one of the reasons why, although it is not the only reason—and I support the living wage. Had the European Union’s Lisbon treaty allowed it, the Procurement Reform (Scotland) Bill would have incorporated a provision whereby the providers under every public contract would have had to offer the living wage before they could even be considered for the tender. When we took advice, we were strongly advised by the European Union that that was
totally unacceptable under the terms and conditions of the Lisbon treaty. We therefore have to consider other ways to ensure a good-quality standard of living for people working in the social care sector. I fully accept the need to do more.

Neil Findlay: Senior figures in the European Commission, including its President, offer the Scottish Government a lot of advice, some of which it wants to ignore. Is it a choice as to which advice the Scottish Government listens to?

Alex Neil: We listen to advice from officials who are properly informed in the law; not everyone is, even at a very senior level.

That was the situation, and the Procurement Reform (Scotland) Bill could have been called in if we had included such a provision in it.

I absolutely accept the general principle that we have to do more in relation to people working in the social care sector, and we are in discussion with representatives of the sector about how best to do that.

Neil Findlay: Will the minister take another intervention?

Alex Neil: I will not take another one.

Neil Findlay: Will the minister take another intervention on that point?

The Deputy Presiding Officer: The minister has said no.

Alex Neil: I should gently point out to Neil Findlay that the situation would have been helped had the minimum wage been raised in line with inflation in recent times, which is not the case.

Neil Findlay: Will the minister take an intervention?

Alex Neil: I fail to understand why Neil Findlay is voting for a union in which the real-terms value of the minimum wage has been decreased, instead of voting for independence, when we have a commitment to raise the minimum wage in line with inflation.

Amendment 9 agreed to.

Amendment 100 moved—[Malcolm Chisholm].

The Deputy Presiding Officer: The question is, that amendment 100 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beanish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)
Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilnamock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Pertshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Amendment 101 moved

Amendment 100 disagreed to.

The question is, shall amendment 101 be agreed to?

The division is: For 54, Against 62, Abstentions 0.

The Deputy Presiding Officer: The result of the division is: For 54, Against 62, Abstentions 0.

Amendment 100 disagreed to.

Amendment 101 moved—[Nanette Milne].

The Deputy Presiding Officer: The question is, that amendment 101 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahan, Michael (Uddingston and Bellshill) (Lab)
McMahan, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greeenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfrieshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (SNP)
Scalan, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eddie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
The Deputy Presiding Officer: The result of the division is: For 54, Against 62, Abstentions 0.

 Amendment 101 disagreed to.

 Amendment 102 moved—[Nanette Milne].

 The Deputy Presiding Officer: The question is, that amendment 102 be agreed to. Are we agreed?

 Members: No.

 The Deputy Presiding Officer: There will be a division.

 For
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchan, Cameron (Lothian) (Con)
Carlaw, Jackie (North Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glascow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfries and Galloway) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Dorris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eddie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbraid) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
The result of the division is: For 52, Against 64, Abstentions 0.

Amendment 102 disagreed to.

Amendment 10 moved—[Alex Neil]—and agreed to.

Amendment 103 moved—[Malcolm Chisholm].

The Deputy Presiding Officer: The question is, that amendment 103 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northem and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfries and Galloway) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)

Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
The Deputy Presiding Officer: The result of the division is: For 53, Against 61, Abstentions 0.

Amendment 103 disagreed to.

Amendment 104 moved—[Malcolm Chisholm].

The Deputy Presiding Officer: The question is, that amendment 104 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Ferguson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser-Murdo, Mid Scotland and Fife (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, lain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Mid Scotland and Islands) (Lab)

Against
Adam, George (Paisley) (SNP)
Adamson, Clara (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Pertshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabian, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Graham, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
Amendment 105 moved—[Malcolm Chisholm].

The Deputy Presiding Officer: The question is, that amendment 105 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glascow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)

Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Alieen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willis (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Graham, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Roberson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 54, Against 62, Abstentions 0.

Amendment 105 disagreed to.

The Deputy Presiding Officer: I ask for order in the chamber when results are being given.

Section 5—Power to prescribe national outcomes

The Deputy Presiding Officer: We move on to group 6, on the national health and wellbeing outcomes. Amendment 11, in the name of the cabinet secretary, is grouped with amendments 12, 13, 119 and 87.

Alex Neil: Amendments 11 to 13, 119 and 87 relate to the provisions that enable the Scottish ministers to prescribe national outcomes for health and wellbeing.

Amendments 11, 12 and 87 clarify what the national outcomes for health and wellbeing are, as defined by the bill, and where they are to be found, for readers of the National Health Service (Scotland) Act 1978.

Amendment 13 will add housing stakeholders to the list of persons whom the Scottish ministers must consult before they prescribe national outcomes for health and wellbeing. It is particularly important to ensure a strong role for housing in integration. After all, it is our policy commitment to enable people to be cared for at home or in another homely setting for as long as possible. Amendment 13 provides that assurance.

Amendment 119 is a minor amendment that is consequential to amendments 11, 12 and 18.

I move amendment 11.

Rhoda Grant (Highlands and Islands) (Lab): I welcome amendment 13 and the involvement of housing providers. Providers of sheltered and supported care have a lot to contribute to enable people to stay at home and be more independent for longer, so it is important that they are involved.

Amendment 11 agreed to.

Amendments 12 and 13 moved—[Alex Neil]—and agreed to.

Section 7—Approval of integration scheme

Amendment 14 moved—[Alex Neil]—and agreed to.

Section 11—Other staff of integration joint board

The Deputy Presiding Officer: Group 7 is on integration joint boards: staff, finances and so on. Amendment 15, in the name of the cabinet secretary, is grouped with amendments 16 to 18.

Alex Neil: Amendment 15 provides clarity with respect to the order-making power in section 11 to enable integration joint boards to employ staff other than a chief officer. The word “employ” is used, rather than “appoint”, to make it clear that what is envisaged under such circumstances is a relationship of employment.

Amendment 16 will remove section 11(3), because it is not considered necessary.

Amendments 17 and 18 reflect the position that the chief officer is accountable for all matters that relate to the integration joint board, and they enable the integration joint board to appoint an officer for matters of financial administration. The effect is to allow the integration joint board to place financial accountability in the hands of a finance professional, if the board agrees that that is appropriate, which will strengthen the financial governance of the integration joint board. Such an arrangement will not be obligatory—the chief officer can be the accountable officer for all matters, including financial administration—but the approach allows for local flexibility.

I move amendment 15.

Amendment 15 agreed to.

Amendment 16 moved—[Alex Neil]—and agreed to.

Section 12A—Integration joint boards: finance and audit

Amendments 17 and 18 moved—[Alex Neil]—and agreed to.

After section 18

Amendment 19 moved—[Alex Neil]—and agreed to.
Section 18A—Health funding: further provision
Amendment 106 moved—[Alex Neil]—and agreed to.

Section 19—Transfer of staff: effect on contract of employment
Amendments 20 and 21 moved—[Alex Neil]—and agreed to.

Section 20A—Carrying out of functions conferred on officers of local authorities
The Deputy Presiding Officer: Group 8 is on the carrying out of functions that are conferred on officers of local authorities and health boards. Amendment 22, in the name of the cabinet secretary, is grouped with amendments 23 to 31.

15:30

Alex Neil: The amendments will ensure that sections 20A and 20B operate in practice in the intended way. The deeming provisions in those sections are necessary to ensure that certain specific functions operate properly when health and social care functions are integrated.

Amendments 24, 26, 29 and 31 provide that the deeming provisions in sections 20A and 20B relate only to provisions that are prescribed by regulations. Amendments 22 and 27 are minor amendments to refer to functions that are conferred on local authority and health board officers by, or by virtue of, an enactment. Amendments 23 and 28 provide that, before the deeming provisions apply, any additional conditions that are prescribed by regulations must be satisfied. The amendments will make the position subject to further ministerial control, to ensure on a case-by-case basis that it is appropriate for section 20A(2) or 20B(2) to apply to a particular function.

Amendments 25 and 30 are minor amendments to ensure that sections 20A and 20B apply when an integration authority is a health board and local authority acting jointly, as provided for under section 42(d), so that staff of either body can carry out any function to which sections 20A and 20B apply.

I move amendment 22.

Amendment 22 agreed to.

Amendments 23 to 26 moved—[Alex Neil]—and agreed to.

Section 20B—Carrying out of functions conferred on officers of Health Boards
Amendments 27 to 31 moved—[Alex Neil]—and agreed to.

Section 22—Directions by integration authority
The Deputy Presiding Officer: Group 9 is on directions by an integration authority. Amendment 32, in the name of the cabinet secretary, is grouped with amendments 33 to 42.

Alex Neil: Amendments 32, 33 and 36 make it clear that a person who is carrying out a function under a direction from an integration authority is accountable for carrying out that function.

Amendment 34 clarifies finance matters as they pertain to directions and provides that, when a health board function that is carried out in a hospital that serves two or more local authority areas has been delegated, the direction must set out the amount that the health board has set aside for use by the person who is to carry out the function. Amendment 37 requires the direction to include instructions on how the amounts that have been set aside or paid are to be used.

Amendments 35 and 39 provide consistency with amendment 34. Amendment 38 provides consistency on liability, as set out at stage 2. Amendment 40 removes a redundant provision that is unnecessary to achieve the required effect.

Amendments 41 and 42 clarify the circumstances in which the Scottish ministers may make an order to provide that an integration joint board may decide not to issue directions as being when the Scottish ministers consider that an order would not only contribute to achieving the national health and wellbeing outcomes but further achieve the integration delivery principles.

I move amendment 32.

Amendment 32 agreed to.

Amendment 33 moved—[Alex Neil]—and agreed to.

Section 22A—Section 22: supplementary
Amendments 34 to 42 moved—[Alex Neil]—and agreed to.

Section 23—Requirement to prepare strategic plans
The Deputy Presiding Officer: Group 10 is on integration authority: strategic planning. Amendment 43, in the name of Rhoda Grant, is grouped with amendments 44, 107, 45, 46, 114 to 116, 50 and 117.

Rhoda Grant: Amendment 43 is about allowing people who require support packages to move with confidence between local authority areas. Currently, the person must live in a local authority area before he or she can be assessed for care. That prohibits people from moving because they...
have no confidence in the services that they will receive, or in whether the services will be adequate for their particular needs.

People need to move for personal and work-related reasons, therefore it is important that when they make those decisions they have confidence that what they will receive from a service provider is adequate for their needs immediately, when they move. They also need to take into account the different rates that different local authorities charge for services. That must be factored in if they are moving for work-related reasons. The rest of us would factor in things such as pension payments, overtime and travel to work, but they need to factor in the cost of living within an area before they can make a decision. Therefore, it is important that they have that information as soon as possible when they start to consider such decisions. That is a basic human right that the rest of us take for granted.

We all know that moving house can be daunting and it is not a decision that we take lightly, but it is much more difficult for someone who is dependent on assistance to live their life. Amendment 43 would place on local authorities a duty to take into account the needs of service users who move into their areas. That must be put into action as quickly as possible to allow those people to make those decisions and to have informed choices.

Amendment 116 would ensure that a representative of service users and a representative of carers were placed on the strategic planning group. It is important that we embrace co-production. Care is not something that just happens to people; it is something that they should have control over in terms of both its design and what it helps them to achieve. They must have autonomy in that and they must be involved in how we design their care.

Person-centred care is widely recognised, but sometimes it is delivered in a paternalistic way. We need to recognise that when people need assistance to live and go about their daily lives, they are still entitled to live their lives as they see fit. Amendment 116 would put those principles at the heart of service design, so I urge members to support it.

I also support the other amendments in the group, especially Nanette Milne’s amendment 117, which would involve the voluntary sector in the strategic plan, which I think is very important.

I move amendment 43.

**Alex Neil:** The amendments in the group relate to integrated strategic planning, which lies at the heart of the bill and the process of reform.

The aim of Rhoda Grant’s amendment 43 is to improve portability of services when a service user moves between two local authority areas. I am sympathetic to Rhoda Grant’s concerns in that regard. When we updated guidance on the issue in 2010, we were made aware of how difficult it can be for people to move if they are not sure that the care services that they need will be in place when they move.

However, I do not believe that amendment 43 provides a workable approach to tackling that challenge. The provision of a service by a local authority to a service user is based on the person’s physical presence in that local authority area, so a local authority cannot begin to provide services to an individual until the service user is physically present in its area.

As I said, however, I am aware of the importance of the issue. The bill will place a duty on integration authorities to have regard to the effect of their strategic plans on other integration authorities, which provides for the broad imperative that no integration authority can plan for and deliver care in isolation from others. The bill also places service users firmly at the centre of service planning and delivery and will embed their perspective within all the processes of co-production that it describes.

For those reasons, I cannot support amendment 43 and call on Rhoda Grant to seek to withdraw it.

Nonetheless, I commit to continuing to work closely with stakeholders and partners on guidance to ensure that local systems set up effective voluntary systems that work together to carry out assessments in advance of a person moving between local authority areas, especially for people who may move frequently, such as Gypsy Traveller communities.

The effect of Rhoda Grant’s amendment 116 and Nanette Milne’s amendment 117 would be to provide that the service user, a representative of carers and a broad range of third sector organisations would all be directly involved in strategic planning. The amendments are not necessary. At stage 2, I provided the Health and Sport Committee with policy statements that made clear my intention to set out in regulations which groups of people must be included in local strategic planning groups. Under those regulations, service users, carers and representatives of the third sector will be included. It would be disproportionate to list individual groups in the bill, while leaving the involvement of other key parties, such as health boards, local authorities, GPs and social care professionals, to regulations. Therefore, I do not support amendments 116 and 117 and call on Rhoda Grant and Nanette Milne not to move them.

I turn to the amendments in my name. Amendment 44 will ensure that, when an
integration authority sets out a start date for integration in its strategic plan, that date can only be earlier than the date that will be prescribed by the Scottish ministers for integration to begin.

Amendments 45 and 46 are minor amendments that will provide clarity that the integration authority must have regard to the effect of its strategic plan on services, facilities and resources used.

Amendment 50 makes it clear that the strategic planning group is the integration authority’s, not the constituent authority’s. It also allows for the fact that a health board may have representatives on more than one strategic planning group if it is involved in integrated arrangements with more than one local authority.

Amendment 107 will correct a reference to another section of the bill.

Amendment 114 is a minor amendment that will ensure that it is clear that it is the local authority that will nominate its representative on the strategic planning group.

Amendment 115 is a minor amendment that will ensure that it is clear that, when the integrated arrangement includes more than one local authority with a single health board, it is the local authorities that will nominate their representative on the strategic planning group.

Amendment 117 is, arguably, the most important of my amendments. It respects the third sector as a key strategic partner, alongside health boards and local authorities. The third sector forms a major part of the wider health and social care landscape, particularly in relation to preventative support, and it delivers more than a third of registered social care. As such, its role should certainly be clearly articulated in statutory guidance and secondary legislation, if not in the bill.

The Health and Social Care Alliance and many others have called, and continue to call, for third sector sign-off of strategic plans that are prepared by health and social care partnerships. They cite the fact that the sector’s involvement in joint signing-off under the reshaping care for older people change fund has enabled many areas to overcome barriers to partnership and has been a key driver for the cultural change that is widely acknowledged to be the essential foundation of integration. The sector thinks that without its having a more formalised role there is a risk that the bill will not fully achieve its policy objectives.

Although the arrangements that amendment 117 proposes are not as strong as the joint sign-off arrangements under reshaping care for older people, the Health and Social Care Alliance has given its support to my amendment, which proposes that third sector organisations be invited to express their views on draft strategic plans, and that those views would have to be taken into account. That would help to embed in the bill the role of the third sector as a key strategic partner.

I am happy to support Rhoda Grant’s amendment 43, which would require strategic plans to set out arrangements for considering the needs of service users who move between local authority areas, and her amendment 116, which would give service users and carers representation on strategic planning groups. In addition, I am happy to support the cabinet secretary’s amendments.

The Deputy Presiding Officer: No other members wish to speak, so I ask Rhoda Grant to wind up and to indicate whether she intends to press amendment 43.

Rhoda Grant: I say to the cabinet secretary that I understand that guidance is in place on portability of care, but it is not working. Legislation is necessary to address the issue.

15:45

The cabinet secretary said that local authorities cannot design a care package for a person until that person is living in the area. However, any of us who has experience of trying to bring together a care package for elderly parents or others knows how long it takes to decide. It is a real barrier and it stops people moving about, but surely that is part of their human rights. They cannot choose to move without knowing about the service that they are going to receive. I ask the cabinet secretary to reconsider and to support amendment 43, which would really put users and carers at the heart of the bill. It is a hugely bureaucratic bill that is all about systems and bodies, and how we set them up. However, if we are not delivering—

The Deputy Presiding Officer: Ms Grant—I am sorry, but can I stop you for a moment? There is too much chatter going on in the chamber. Can you pull your microphone around slightly, Ms Grant? Thank you.

Rhoda Grant: If we are not legislating in the bill for service users and carers and if it is not designed to make their lives better, then I do not know what we are here for. Therefore, it is important that they be at the very heart of the bill and on the face of the bill. I urge members to support amendment 42 as well as amendment 43.

The Deputy Presiding Officer: The question is, that amendment 43 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division. As this is the first division in the group,
there will be a one-minute division. Please vote now.

For

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, lain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Etrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Dundee City East) (SNP)
McInnes, Alison (South Scotland) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McInnes, Alasdair (Mid Scotland and Fife) (Lab)
Pearson, Graeme (South Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Lamb (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame North) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eddie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabian, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Graham, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gill (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Wat, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 53, Against 62, Abstentions 0.

Amendment 43 disagreed to.

Amendments 44 and 107 moved—[Alex Neil]—and agreed to.

Section 24—Considerations in preparing strategic plan

Amendments 45 and 46 moved—[Alex Neil]—and agreed to.

Section 25—Integration delivery principles
Amendment 47 moved—[Alex Neil]—and agreed to.

Amendment 108 moved—[Malcolm Chisholm].

The Deputy Presiding Officer: The question is, that amendment 108 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division. This will be a 30-second division. Please vote now.

For
Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Fergusson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (Lab)
Johnstone, Alex (South Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (East Dunbartonshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Lab)
Murray, Elaine (Dumfries and Galloway) (Lab)
Pearson, Graeme (Glasgow) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Alieen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunningham North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Graham, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 54, Against 61, Abstentions 0.

Amendment 108 disagreed to.
The Deputy Presiding Officer: The question is, that amendment 111 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, Janis (Rutherglen) (Lab)
Lamont, John (Etrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (SNP)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alan (Airdreaman an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Begg, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Alastair (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Edie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Andrew (Cumbernauld and Kirkintilloch) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Rennfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Alastair (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Stevenson, Stewart (Aberdeen and Aberdeenshire) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urguhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 53, Against 62, Abstentions 0.

Amendment 111 disagreed to.
Amendment 112 moved—[Malcolm Chisholm].

The Deputy Presiding Officer: The question is, that amendment 112 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Kaye (Highlands and Islands) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Etrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCallum, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nayeem (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eddie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Graeme, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk West) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
Mckelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Roberson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 53, Against 62, Abstentions 0.

Amendment 112 disagreed to.

Amendment 113 moved—[Malcolm Chisholm].

The Deputy Presiding Officer: The question is, that amendment 113 be agreed to. Are we agreed?
Members: No.

The Deputy Presiding Officer: There will be a division.

For

Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McColluch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfrieshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Alani, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Stevenson, Stewart (Midlothian and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 54, Against 62, Abstentions 0.

Amendment 113 disagreed to.

Amendment 49 moved—[Neil Findlay].

The Deputy Presiding Officer: The question is, that amendment 49 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.
The Deputy Presiding Officer: The result of the division is: For 39, Against 77, Abstentions 0.

Amendment 49 disagreed to.

Section 26—Establishment of strategic planning group

Amendment 114 moved—[Alex Neil].

The Deputy Presiding Officer: If members will stop the chat, I will ask the question, which is that amendment 114 be agreed to. Are we agreed?

Members: Yes.

Amendment 114 agreed to.

Amendment 115 moved—[Alex Neil]—and agreed to.
Amendment 116 moved—[Rhoda Grant].

The Deputy Presiding Officer: The question is, that amendment 116 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Javert (Highlands and Islands) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnston, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherford) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (LD)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Rowley, Alex (Cowdenbeath) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Edie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Robin (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh West) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 54, Against 62, Abstentions 0.

Amendment 116 disagreed to.

Amendment 50 moved—[Alex Neil]—and agreed to.
Section 27—Preparation of strategic plan

Amendment 117 moved—[Nanette Milne].

The Deputy Presiding Officer: The question is, that amendment 117 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, John (Ayr) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)

Against
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aliean (Clydesdale) (SNP)
Campbell, Rodenick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Ferguson (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentland) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aliean (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Youasuf, Humza (Glasgow) (SNP)

The Deputy Presiding Officer: The result of the division is: For 53, Against 62, Abstentions 0.

Amendment 117 disagreed to.
Section 30A—Review of strategic plan

The Deputy Presiding Officer: Group 11 amendments are on the review and replacement of the strategic plan. Amendment 51, in the name of the cabinet secretary, is grouped with amendments 52 to 55.

Alex Neil: These amendments will ensure that when a replacement strategic plan is produced following a review of the plan, the integration authority is subject to the same requirements as apply to the development of a first strategic plan. In other words, the integration authority must pay regard to the national outcomes for health and wellbeing and the integration delivery principles, along with the requirements on consultation, provision of information and publication that are set out in the bill in relation to strategic planning, when it is producing a replacement strategic plan.

Amendments 52 and 53 are drafting amendments

I move amendment 51.

Amendment 51 agreed to.

Amendments 52 and 53 moved—[Alex Neil]—and agreed to.

Section 30B—Requirement to prepare replacement strategic plan

Amendments 54 and 55 moved—[Alex Neil]—and agreed to.

Section 31—Carrying out of integration functions: general

Amendments 118 and 119 moved—[Alex Neil]—and agreed to.

Section 32—Carrying out of integration functions: localities

Amendment 56 moved—[Alex Neil]—and agreed to.

Section 33—Integration authority: performance report

Amendment 57 moved—[Alex Neil]—and agreed to.

Section 33B—Review of integration scheme

The Deputy Presiding Officer: Group 12 is on the review of the integration scheme and the impact on children. Amendment 120, in the name of Bob Doris, is grouped with amendments 121, 122 and 123.

16:00

Bob Doris (Glasgow) (SNP): These amendments were partly inspired by my meeting parents at a Glasgow project, which was a children’s inclusion partnership service jointly run by Barnardo’s Scotland and Stepping Stones for Families in Maryhill.

Like many families across Scotland, many families in Maryhill who are living in poverty need the support that local children and family services provide. It is vital that the bill improves the services that they rely on. Throughout its scrutiny of the bill, the Health and Sport Committee has been considering carefully the potential impact of the bill on children’s services.

I welcome the cabinet secretary’s amendments at stage 2, which clarify that a number of options are available to health boards and local authorities as they consider whether children’s services should be part of the wider integration agenda along with adult health and social care.

Whether children’s services are moved into integration schemes or kept separate will of course be up to local decision making—that is absolutely right. However, it is particularly important that we do not create a situation in which transitions for young people who are moving from children’s services to adult services become difficult or systems that do not integrate well or do not dovetail with each other.

Barnardo’s Scotland argued at stage 1 that it was not always clear where the responsibility for children’s services would lie, particularly in areas where integration authorities do not choose to take on responsibility for children’s services. Barnardo’s said at stage 1 that it was concerned that any confusion could create uncertainty. However, Barnardo’s—like most other organisations—is fully supportive of the principles that underpin the integration agenda.

I seek a commitment from the cabinet secretary that he is willing to ensure that transitions do not become an issue and that, regardless of whether children’s services are integrated or not, guidance will ensure that local authorities and health boards consider the impact of integration on children and children’s services as they review their integration schemes in due course. I also seek a commitment that children’s organisations will be involved as appropriate and as guidance is developed. I would welcome that reassurance. If those commitments are forthcoming, I will be content not to press the amendments in this group.

I move amendment 120.

Jim Hume: I recognise that Bob Doris wants to make a point about making children’s rights a key part of the bill. That is a very good thing—children should be considered in any decisions that are made and I will support Bob Doris if he presses his amendments.
However, the cabinet secretary has already said in relation to Malcolm Chisholm’s amendments on independent living that disabled people should not be highlighted for special treatment as the bill is about everybody. It should be a given that children will be considered in any health and social care integration, as should older people, disabled people, lesbian, gay, bisexual and transgender people, women and people from ethnic minorities—all sectors of our community, in fact. I am quite interested in why Bob Doris thought it necessary to have these amendments, which highlight only children’s rights, but not other amendments to highlight other people’s rights.

Alex Neil: The bill rightly provides for local flexibility for health boards and local authorities to include other services beyond adult health and social care in their integrated arrangements, such as children’s services.

When statutory partners choose not to include children’s services, that does not negate the need to plan effectively for those services; nor does it remove the need to ensure effective transitions between children’s and adult services.

When children’s services are included in the integrated arrangement, the integration planning principles require health boards and local authorities to take account of the needs of service users.

Similarly, the national health and wellbeing outcomes must be applied and taken into account for all users of services within the integrated arrangement when reviewing an integration scheme.

It is important that the planning requirements of the Children and Young People (Scotland) Bill and this bill are aligned, so amendment 84 in group 14 provides for that statutory link.

I also committed at stage 2 to ensuring that integration joint boards are included as partners in community planning under the community empowerment (Scotland) bill.

Further, under part 1 of the Children and Young People (Scotland) Bill, local authorities and health boards—among others—will be required to report on how they are addressing children’s rights as set out in the United Nations Convention on the Rights of the Child.

I welcome the opportunity to assure Parliament that where statutory partners choose to integrate only adult services, appropriate mechanisms are in place and robust consideration has been given to the planning of other services. Statutory guidance will further strengthen those arrangements. I therefore hope that I have reassured Bob Doris on all the perfectly legitimate points that he raised. I hope that I have reassured him that we are doing the right thing by our children. I therefore ask him to withdraw amendment 120 and not move amendments 121 to 123.

Bob Doris: Jim Hume made a reasonable point about singling out certain groups over others on the face of the bill. That said, Barnardo’s and others want to ensure that guidance is appropriate and fully consistent with the ambitions contained in the bill. Given the comments that the cabinet secretary has made and the strong reassurances that he has given, I am minded to withdraw amendment 120 and not to move amendments 121 to 123.

Amendment 120, by agreement, withdrawn. Amendment 121 not moved.

Section 33C—Requirement to review integration scheme
Amendment 58 moved—[Alex Neil]—and agreed to. Amendments 122 and 123 not moved.

Section 34—Revised integration scheme
Amendments 59 to 62 moved—[Alex Neil]—and agreed to.

Section 35—New integration scheme
Amendment 124 moved—[Alex Neil]—and agreed to.

Section 36—Power to make provision in consequence of new integration scheme
Amendment 63 moved—[Alex Neil]—and agreed to.

Section 37—Information-sharing
Amendment 64 moved—[Alex Neil]—and agreed to.

Section 41A—Social Care and Social Work Improvement Scotland

The Deputy Presiding Officer (John Scott): Group 13 is on inspections by Social Care and Social Work Improvement Scotland and Healthcare Improvement Scotland. Amendment 65, in the name of the cabinet secretary, is grouped with amendments 66 to 82.

Alex Neil: The bill allows Healthcare Improvement Scotland and Social Care and Social Work Improvement Scotland, known as the Care Inspectorate, to inspect the co-ordination of health and social care services. Upon reflection, I do not think that that goes far enough. I have extended the remit to include the planning, organisation and
co-ordination of those services. That broader inspection framework will provide a better basis for scrutinising integrated services.

Amendment 82 allows HIS and SCSWIS, when undertaking a joint inspection, to invite other bodies mentioned in section 115(6) of the Public Services Reform (Scotland) Act 2010 to carry out an inspection with them.

I move amendment 65.

Amendment 65 agreed to.

Amendments 66 to 70 moved—[Alex Neil]—and agreed to.

Section 41B—Healthcare Improvement Scotland

Amendments 71 to 81 moved—[Alex Neil]—and agreed to.

Section 41C—Joint inspections of health services and social services

Amendment 82 moved—[Alex Neil]—and agreed to.

Section 41D—Amendments of section 56 of Local Government (Scotland) Act 1973

Amendment 83 moved—[Alex Neil]—and agreed to.

After section 41D

The Deputy Presiding Officer: Group 14 is on children’s services planning. Amendment 84, in the name of the cabinet secretary, is the only amendment in the group.

Alex Neil: Amendment 84 will insert a new section after section 41, adding a new paragraph into the definition of “other service provider” in section 7(1) of the Children and Young People (Scotland) Bill, to add integration joint boards to that definition.

The amendment will ensure proper cohesion of the planning requirements placed upon statutory bodies under this bill and the Children and Young People (Scotland) Bill, by ensuring that those requirements apply to integration joint boards established under this bill.

I move amendment 84.

Bob Doris: When we debated my amendments in group 12, the cabinet secretary referred to amendment 84. The purpose of group 12 was to ensure that a review of health and social care integration would place the rights of the child and outcomes for children at its heart. I was reassured that that could be dealt with in guidance but, on amendment 84, I agree with the cabinet secretary that such matters need to be placed in the bill.

I very much hope that integration boards will choose to integrate children’s services, if not in the short term then at some point in the future. Therefore, we must ensure that Government legislation in various areas is properly aligned and it is right to amend the newly passed Children and Young People (Scotland) Bill to ensure that, should children’s services be integrated, the integration board that decides to do that is fully recognised in the Children and Young People (Scotland) Bill.

That is crucial for strategic planning and to ensure that the ambitions of the Children and Young People (Scotland) Bill are realised as part of the integration agenda.

I will support amendment 84.

Amendment 84 agreed to.

Section 46—Scottish Ministers: power to form companies etc

The Deputy Presiding Officer: Group 15 is on the Scottish ministers and the power to form companies. Amendment 85, in the name of the cabinet secretary, is grouped with amendment 86.

Alex Neil: Amendment 85 seeks to achieve the stated policy intention of allowing NHS bodies access to a range of joint-venture structures for the management and disposal of assets. It extends the purposes for which joint-venture structures can be formed by NHS bodies to include the management and disposal of assets.

The purposes for which NHS bodies can form joint ventures are closely defined in section 84B of the National Health Service (Scotland) Act 1978. Amendment 86 is a technical amendment that introduces a mechanism to provide future flexibility in the use of joint-venture structures by allowing the Scottish ministers to make regulations prescribing additional purposes for which joint ventures may be formed. Such purposes must relate to health functions under the 1978 act.

I move amendment 85.

Nigel Don (Angus North and Mearns) (SNP): I speak as the convener of, and on behalf of, the Delegated Powers and Law Reform Committee. I seek clarification and reassurance from the cabinet secretary on concerns that the committee has about amendment 86. This morning, the committee considered the stage 3 amendments to the bill that relate to delegated powers. There is an unusually high number of such amendments for stage 3, but the committee has concerns only about amendment 86.

In a letter to the committee, the Scottish Government explained that the amendment
conferred power on the Scottish ministers to prescribe purposes additional to those expressed in the bill for which they may form, or participate in forming, bodies corporate and participate in bodies corporate that are formed. The letter further explains that the power will enable ministers to adjust the purposes for which the Scottish ministers and health boards may form, or participate in, bodies corporate without the need for further primary legislation but that the power is limited in that the purpose must relate to the functions conferred by the National Health Service (Scotland) Act 1978.

However, the letter offers no further explanation of why the power has been taken and no explanation of why the need for the power has become apparent only at this juncture, nor is any explanation offered or are any examples given of how the power might be used.

In the absence of such an explanation or examples, the committee was unable to form a clear view on the appropriateness of the power contained in the amendment. Furthermore, the committee is unclear about the significance of the matters that might be provided for by the power and, therefore, unable to form a clear view on whether the negative procedure is the appropriate procedure to attach to the power or whether a higher level of parliamentary scrutiny would be more appropriate.

Therefore, I invite the cabinet secretary to provide further explanation of why the power is being taken, how it might be used, the significance of the matters for which it might be used and the appropriateness of the use of the negative procedure for regulations under the power.

Neil Findlay: Amendment 86 was a significant omission from the bill at stages 1 and 2 and should have been introduced then. It should not have been introduced at this late stage without having gone through any real scrutiny. Introducing the ability to form a company or a body corporate for a broad range of purposes without any real scrutiny is not the way to legislate. Introducing the ability to form a company or a body corporate for a broad range of purposes without any real scrutiny is not the way to legislate. There may be perfectly legitimate reasons for forming such bodies, but the minister must respect Parliament and the parliamentary process when introducing legislation.

Alex Neil: I am happy to explain to the committee the reasoning behind the amendment.

The purpose behind section 84B of the 1978 act is to ensure that best value is obtained in the use of health service resources and that services can be provided in conjunction with other bodies, where that is in the interests of the public purse.

It is likely that the majority of purposes for which joint ventures are used will be covered by the wording of the 1978 act. However, amendment 86 is necessary to allow an expansion of the purposes for which joint ventures may be used, so as not to stifle innovation.

I can reassure members that this power is intended to be used for narrow purposes. The power of the Scottish ministers to prescribe purposes is constrained by the provision requiring them to be linked to the functions under the 1978 act. Given that restriction, and the intention to use the power to make narrow, technical changes to the purposes for which joint ventures are permitted, negative parliamentary procedure allows a sufficient level of scrutiny.

Examples of which joint ventures might be formed in future include the provision of shared services or support services in conjunction with local authorities, such as hard and soft facilities management, which would include non-NHS buildings services or services such as catering, vehicle maintenance and so on. The amendment will allow further, similar uses of joint ventures, which might otherwise be obstructed.

Section 84B was established for a particular purpose, and the key point is that, where innovation in this area becomes possible, seeking an appropriate primary legislative vehicle to amend the purposes that are set out in section 84B is restrictive. The amendment seeks to enable innovation and remove barriers and delay.

I hope that that provides the necessary reassurance to the committee convener and to the Delegated Powers and Law Reform Committee itself.

Amendment 85 agreed to.

Amendment 86 moved—[Alex Neil]—and agreed to.

Section 48—Interpretation

Amendments 125, 87 and 88 moved—[Alex Neil]—and agreed to.

Amendment 89 moved—[Neil Findlay].

The Deputy Presiding Officer: The question is, that amendment 89 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Standing Orders, Decision Time be taken at 5.20 pm.

—

5.20 pm.

Standing Orders, to bring forward decision time to

Parliamentary Bureau, under rule 11.2.4 of the

take a motion without notice on behalf of the

amendments ahead of schedule, I am minded to

consideration of amendments.

Agreed to.

Amendment 90 disagreed to.

The Deputy Presiding Officer: The result of
the division is: For 52, Against 59, Abstentions 0.

Amendment 89 disagreed to.

Section 49—Subordinate legislation

Amendment 90 moved—[Alex Neil]—and

grounded to.

Schedule—Enacts conferring on local
authorities functions which may be delegated

Amendments 91 to 94 moved—[Alex Neil]—and

grounded to.

The Deputy Presiding Officer: That ends the
consideration of amendments.

As we have completed the consideration of amendments ahead of schedule, I am minded to

take a motion without notice on behalf of the Parliamentary Bureau, under rule 11.2.4 of the
standing orders, to bring forward decision time to 5.20 pm.

Motion moved.

That the Parliament agrees that, under Rule 11.2.4 of Standing Orders, Decision Time be taken at 5.20 pm.—[Joe FitzPatrick.]

Motion agreed to.
Public Bodies (Joint Working) (Scotland) Bill

The Deputy Presiding Officer (John Scott):
The next item of business is a debate on motion S4M-09115, in the name of Alex Neil, on the Public Bodies (Joint Working) (Scotland) Bill.

16:20

The Cabinet Secretary for Health and Wellbeing (Alex Neil): It gives me considerable pleasure to open the stage 3 debate on the Public Bodies (Joint Working) (Scotland) Bill, which brings together health and social care services in Scotland. It is particularly appropriate that the bill’s development has been characterised by strong, committed effort—joined-up teamwork, in other words—by members across the chamber and in committee. If I may quote myself, I think that we have all been on the same page and trying to achieve the same things, even when we have disagreed about wording.

I particularly thank Duncan McNeil and the Health and Sport Committee, which was the lead committee, for their careful consideration of the bill. I also thank the Local Government and Regeneration Committee, the Finance Committee and the Delegated Powers and Law Reform Committee for their careful scrutiny, input and support. I pay tribute to the work of my team in the civil service, which has provided me, as it always does, with first-class support at every stage.

We have heard before today that it is much to the benefit of the bill that it draws on the commitment, co-operation and inspiration of a broad and deep range of partners and stakeholders across all sectors. Local government, the national health service, the third and independent sectors, professional groups and representatives of patients, carers, service users and families have all, in different and complementary ways, lent us their expertise, experience, ambitions and aspirations.

Our consultation on the proposals that underpin the bill received more than 300 responses, and the information sessions that we ran during the consultation exercise attracted roughly 900 attendees to the discussion and debate.

The bill as introduced in May last year yielded 85 written responses during stage 1, and the interests of many of our stakeholders and partners were represented during committee sessions at stage 2.

Last, but by no means least, our various working groups—particularly our bill advisory group and the ministerial strategic group on health and community care, both of which I chair—have been active participants in the development process right up until today.

I signal my sincere thanks to everyone who has been involved so far—but the job is not yet finished, of course. I look forward to continuing to work with everybody as we develop regulations and guidance to support the bill and—most important—as we put integrated arrangements into place.

The whole point—indeed, the only point—of integrating health and social care is to improve people’s lives. Even as we debate the bill, our focus is on improving outcomes for people who currently use health and social care services across Scotland.

The Public Bodies (Joint Working) (Scotland) Bill—perhaps that is not the sexiest name for a piece of legislation, albeit one that is very important—provides a legislative framework for integrating health and social care services. I remember that, at the start of the process, a former Labour minister advised me that we should stick to our guns to make joint working a statutory requirement for local authorities and health boards, because there have been many attempts in the past to integrate health and social care services with varying degrees of success—or lack of success. The statutory underpinning that we will provide is essential to ensuring that such integration works, and does so within a timeous period.

Neil Findlay (Lothian) (Lab): One thing that we can learn is that many of the advances that have been made where I live in West Lothian have been made without legislation. Much of the challenge is perhaps not so much about statutory change but about the cultural change in health and social care.

Alex Neil: Absolutely. West Lothian is a very good example of an area where integration has worked successfully under successive administrations. Unfortunately, I could give many examples of other local authority areas where that has not been the case. We need to put integration on a statutory basis so that the experience of West Lothian can be rolled out across the country.

The bill also sits very well alongside the Social Care (Self-directed Support) (Scotland) Act 2013, which was piloted through Parliament last year by my colleague Michael Matheson, and other policies, such as that in the Children and Young People (Scotland) Bill, which we passed last week, that drive forward our commitment to personalising care. By focusing on person-centred planning and delivery, the Public Bodies (Joint Working) (Scotland) Bill will help to ensure joined-up, seamless health and social care provision that will improve people’s lives. It will support our
commitments to ensure that people get the right care in the right place at the right time and to support people to stay in their own home or another homely setting as independently as possible for as long as possible.

I will take a moment to remind members of the foundations of our approach. We are legislating for national health and wellbeing outcomes and we will underpin the requirement for health boards and local authorities to plan effectively together to deliver quality sustainable care services for the people whom they serve. We are bringing together the very substantial resources that we commit to health and social care in Scotland, to make it easier for local systems to deliver joined-up, effective and efficient services that meet the needs of increasing numbers of people with long-term and often complex conditions. Many of those people are older, but not all of them are, and an important feature of our approach is that local systems must integrate for all adults. In addition, those systems are free to choose locally to integrate children's services as well.

We are bringing together accountability for results across health and social care. Too often in the past, people have found themselves between systems when there is no division in their lives between what we have categorised historically as health needs and social care needs. The bill focuses on the whole person and the needs of the community in which they live. It places on statutory organisations co-ordinated planning and delivery requirements that radiate from people's needs, rather than expecting people to fit into historical patterns of service planning and delivery.

The bill is a response to the findings of the report of the Christie commission on the future delivery of public services that effective services must be designed with and for people and communities—and I believe that they should be designed by people and communities as well—not delivered on a top-down basis for administrative convenience. Also—and this is key—the bill will ensure a full and proper role for clinicians and other professionals in planning and delivering services. We have listened to concerns that that role has been lost or diluted in recent years, and we have responded. We recognise that the expertise and sharp-end experience of the professions and of people who use services must together guide the shape of services in future.

Locality planning arrangements under the bill provide the locus and opportunity for effective professional leadership of integration. We know from the evidence on integrated care that it is all about successful co-production: people working together to tackle challenges in innovative ways.

When it comes to health and social care support, our emphasis in Government is on prevention. We know that a concerted effort to anticipate people's needs and prevent problems from arising in the first place is the way to improve outcomes.

The challenges are difficult. As we have worked with partners and stakeholders to develop the bill, we have not always agreed with one another. What is important, though, is that we have a shared goal: we know what our destination is and we have worked together to agree the route.

That work goes on. We have today released updated data on delayed discharges, which shows us clearly that although we have made great strides in recent years, we have more work to do to ensure that people receive the quality of care that we all want to be proud of in Scotland. Of course, we are not starting from scratch. We can already see many examples—we have just referred to some of them—of good partnership working across Scotland. I saw one this morning. Cowan Court in Penicuik in Midlothian is a brilliant example of an innovative approach to integrating housing, social care and healthcare. We need to build on and develop that good practice and increase the pace at which such facilities are rolled out across Scotland.

The bill provides the right foundation for those improvements, and it provides the imperative that I believe is needed to ensure consistent progress across the country. The bill offers a good and careful balance. It sets out the framework for integration and makes it a necessary requirement of health boards and local authorities to deliver effective integrated care. At the same time, it provides flexibility to allow local arrangements to respond to local needs and to encourage and enhance local innovation and leadership. I welcome this opportunity to provide further clarity on the bill, and to discuss the stage 3 amendments, which we have just completed.

When we pass the bill, we will significantly enhance both the health and the social care of the people of Scotland.

I move,

That the Parliament agrees that the Public Bodies (Joint Working) (Scotland) Bill be passed.

16:30

Neil Findlay (Lothian) (Lab): The issue of social care should be at the top of the political agenda in Scotland. As politicians discuss the intricacies of currency unions, European Union membership and all the rest of it, our elderly and vulnerable people are experiencing a care system that is in crisis as a direct result of cuts to local government.
We know that most people want to remain in their own homes when appropriate, among familiar people and surroundings for as long as possible. We also know that, over the next decade, the elderly population will increase significantly as we live longer lives—or as some of us live longer lives, depending on where we live and how rich or poor we are. We have to be careful when we speak about the issue. Increasing life expectancy is all too often spoken of in negative terms, with phrases such as “time bomb” and “burden” bandied about, but living longer also throws up tremendous work, leisure, travel and community opportunities for the older population. More people should have more time to enjoy a more fulfilling life and contribute to our society. We should all be careful about how we refer to our ageing population.

We cannot, however, get away from the fact that there will be financial and practical implications. Politicians and policy makers have to address those matters and plan for the situation now, not when it becomes a reality, although it is a reality at the moment. The bill will move us a bit down that road, but it has missed the real issues that are facing social care in the here and now. My frustration at the way in which the bill has progressed is that it has failed to address the deep-seated problems in the care system.

One of those is an issue that many of us perhaps want to avoid, which is money. The savings that the Christie commission identified that are supposed to be achieved by freeing up NHS beds through people remaining at home do not have a cat in hell’s chance of being achieved under the current social care system. Organisation after organisation that I have met and spoken to has said, when asked the question, that the social care system is in a state of crisis.

In the care home sector in Edinburgh, 15 per cent of private care home places are out of commission, and the figure is 20 per cent in Glasgow and 15 per cent in Highland. All those places are out of commission because of concerns about standards. In Edinburgh alone, more than 100 NHS beds are blocked because there is no safe place for people to be discharged to, and I understand that there was further bad news on that today. A few weeks ago, a care home in Fife got top marks from an inspector one week and then, the next week, appalling levels of care were identified, and the same inspector regraded the home at a much lower level.

In home care, we have a social care system that is based on the minimum wage, with working conditions being driven down to the lowest common denominator, contract prices being forced down, training budgets being cut, a recruitment crisis and staff morale on the floor. One carer told me recently:

“People only go into home care because they can’t get another job and only stay long enough until another one is found.”

Last week, Unison Scotland published the very disturbing report, “Scotland—It’s time to care. A survey of Scotland’s homecare workers”. The report said that 56 per cent of staff surveyed said that they were on time-limited visits to their clients and that, although the visits normally lasted 15 minutes, some were as short as seven minutes. One worker said that it is

“Rush, rush, rush, I think they forget we are dealing with human beings, old ones at that.”

Another said:

“Clients are anxious they don’t know which carer is coming from day to day”,

while another said:

“Clients are losing out, care is not given properly, clients are missed out or forgotten about, no one cares or listens to staff or our clients.”

Fifty per cent of care staff said that they do not get paid for the time taken to travel between clients, some said that they have to pay for their uniforms, others said that they have to pay for phone calls to their employer, and many said that they do not get breaks.

Another member of care staff said that the

“Service is not able to retain staff due to terrible wages, my work load has increased and I’m getting paid less.”

Another said:

“Before Christmas I ended up 2 weeks on sick leave, because I was doing 16-18 visits during long day and my body couldn’t cope any more, I had to work although I was sick, and when I asked my manager to take half a day off I was told there is no one to cover my shift. My breaks were reduced to minimum and there was not even time for having hot meal during day.”

The report highlights that care visits are missed out, staff are asked to administer medication with almost no training and corners are cut at every turn. In short, it is a system in crisis at a time when the Scottish Government’s white paper, “Scotland’s Future: Your Guide to an Independent Scotland”, claims that we have “world-leading ... social care”. I ask the minister to come into the real world, speak to the people who are delivering care services and ask them whether the social care system in Scotland is world leading. I ask him to read the report and then reflect on that statement in the white paper.

We need to change how social care is procured and delivered. I support moves in the Procurement Reform (Scotland) Bill to omit the need for social care contracts to be advertised and for organisations to compete. If contracts are awarded
to the private sector or the third sector, that should be based not on price but on what added value can be offered. People who work in social care do a vital job that should have a career structure, a training regime and pay and status to match.

I hope that the bill will begin to move matters forward, but I fear that we have missed an opportunity to address the very real and deep-seated problems that exist in the here and now. Good practice takes place across Scotland, but if we do not get the basics right, the system will continue to fail our vulnerable people.

16:37

Nanette Milne (North East Scotland) (Con): I confirm that the Scottish Conservatives will support the bill at decision time. It is a better bill following the amendments that have been agreed to at stages 2 and 3—many of them from the Government—and I am pleased that the cabinet secretary has taken on board a number of stakeholders’ and Opposition members’ suggestions.

There is no doubt that, across the board, we have been seeking to achieve the best possible outcomes for adults who require health and social care services. However, there have been differences of opinion along the way on how best to reach that goal. Those have centred mainly on what should be in the bill and what should be in guidance and statutory regulation.

As I said at stage 1, I fully accept the necessity for the legislation because, despite many initiatives in recent years—some of them very successful—to secure better integration of health and social care, joint working between partners to bridge the gap between primary and secondary healthcare and between health and social care is still at best patchy across the country.

The bill is fairly technical. Basically, it sets the framework for the changes that are needed to achieve the joined-up services that are required by many adults in Scotland today and in the future if they are to remain in their local communities living a fulfilled and dignified life within their capabilities for as long as possible. That particularly applies to the increasing number of elderly people with multiple health problems, both physical and cognitive, who have complex care needs that require significant support from social services.

However, the legislation will be successful only if its fundamental aim of improving the wellbeing of care recipients is at the forefront of its implementation. That will require a change of culture and attitudes, and will depend on strong leadership at the local level and the full cooperation of people across many disciplines, with everyone focused on achieving the best possible outcomes for those in their care. That is not a cheap option and it will involve some innovative thinking in service provision in an environment of ever-scarce resources. Neil Findlay makes a fair point about resources. In my city of Aberdeen, it is difficult to get home carers because of the competing high salaries in the oil industry.

Many people have been involved, at stakeholder and government levels, in the development of the bill, and all are to be congratulated on bringing it thus far, although much more co-operative work will be required to develop the statutory regulation and guidance that will determine the effectiveness of integration.

Much is already going on in different parts of the country to integrate health and social care services at the local level. Health and Sport Committee members have seen the enthusiastic commitment of staff in Highland and in West Lothian as they work to that end under the two different models in the bill. The work is on-going, but the commitment in Highland and West Lothian to person-centred care and the development of services that are focused on securing the best possible outcomes for people is encouraging. Different parts of Scotland are at different stages in the development of integrated services, and many areas are awaiting the statutory regulation and guidance, so it will be important to get that right.

There is no doubt that concerns remain about how the legislation will work on the ground. I mention three concerns, which the British Medical Association set out in its briefing for stage 3. First, there is a lack of clarity about the detail of the implementation of integration and there is a need for the Scottish Government to engage with organisations such as the BMA in the development of regulations and guidelines. Secondly, there is a lack of clarity on how the third sector will interface with the statutory bodies, to ensure a closer working relationship. The sector has a crucial role, at the strategic and local levels, in the planning, design and delivery of care. Thirdly, it is vital that general practitioners are embedded as key stakeholders in the reshaping of services, as the health secretary has promised and as I have said in the past. If that does not happen, GPs will walk away and the new system will be no more successful than the discredited community health partnerships that it replaces.

At the local level, all interested parties must be closely involved in planning the care services that are required. GPs, specialists in secondary care, nurses, allied health professionals, social workers, the third sector, service users and carers must all have an input into planning services so that they properly meet the needs of and achieve the best outcomes for people who require health and social
care and so that those people are able to live a life that is as fulfilled as possible in their local communities.

As I said, we will support the bill, but key to its success will be the guidance and regulation that underpin it. We will keep a careful watch on how that develops, and we will ask the cabinet secretary for updates on progress towards achieving the integrated services that our older population throughout Scotland deserves, now and into the future.

16:42

Aileen McLeod (South Scotland) (SNP): I am delighted to speak in support of the bill, which will implement substantial and wide-ranging reforms to how we deliver adult health and social care.

The Health and Sport Committee benefited from a wealth of collective experience and expertise from a wide range of stakeholders, including local government, the NHS, housing, allied health professionals and the third and independent sectors. Representatives provided invaluable written and oral evidence to the committee throughout our scrutiny of the bill, and we are grateful for their efforts.

I sincerely hope that those representatives feel, as I do, that their contribution helped us to reach a stage at which we have the legislative framework that will achieve the aim that the cabinet secretary set out when we first debated integrating health and social care services throughout Scotland: to improve outcomes for the growing number of people who need health and social care support, most of whom have multiple complex needs, some of whom are older and all of whom should have access to the right care, at the right time, in the right place.

I very much welcome the Government’s recognition of the key role that housing has to play in improving the health and wellbeing outcomes of our citizens, not least given the policy commitment and 2020 vision of enabling people to be cared for “at home, or in a homely setting” for as long as possible, and in a way that enables them to be as independent as possible, as the cabinet secretary said. I am therefore glad that housing stakeholders have been added to the list of persons whom the Scottish ministers must consult before they prescribe national outcomes for health and wellbeing.

Many members can point to good examples of integrated care in our areas. I recently visited the Crossroads Newton Stewart & Machars Care Attendant Scheme in Wigtown, in Dumfries and Galloway, which provides a range of services, including respite care, personal care, palliative care and assistance with transport and shopping. The staff do a fantastic job in enabling more people to live independently, through close partnership working with social work services, the NHS, the community hospital in Newton Stewart, Marie Curie Cancer Care nurses, occupational therapists and other health professionals. Their services help to integrate the care that an individual receives. They already deliver care in a person-centred way, but of course they are working in one area of a large rural region.

The local council and the health board in Dumfries and Galloway have recognised the inherent strengths of existing arrangements, which already deliver measurable benefits. They also recognise that the locality is where we can make a big difference to people’s outcomes. It is very much at the local level where service provision in the community is critical.

I have reflected before, as has the cabinet secretary, that the localities are where the action will happen and where important decisions will be made. The model that Dumfries and Galloway has chosen—of four localities that are based on the areas of the current area partnership committees—very much reflects that. There is broad agreement across the region that integration will produce a radical improvement at all levels of health and social care.

That is our ultimate aim. This evening’s vote represents the culmination of a lengthy process of engagement, debate, scrutiny and amendment. I am confident that it will produce an outcome that we can all be proud of—an approach to adult health and social care that is genuinely seamless and responsive, with services that are firmly integrated around the needs of individuals, their carers and their families and which place people at the centre of service planning and delivery. That was the message that the Christie commission gave, and I believe that the bill will enable us to change how we deliver public services to meet the needs of people in our communities better.

I hope that members across the chamber will support the bill.

16:46

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I welcome the bill and the changes that the cabinet secretary was willing to make at stages 2 and 3. For example, although he did not go as far today as I, disability organisations and other third sector organisations wished, he incorporated to some extent the language of rights into the bill.

At stage 2, the cabinet secretary addressed some of the problems that I and others highlighted
at stage 1 in relation to the financial arrangements. For example, the bill originally said:

“...The Health Board must make a payment to the integration joint board”.

The fear was that that would reintroduce contracting arrangements, which we in Scotland put behind us several years ago. He changed the arrangement at stage 2 by introducing a reference to money being set aside. I welcome the changes that he made.

However, in welcoming the bill, we must not overstate the difference that it will make per se. It is a necessary but not a sufficient condition for making progress on better integrated care. As Alison Petch—perhaps the leading Scottish academic on community care—said to the committee a few months ago,

“...legislation is not really what drives day-to-day delivery.”—[Official Report, Health and Sport Committee, 10 September 2013; c 4205-6.]

We can look at that from two points of view. As Neil Findlay said at various times today, wider issues must be addressed, such as the length of care visits. The other point is that what really drives change is culture change—that phrase has been used today and at other times—as well as leadership and bringing teams together on the ground.

The words “on the ground” are fundamental. In its briefing, which Nanette Milne just mentioned, the BMA uses that phrase when it expresses concern about

“...the lack of clarity of what integration will actually ‘look’ like on the ground.”

It also says that

“...the success or failure of integration will be the result of the effectiveness of the locality partnerships.”

In the committee, I expressed concern that the bill does not contain more on the locality arrangements. There is only one reference, in section 23, which says that the local authority area will be divided

“...into two or more localities”.

We had quite a long debate about that in the committee, and it was reassuring to hear from the cabinet secretary that he will produce statutory guidance on localities. However, given that that is where the bill’s success or failure is to be determined, I think—like many others—that it is somewhat surprising that the bill does not contain more on the subject.

When I mentioned the issue at stage 1, I said that

“I would like it to be included in negotiations on the GP contract.”—[Official Report, 26 November 2013; c 24890.]

The fact that GPs were not involved sufficiently in community health partnerships was one of the fundamental reasons why they failed. I must take responsibility for that, although it is partly because of that experience that I am saying that more should be included in the bill.

Community health partnerships did not turn out exactly as I had envisaged them in terms of the locality arrangements, and I hope that things will be different this time. In the past few weeks, I have read that something was incorporated into the renegotiated Scottish GP contract about GPs’ role in the integration locality arrangement. If the cabinet secretary could say something about that in his winding-up speech, that would be appreciated.

The issue is not just about GPs, though, as secondary care clinicians must be involved on the ground as well. The bill is about integration that should be vertical as well as horizontal. The third sector—including disability organisations, which we should remember have a particular contribution to make—also needs to be involved on the ground, and it is on the ground where the bill will succeed or fail.

Yes, the bill is necessary, and we all agree that it is a step forward and we all hope that it will lead to the improvements that we want. However, as a final word, let us have the statutory guidance and regulations as quickly as possible. Processes must obviously be gone through, but one of the issues that I raised in committee was about regulations on what could not be handed over to the integration authority, as I heard concerns that local authorities and NHS boards will have to wait to see what they can put into the plans. Let us at least know as quickly as possible what is ruled out, and let us then leave it to health boards and local authorities to get on with the delivery on the ground.

16:51

Bob Doris (Glasgow) (SNP): As the deputy convener of the Health and Sport Committee, I thank all stakeholders who were involved in the bill process. I also thank the Scottish Government, which has been very willing to adapt and change the bill on the basis of representations that have been made to it.

I thought that an earlier speech was going to be about project fear but, to be fair to Mr Findlay, the member went on to talk about project care. I would like to stress that it is actually project health and social care. We have heard a lot about social care without hearing about the other side of the coin, and it is important to get that balance. Nevertheless, there is a meeting of minds and political will on the issue across all the political...
parties. I am reminded of what Malcolm Chisholm said about what is going to happen at the coalface—I hope that I will have time to speak about that.

The bill—shortly to be an act—is not the change in itself but is designed to facilitate change. The change will be an end to cost shunting at a local level with the development of single budgets, so that, for example, the bed blocking that perhaps happened for financial reasons will no longer take place. The change will be the strategic commissioning or the co-production of integrated services. The change will be building on existing best practice and, just as important, redesigning services in every local area in a way that improves the health and social care outcomes of the people we represent.

Some of that change is happening right now through the change fund for older people, which is providing £300 million over four years or so to promote such change. Importantly, that money is to be spent only if it is agreed by both councils and health boards. They can and do work jointly when they are instructed to do so, and I am sure that there is a will to go further in addition to the statutory basis that the bill will introduce. It is also significant that the change fund requires sign-off by the third sector.

With the statutory underpinning of health and social care integration, a far larger single budget will come into play in the innovative service redesign right across health and social care. Although the third sector, as non-statutory bodies, will not have sign-off over that larger budget, I expect it at a local level to be directly involved in the co-production and, where appropriate, the co-commissioning of services and in looking at new ways of service delivery right across Scotland. Likewise, I expect our communities to have a direct say about what they want services to look like, and I expect other stakeholder professionals, whether allied health professionals or our GPs, to have a strong say as well.

With that in mind, I think that some of the points that the BMA has made are a bit oxymoronic. As soon as we start dictating what a local plan should look like, it is not truly a local plan. There has to be a degree of flexibility to allow the new body corporates that are coming online and all the stakeholders at local and strategic level to have their say, and to avoid their being presented with a fait accompli on the ground locally, which would not serve anyone’s interests.

As Aileen McLeod did, I will finish by mentioning a good local project as an example of the good work that we want to see: the good morning project in Glasgow, which I know that the cabinet secretary has been to visit. As part of that project, older people get a daily telephone call from a volunteer caller—who is called “a friend on the phone”—to ensure that they are okay, that they are not lonely and that they have no health needs that are going unmet.

I have no doubt that such innovative services keep older people safe, secure, happy and content in their own homes for longer and prevent them from presenting elsewhere, which would be a poorer outcome for them and a more expensive one, too. I want to see such initiatives on health and social care integration being implemented on the ground right across the country.

16:56

Jim Hume (South Scotland) (LD): Liberal Democrats have long called for the delivery of a commonsense approach of having health boards, local authorities and the third sector work more closely together to provide more joined-up care and better outcomes for patients. All sectors agree that the integration of health and social care is a move in the right direction that is needed if integrated, person-centred care is to be achieved.

We know that the incidence of emergency admissions has increased in the past few years and that the largest increase has been among the over-75 age group. That contributed to a 7 per cent increase between June 2012 and June 2013 in the number of bed days associated with delayed discharge patients. The fact that we have an ageing population and an increasing incidence of patients who present with multiple conditions makes such figures inevitable. They exist in a climate in which the number of staffed beds in the NHS has reduced dramatically over the past six years, which makes the problems of an ageing population and bed blocking all the more acute for the NHS.

The number of geriatric beds dropped from 7,500 in 2012 to 7,229 in 2013. In 2007, there were more than 9,000 geriatric beds. The number of staffed geriatric beds is the lowest in more than 10 years, while the number of emergency admissions of older people is at its highest level in that period. The Government is failing to meet the national indicator to reduce emergency admissions to hospital, and an Audit Scotland report found that at least 90 per cent of the patients who experienced a delay of more than three days were aged 65 or over. It is against that backdrop of the pressures and challenges that the NHS faces that integration is necessary.

In supporting the bill at stage 1, Liberal Democrats had some concerns that we felt needed further attention. It is critical that proper engagement is entered into with the NHS, local authorities and the third sector so that a truly integrated pathway delivers for the patient. Health
and social care partnerships must work with GPs, carers, the voluntary sector and the independent sector in a locality planning framework.

GPs talk about the fact that they very much welcome the bill but, worryingly, they are still unclear about what it will mean for them on the ground on a day-to-day basis. Therefore, we need to involve and engage GPs in the new integrated arrangements. One of the reasons why community health partnerships were not successful was that GPs were not engaged. In its submission, Glasgow City Council stated:

“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.”

The proportion of the NHS budget that goes to general practice fell from 9.47 per cent in 2004-05 to 7.78 per cent in 2011-12. If GPs are to play a more central role in a person’s care by engaging with the new health and social care framework, the Government needs to acknowledge the demands that are being placed on their time against a backdrop of constricting budgets.

The legislation will mean nothing if it cannot be tailored to best fit the needs of the local population, using the knowledge of health and social care professionals working in communities. Indeed, the Convention of Scottish Local Authorities has argued that the bill’s provisions are at times too prescriptive and detailed and that they should allow more flexibility at a local level to determine the shape and governance of the proposed partnership arrangements—hence my earlier concerns regarding ministerial powers versus local accountability.

I am glad that the minister stated in his opening remarks that the job has not finished and will continue. We shall therefore support the bill today.

The Deputy Presiding Officer: We move to closing speeches. I call Cameron Buchanan, who has four minutes, please.

17:00

Cameron Buchanan (Lothian) (Con): I am pleased to contribute to this afternoon’s stage 3 debate and to support the Public Bodies (Joint Working) (Scotland) Bill, which perhaps does not have a sexy title, but is about removing barriers to better working between our public bodies. Given the potential that it holds for improved and more efficient services, it is indeed a welcome move by the Scottish Government.

However, I find it to be a bill of two halves. If I may, I will address the latter half first. Part 2 and onwards largely concerns barriers to existing working. There are already moves towards joint commissioning of facilities—for example, with the hub initiatives—and large-scale procurement through National Services Scotland. However, ambition in this regard has been restricted in scope or blocked altogether due to the limitations of existing legislation. The bill is straightforward and adopts a commonsense approach by removing such restrictions for the future.

Part 1 of the bill is, however, another matter entirely, in that it is designed to deliver momentum towards integrated working and the statutory basis to facilitate it, which is a far more complex and ambitious proposition. As the cabinet secretary and my colleague Nanette Milne have pointed out, the bill provides a framework and an initial push.

However, it is widely accepted that there is also a need for a culture change. Already there are local authorities and health boards that are well down the road to integration, including NHS Lothian and the City of Edinburgh Council, West Lothian Council and Midlothian Council in my region. However, the picture is very different elsewhere, so the Government will have to maintain pressure if we are to see change and overcome the resistance to that change that undoubtedly exists.

That was borne out by the evidence of Professor Alison Petch to the Health and Sport Committee. She warned of the ignorance about one another’s working that exists between the various professional groups. With so much of the detail still to be consulted on and confirmed, in particular around financial accountability and conflict resolution, the Government must ensure that no momentum is lost later, and it must press local authorities and health boards to commit to the integration process and, beyond that, to begin their strategic planning.

Even assuming that there is that vital impetus and the bill achieves better integration between health and social work, we already have evidence that that will not, in itself, be enough. I have learned quickly that with every new bill or subject in the Scottish Parliament there comes a complete set of new buzzwords and accompanying jargon. With this bill we have the word “disconnect”; the bill highlights the key disconnect in co-ordination between health and social care agencies. However, as Glasgow City Council pointed out in its evidence to the Health and Sport Committee, there is as much of a problem with co-ordination and working between primary healthcare professionals and those in acute care—that is, within the health profession. The bill does not directly address that, but it is vital to delivery of the type of change that we are looking for. Working within agencies is as important as working between agencies, especially if we are to achieve
the reduction in spending on hospital visits, and to focus more on community-based care.

There has been a good deal of comment from Malcolm Chisholm and others on how demographic changes—in particular the challenges of an ageing population—make the bill necessary. I think that we all agree that we must be smarter in our public spending; a co-ordinated focus on preventative spending is central to that. However, if we are to deliver a genuinely integrated, joined-up and person-centred approach, the bill must be the start of the process, and not the end. The real test of the legislation will be in the experiences of those who use our health and social care services. The overarching goals must be improved delivery, fewer delays, reduced waiting times and fewer non-scheduled hospital admissions. Those are the standards by which reform will be judged; the bill, though welcome, is just one step towards achieving them. However, we shall support the bill.

17:04

Rhoda Grant (Highlands and Islands) (Lab): I thank all the stakeholders who gave evidence to the Health and Sport Committee when we were scrutinising the bill. I also thank the committee clerks and the support staff for their assistance, and the Scottish Parliament information centre, which helped us very much. I give special thanks to the bill team, who helped us all to draft amendments for the bill. Without that help, we would have been in an even more difficult situation today in respect of lodging our amendments. I thank all the people who made it possible to do that.

We in the Labour Party support the general principles of the bill. We want a seamless service for users, who must be at the heart of the service in planning their own care to fit their needs and their life chances. I agree with Malcolm Chisholm about the bill being necessary but insufficient to make the change that we need. We need to go much further to properly integrate health and social care, and I agree with the cabinet secretary that there is much unfinished business in the area.

The catchphrase that the minister has used all the time as we have gone through the bill process is that we are “on the same page”. Some of us had hoped that the script on that page would be a little bolder, so we will continue to push for a bolder vision of integration of health and social care.

We need a change of culture. Nanette Milne mentioned that in her speech today, but it has run through the whole debate. The culture needs to change, but we cannot legislate for that.

We have to embrace co-production. The bill will improve that to an extent, but we have a huge distance to go to ensure that the person is at the very centre of care—that they are at the heart of the legislation and how we deliver care. We provide services to allow people to go out and live their lives, so we cannot dictate to them how they should do that. They need to be at the centre of it, and that is where the culture change comes. It involves our recognising that their needs are much more important than the needs of the organisations and the people who deliver the care.

We have all heard stories of people being told what they can and cannot eat, what time they must eat, what time they need to get out of bed and when they have to go to bed. I have heard heartbreaking stories about situations in which parents are not even allowed to sit up with their teenage children of an evening because the parents have to go to bed long before they would put their children to bed. How can they parent their children under those circumstances? We need to look at how we deliver services in order to ensure that the needs of service users, their carers and families are met, and that their ambitions are met.

Neil Findlay talked about the Unison survey. I read it, and it makes stark reading, covering—as it does—what the people who deliver care services feel. They are underpaid and undervalued and they are not given enough time to care. They see what needs to be done, but they are not given the time to deliver it. We need to involve and value all workers who deliver care. Many members talked about GPs, including Jim Hume and Malcolm Chisholm, and we heard about the third sector and those who represent service users, but we must also consider care providers. Bob Doris mentioned allied health professionals. All those people are crucial. We have to remember that they are involved in delivering care and we need to respect their views and pay them accordingly. Caring should not be a Cinderella service. If we really value the people for whom we care, we need to ensure that we also value the people who deliver that care.

As I said, I agree with the cabinet secretary that there is much unfinished business; inspection is one area that falls into that category. The inspection landscape is cluttered, with different regimes for health and social care. We need them to be integrated. We recommend that there be a new independent body that would be available to both staff and patients, because it is important that we have protection for whistleblowers. Many of the complaints about how care is delivered have come from staff who work for inadequate providers. They need to be able to raise their concerns, and the inspection regime needs teeth—it needs to be able to take steps to right the wrongs.
The inspection regime also needs to be transparent. One of the big challenges that we have learned of while considering the bill is in respect of inspection of home care. How do we get into a person’s home to inspect the care that they receive, especially when they are so dependent on the person who delivers the care to them? We need to look at all those things and see how we can tighten up services.

We heard today from Neil Findlay that social care is in crisis; he talked about the number of care homes that are out of commission due to poor standards. Surely we should find out about that sooner and steps should be taken sooner to try to bring them up to standard. We are seeing bed blocking increasing and people are not receiving care that is appropriate to their needs because it is not available in the community. We need to look at how we can improve standards throughout the care sector.

We all understand that shifting the balance of care from acute hospitals to communities is what we desire. It keeps people out of hospital, and allows them to be independent and enabled. It is what we would want in that situation, and it is also more cost effective. However, we cannot shift the balance of care out of acute care altogether. Neil Findlay raised concerns about the savings that were highlighted by the Christie commission and how we can possibly achieve them. People will still need acute care and that has to be delivered in hospital settings, but if we want to keep people well for longer, we also have to provide high-quality care in the community. That care will also have to deal with multiple conditions. As people live for longer, they will have more conditions that need to be dealt with, so we need all workers to be working towards that.

Integration of health and social care is really necessary. I hope that the bill will start the process. Legislation will not change everything; it will not change the culture, so we need to take the lead in order that we can do that. I hope that the bill helps us to do that.

The Presiding Officer (Tricia Marwick): Thank you Ms Grant. Alex Neil will wind up the debate. Cabinet secretary, I would appreciate it if you would continue until 5.20.

17:11

Alex Neil: Thank you, Presiding Officer, I shall do my best to continue until 5.20.

First, I will respond to a number of the important points that have been made by members from all sides of the chamber.

On the question about where we go from here the bill gets royal assent, the next step is to move on secondary legislation, regulations, and guidance. I am very keen to do that as soon as possible because we want the integration boards to be fully operational from April 2015. It is also important that we continue, as we have throughout this exercise, to take the key stakeholders with us. We have agreement from the members of the stakeholder groups and the bill advisory group, which has been advising the Government on the bill throughout the entire process, that they will continue to advise the Government about discussions on secondary legislation, regulations, guidance and all the rest of it. Continuing with that group and the stakeholders is the right way to proceed. The more consensus we get, the more buy-in we will get throughout the process, and the more success we will have in implementing the provisions of the legislation.

On general practitioners’ involvement, I could not agree more that they have an absolutely vital role to play. The entire primary care sector has a vital role to play—although I should say that I expect consultants from the hospitals to play a much bigger role in the community, as well. I agree about the importance of GP involvement, particularly in localities and partnerships themselves.

Having said that, I should also emphasise to members something that they probably already know. In the guidance that I have issued for local delivery plans being submitted by boards to the Scottish Government for approval, I have stated very clearly that I expect every local delivery plan from every health board in Scotland to show a significant increase in spend in the primary care sector from April 2014 onwards. That will not mean a cut in acute services, because there will be a real increase in every board’s future budgets. It means that a bigger share of the growth should be allocated to primary care services in order to allow us to increase the resources that are available to primary care while simultaneously ensuring that there are not cuts in the acute services that are—as Rhoda Grant said—absolutely essential.

Rhoda Grant: The cabinet secretary will be aware that one of the major growth areas in health board budgets is the cost of medicines. One person told me that that cost is now ahead of staff costs in healthcare budgets. Will he factor that in when he is looking at increases to health board budgets?

Alex Neil: As far as I am concerned, we account for the prescriptions budget separately from the budget for primary care services, although much of it is paid through primary care. For example, if Rhoda Grant looks at the accounts that we present to Parliament, she will see that we have a specific line item on the cost of
prescriptions, which is running at roughly £1.3 billion a year.

When I talk about additional spend in the primary care sector, I am not talking about the prescription element of it—I am talking about the services element. That includes primarily GP services, because there is no doubt at all in my mind that in order for us to achieve our health outcomes—including a reduction in unnecessary admissions to hospital—we have to improve and expand primary care services as part of the integration process. Primary care services must be absolutely integral to commissioning and strategic planning of the integrated authorities. I agree that speed is of the essence.

I also agree with Malcolm Chisholm about the importance of involving disability organisations. Clearly, although integrated services are for the entire adult population, the main users of the services are older people and disabled people. They and their stakeholder groups need to be involved in discussions nationally and locally.

The cultural issues that have been referred to by a number of members are also important. I believe that the bill itself will be a major tool in changing the culture—in particular, in changing it from one that delivers services to people to one that delivers services with people and for people, in agreement with them. It will be a change to a culture in which people are involved in designing delivery of services.

The role of users and user groups in the design and delivery of services is also crucial. Again, in particular at locality level, that will be an essential prerequisite to success.

I emphasise that although the bill is largely about the financial and organisational arrangements for integration, we should never lose sight of the purpose of the bill, which is to improve dramatically service provision for people who use the services. It is not just about delayed discharges; I believe that experience shows that where there is integration, the problem of delayed discharges is much easier to deal with. I believe that, over time, we can eliminate delayed discharges, as has largely been done, for example, in West Lothian. The bill is also about, for example, ensuring that people can be treated much more in the community, either at home or in a homely setting in the community—both in terms of their healthcare and social care. That is a key element in improving the health outcomes of the population.

Neil Findlay: The minister has spoken at length and I have yet to hear him mention anything about the two fundamental problems that we have: the poor pay and conditions of the staff who deliver the care, and the time-limited appointments that are made for clients. I have yet to hear him mention those problems.

Alex Neil: On the latter point, there are already two or three investigations on issues related to social care outcomes. The time element is being looked at as part of those investigations. Neil Findlay should know that because the Association of Directors of Social Work and the Care Inspectorate are looking at those specific issues.

I said earlier that terms and conditions in the social care sector need to be addressed and that we need to do that with our local authority colleagues. It is a bit rich for Neil Findlay of the Labour Party to be complaining about how the workers are treated when we have seen what has happened in Glasgow City Council, where the workers have been treated with total contempt by the Labour administration—[Interruption.]

The Presiding Officer: Mr Findlay—enough.

Alex Neil: —so much so that they have been forced into industrial action. I do not think that we will be taking any lessons from Mr Findlay or from any of his Labour colleagues on how to treat workers.

I will not mention Aberdeen, where there has been what has been described by some people as a disastrous move in transferring services to an arms-length external organisation—Bon Accord Care Ltd. That is hardly the model that we want. Again, we will certainly not be taking any lessons from the Labour administration in Aberdeen or from the Labour spokesperson on how to treat workers or how to treat service users.

The Presiding Officer: Can you bring your remarks to a close, cabinet secretary?

Alex Neil: The passage of the bill, which—with the exception of Neil Findlay’s contribution—has happened on a consensual basis, is a significant landmark in health and social care in Scotland. I believe that its passage will do a great deal to improve both healthcare and social care in Scotland. I hope that every member will vote for it.
CONTENTS

Section

PART 1

FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

Integration schemes
1 Integration schemes: same local authority and Health Board area
2 Integration schemes: two or more local authorities in Health Board area
3 Considerations in preparing integration scheme
4 Integration planning principles
5 Power to prescribe national outcomes
6 Consultation
7 Approval of integration scheme
8 Publication of integration scheme

Implementation of integration scheme
9 Functions delegated to integration joint board
10 Chief officer of integration joint board
11 Other staff of integration joint board
12 Integration joint boards: further provision
12A Integration joint boards: finance and audit
13 Payments to integration joint boards in respect of delegated functions
14 Functions delegated to local authority or Health Board
15 Transfer of staff where functions delegated to local authority or Health Board
16 Integration joint monitoring committees: further provision
17 Payments to Health Boards in respect of delegated functions
18 Payments to local authorities in respect of delegated functions
18ZA Power of Scottish Ministers to make provision giving effect to integration scheme
19 Transfer of staff: effect on contract of employment
20 Co-operation
20A Carrying out of functions conferred on officers of local authorities
20B Carrying out of functions conferred on officers of Health Boards

Carrying out of delegated functions
21 Effect of delegation of functions
22 Directions by integration authority
22A Section 22: supplementary
18A Health funding: further provision

Strategic planning etc.
23 Requirement to prepare strategic plans
24 Considerations in preparing strategic plan
25 Integration delivery principles
26 Establishment of strategic planning group
27 Preparation of strategic plan
27A Provision of information for purpose of preparing strategic plan
29 Publication of strategic plans
30 Significant decisions outside strategic plan: public involvement
30A Review of strategic plan
30B Requirement to prepare replacement strategic plan
30C Strategic plan: annual financial statement

Carrying out of integration functions

31 Carrying out of integration functions: general
32 Carrying out of integration functions: localities
33 Integration authority: performance report
33A Reports

Review of integration scheme

33B Review of integration scheme
33C Requirement to review integration scheme
34 Revised integration scheme
35 New integration scheme
36 Power to make provision in consequence of new integration scheme

Supplementary

37 Information-sharing
38 Grants to local authorities
39 Default power of Scottish Ministers
40 Directions
41 Guidance
41A Social Care and Social Work Improvement Scotland
41B Healthcare Improvement Scotland
41C Joint inspections of health services and social services
41D Amendments of section 56 of Local Government (Scotland) Act 1973
41E Children’s services planning
42 Meaning of “integration authority”
43 Meaning of “integration functions”
43A Meaning of “constituent authority”

PART 2
SHARED SERVICES

44 Shared services
44A Section 44: consequential provision
44B Common Services Agency for the Scottish Health Service: residual liabilities
45 Extension of schemes for meeting losses and liabilities of health service bodies

PART 3
HEALTH SERVICE: FUNCTIONS

46 Scottish Ministers: power to form companies etc.
Health Boards: carrying out of functions

**PART 4**

**GENERAL**

- Interpretation
- Subordinate legislation
- Ancillary provision
- Repeals and revocation
- Commencement
- Short title

Schedule—Functions of local authorities which may be delegated
- Part 1—Functions conferred by enactments
- Part 2—Functions conferred by virtue of enactments
Amendments to the Bill since the previous version are indicated by sidelining in the right margin. Wherever possible, provisions that were in the Bill as introduced retain the original numbering.

Public Bodies (Joint Working) (Scotland) Bill
[AS PASSED]

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

PART 1
FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

Integration schemes

1 Integration schemes: same local authority and Health Board area

(1) Subsection (2) applies where the area of a local authority is the same as the area of a Health Board.

(2) The local authority and the Health Board must jointly prepare an integration scheme for the area of the local authority.

(3) An integration scheme is a scheme setting out—
   (a) which integration model mentioned in subsection (4) is to apply,
   (b) the functions that are to be delegated in accordance with that model,
   (c) where functions are to be delegated in accordance with the model mentioned in subsection (4)(b), (c) or (d), the functions of the person to whom functions are to be delegated which are to be carried out in conjunction with the delegated functions,
   (ca) in relation to any functions to which subsection (5A) applies that are to be delegated, a method of determining amounts to be made available by the Health Board for use by the person to whom the functions are delegated in respect of those functions,
   (d) in relation to any functions other than those mentioned in paragraph (ca) that are to be delegated (including any functions mentioned in that paragraph but in relation to which the Health Board deems subsection (5A) not to apply), a method of determining payments that are to be made in respect of the delegated functions by the person delegating the functions to the person to whom the functions are delegated,
   (e) prescribed information about such other matters as may be prescribed.
The integration models are—

(a) delegation of functions by the local authority to a body corporate that is to be established by order under section 9 (an “integration joint board”) and delegation of functions by the Health Board to the integration joint board,

(b) delegation of functions by the local authority to the Health Board,

(c) delegation of functions by the Health Board to the local authority,

(d) delegation of functions by the local authority to the Health Board and delegation of functions by the Health Board to the local authority.

A local authority may delegate a function under an integration scheme only if the function is conferred—

(a) by an enactment listed in Part 1 of the schedule, or

(b) by virtue of an enactment listed in Part 2 of the schedule.

A Health Board may delegate a function under an integration scheme only if the function is prescribed.

The Scottish Ministers may by regulations prescribe which of the functions conferred by or by virtue of enactments listed in the schedule local authorities must delegate under an integration scheme so far as the functions are exercisable in relation to persons of at least 18 years of age where the integration model mentioned in subsection (4)(a) or (b) is to apply under the scheme.

The Scottish Ministers may by regulations prescribe functions of Health Boards which Health Boards must delegate under an integration scheme so far as the functions are exercisable in relation to persons of at least 18 years of age where the integration model mentioned in subsection (4)(a) or (c) is to apply under the scheme.

If the integration model mentioned in subsection (4)(d) is to apply under an integration scheme either—

(a) the local authority must delegate the functions prescribed under subsection (4C) so far as the functions are exercisable in relation to persons of at least 18 years of age, or

(b) the Health Board must delegate the functions prescribed under subsection (4D) so far as the functions are exercisable in relation to persons of at least 18 years of age.

The Scottish Ministers may by regulations prescribe functions of Health Boards that a Health Board—

(a) must delegate under an integration scheme other than in prescribed circumstances,

(b) may not delegate under an integration scheme in prescribed circumstances.

The Scottish Ministers may by regulations prescribe which of the functions conferred by or by virtue of enactments listed in the schedule local authorities may not delegate in prescribed circumstances.

The Scottish Ministers may by regulations remove an enactment from the schedule.

A function may not be set out under subsection (3)(c) if it is a function which may not be delegated under an integration scheme.

This subsection applies where functions that a Health Board proposes to delegate under an integration scheme—
Part 1—Functions of local authorities and Health Boards

(a) are carried out in a hospital in the area of the Health Board, and
(b) are provided for the areas of two or more local authorities.

(5B) Regulations under subsection (3)(e) may include provision—

(a) conferring discretion on local authorities and Health Boards,
(b) requiring local authorities and Health Boards to establish processes and
procedures relating to prescribed matters,
(c) imposing requirements on local authorities and Health Boards about the disclosure
of information,
(d) in relation to such other matters relating to integration schemes as the Scottish
Ministers think fit.

(7) In this section, “Health Board” means a Health Board constituted under section 2(1)(a)
of the National Health Service (Scotland) Act 1978 (c.29).

2 Integration schemes: two or more local authorities in Health Board area

(1) This section applies where the areas of two or more local authorities fall within the area
of a Health Board.

(2) Each local authority and the Health Board must comply with subsection (3) or (4).

(3) Each local authority and the Health Board must jointly prepare an integration scheme
for the area of the local authority.

(4) Two or more local authorities and the Health Board must jointly prepare an integration
scheme for the areas of those local authorities.

(4A) For the purposes of subsection (4), if the local authorities and the Health Board decide
that the integration model mentioned in paragraph (c) or (d) of section 1(4) is to apply—

(a) functions are to be delegated under those models to only one of the local
authorities,
(b) the authorities and the Health Board must set out in the integration scheme which
local authority the functions are to be delegated to (the “lead authority”),
(c) paragraph (c) of section 1(4) applies as if for the words “to the local authority”
there were substituted the words “and the local authority or authorities to the lead
authority”, and
(d) paragraph (d) of section 1(4) applies as if for the words from “to”, where it first
occurs, to “local” there were substituted “or authorities to the Health Board and
delegation of functions by the Health Board and the local authority or authorities
to the lead”.

(5) In preparing an integration scheme under subsection (3) or (4), a local authority and the
Health Board must take into account—

(a) any other integration scheme that has been, or is being, prepared in relation to the
area of the same Health Board, and
(b) the likely effect on the Health Board of both or all the schemes prepared under
this section.
3 Considerations in preparing integration scheme

(1) This section applies where a local authority and a Health Board are preparing an integration scheme.

(2) The local authority and the Health Board must have regard to—

(a) the integration planning principles (see section 4), and

(b) the national health and wellbeing outcomes (see section 5).

4 Integration planning principles

(1) The integration planning principles are—

(a) that the main purpose of services which are provided in pursuance of integration functions is to improve the wellbeing of service-users,

(b) that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible—

(i) is integrated from the point of view of service-users,

(ii) takes account of the particular needs of different service-users,

(iii) takes account of the particular needs of service-users in different parts of the area in which the service is being provided,

(iii)a)takes account of the particular characteristics and circumstances of different service-users,

(iii)b)respects the rights of service-users,

(iii)a) takes account of the dignity of service-users,

(iii)b) takes account of the participation by service-users in the community in which service-users live,

(iii)c)protects and improves the safety of service-users,

(iii)d)improves the quality of the service,

(iv) is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care),

(v) best anticipates needs and prevents them arising, and

(vi) makes the best use of the available facilities, people and other resources.

(2) In subsection (1), “service-users” means persons to whom or in relation to whom the services are provided.

5 Power to prescribe national outcomes

(1) The Scottish Ministers may by regulations prescribe outcomes in relation to health and wellbeing (the “national health and wellbeing outcomes”).

(3) Before making regulations under subsection (1), the Scottish Ministers must consult—

(a) each local authority,

(b) each Health Board,

(c) each integration joint board at the time established,
(d) in respect of each group mentioned in subsection (4), such persons appearing to be representative of the group as the Scottish Ministers think fit.

(4) The groups mentioned in subsection (3)(d) are—

(a) health professionals,
(b) users of health care,
(c) carers of users of health care,
(d) commercial providers of health care,
(e) non-commercial providers of health care,
(f) social care professionals,
(g) users of social care,
(h) carers of users of social care,
(i) commercial providers of social care,
(j) non-commercial providers of social care,
(k) such persons having functions in relation to housing as the Scottish Ministers think fit.

6 Consultation

(1) This section applies where a local authority and a Health Board are required by section 1(2) or 2(2) to prepare an integration scheme.

(2) Before submitting the integration scheme for approval under section 7, the local authority and the Health Board must jointly consult—

(a) such persons or groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed, and
(b) such other persons as the local authority and the Health Board think fit.

(3) In finalising the integration scheme, the local authority and the Health Board must take account of any views expressed by virtue of subsection (2).

7 Approval of integration scheme

(1) After complying with section 6 and before the prescribed day, a local authority and a Health Board must jointly submit an integration scheme to the Scottish Ministers for approval.

(3) The Scottish Ministers may—

(a) approve the scheme submitted under subsection (1),
(b) refuse to approve it.

(4) If the Scottish Ministers refuse to approve the scheme they must—

(a) give the local authority and the Health Board reasons for the refusal (including identifying which particular parts of the scheme caused them to decide to refuse approval),
(b) explain how the scheme should be modified, and
(c) specify a day by which the local authority and the Health Board must jointly modify the scheme and submit it for approval.

(4A) Following submission of a modified scheme under subsection (4), the Scottish Ministers may—

(a) approve the modified scheme, or

(b) refuse to approve it.

(4B) Where the Scottish Ministers refuse to approve a modified scheme, the local authority and the Health Board are to be treated as if they failed before the prescribed day to submit an integration scheme under this section; and section 39 applies accordingly.

(5) The Scottish Ministers may, on their own account or on the request of the local authority and the Health Board, specify that subsection (1) applies as if the prescribed day were such later day as the Scottish Ministers may specify.

(6) A request under subsection (5) must be made in writing and must include the reasons for the request.

(7) A day specified under subsection (5) is to be treated as if it were the prescribed day for the purposes of the other provisions of this Act.

8 Publication of integration scheme

As soon as practicable after an integration scheme is approved under section 7, the local authority and the Health Board must publish it.

Implementation of integration scheme

9 Functions delegated to integration joint board

(1) This section applies where the Scottish Ministers approve under section 7 an integration scheme setting out that the integration model in section 1(4)(a) is to apply.

(2) The Scottish Ministers may by order establish the integration joint board to which the functions are to be delegated.

(3) If the functions are not delegated on the day specified by virtue of section 23(3A), they are delegated on the prescribed day.

10 Chief officer of integration joint board

(1) An integration joint board is to appoint, as a member of staff, a chief officer.

(2) Subsection (3) applies where the person to be appointed is an existing member of staff of a constituent authority.

(3) The person is to be seconded to the board by that authority.

(4) Where subsection (3) does not apply, the person to be appointed—

(a) is to be appointed as a member of staff of a constituent authority, and

(b) is then to be seconded to the board by that authority.

(5) The Scottish Ministers may in relation to any integration joint board by order—

(a) disapply the requirements of subsections (2) to (4), and
Public Bodies (Joint Working) (Scotland) Bill

Part 1—Functions of local authorities and Health Boards

(b) make provision enabling the board to employ a chief officer on such terms and conditions as the board determines.

(6) Before appointing a person as chief officer an integration joint board is to consult each constituent authority.

(7) The responsibilities of a chief officer are subject to the agreement of the Scottish Ministers.

11 Other staff of integration joint board

(1) The Scottish Ministers may by order make provision enabling integration joint boards to employ staff other than a chief officer.

(2) Such an order may include such further provision as regards such staff as the Scottish Ministers think fit, including in particular provision as to—

(a) the appointment of staff,
(b) the numbers of staff,
(c) the terms and conditions of staff.

(4) Without prejudice to section 49(1)(a), an order under this section may—

(a) make provision in relation to only one integration joint board, or some integration joint boards,
(b) make different provision in relation to different integration joint boards.

(5) Before making an order under this section, the Scottish Ministers must consult—

(a) if the order relates to integration joint boards generally, each—

(i) local authority,
(ii) Health Board, and
(iii) integration joint board then established,

(b) if the order relates to one integration joint board, or some integration joint boards—

(i) the constituent authorities in relation to that or those boards, and
(ii) that or those boards, to the extent then established.

12 Integration joint boards: further provision

(1) The Scottish Ministers may by order make provision—

(a) about the membership of integration joint boards,
(b) about the proceedings of integration joint boards,
(c) giving integration joint boards general powers (such as powers to contract, acquire or dispose of property or rights or borrow money or incur other liabilities) in connection with the carrying out of functions conferred on them by or by virtue of this Act,
(d) about the supply of services or facilities to integration joint boards by a constituent authority,
(da) enabling integration joint boards to establish committees for any purpose,
(db) about such other matters relating to any such committee as the Scottish Ministers think fit,

(dc) enabling an integration joint board to delegate to its chief officer, any other member of its staff or any such committee functions delegated to the integration joint board in pursuance of an integration scheme,

(e) about any other matter relating to the establishment or operation of integration joint boards that the Scottish Ministers think fit.

(2) Without prejudice to section 49(1)(a), an order under subsection (1) (other than an order containing provision of the type mentioned in paragraph (a) or (b) of that subsection) may—

(a) make provision in relation to only one integration joint board, or some integration joint boards,

(b) make different provision in relation to different integration joint boards.

(2A) Before making an order under this section, the Scottish Ministers must consult—

(a) if the order relates to integration joint boards generally, each—

(i) local authority,

(ii) Health Board, and

(iii) integration joint board then established,

(b) if the order relates to one integration joint board, or some integration joint boards—

(i) the constituent authorities in relation to that or those boards, and

(ii) that or those boards, to the extent then established.

(3) The Scottish Ministers may by scheme make provision about the transfer to an integration joint board of staff, property, rights, liabilities or obligations of their constituent authorities.

(3A) Before making a scheme under subsection (3), the Scottish Ministers must consult—

(a) the integration joint board to which the scheme relates, and

(b) the constituent authorities in relation to that board.

(4) Before making a scheme under subsection (3) in relation to staff, the Scottish Ministers must consult in respect of each group mentioned in subsection (5), such persons appearing to be representative of the group as the Scottish Ministers think fit.

(5) The groups mentioned in subsection (4) are—

(a) health professionals,

(b) social care professionals,

(c) such other groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

12A Integration joint boards: finance and audit

(2) In section 106 of the Local Government (Scotland) Act 1973 (application of Part 7 of Act to bodies other than local authorities etc.)—

(a) in subsection (1), after paragraph (ba) insert—
“(bb) an integration joint board established by order under section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014 (but subject to subsection (1A)),”, and

(b) after that subsection, insert—

“(1A) Despite subsection (1), sections 101A and 105A of this Act do not apply with respect to an integration joint board.”.

13 Payments to integration joint boards in respect of delegated functions

(1) Subsections (2) and (3) apply where—

(a) an integration scheme sets out that the integration model in section 1(4)(a) is to apply, and

(b) the scheme is approved by the Scottish Ministers under section 7.

(2) The local authority must make a payment to the integration joint board of the amount determined in accordance with the method set out in the scheme in relation to each function delegated by it.

(2A) Where an integration scheme contains provision of the type mentioned in section 1(3)(ca), the Health Board must set aside for use by the integration joint board an amount determined in accordance with the method set out in the scheme in relation to each function delegated by it.

(3) Where an integration scheme contains provision of the type mentioned in section 1(3)(d), the Health Board must make a payment to the integration joint board of the amount determined in accordance with the method set out in the scheme in relation to each function delegated by it.

14 Functions delegated to local authority or Health Board

(1) This section applies where the Scottish Ministers approve under section 7 an integration scheme setting out that the integration model in section 1(4)(b), (c) or (d) is to apply.

(1A) If the functions are not delegated on the day specified by virtue of section 23(3A), they are delegated on the prescribed day.

(2) Before the functions are delegated, the local authority and the Health Board must jointly establish a committee (an “integration joint monitoring committee”) for the purpose of monitoring the carrying out of the integration functions for the area of the local authority.

15 Transfer of staff where functions delegated to local authority or Health Board

(1) The Scottish Ministers may by scheme make provision about the transfer of staff from a person who is to delegate functions under an integration scheme falling within subsection (2) to the person to whom the functions are to be delegated.

(1A) Before making a scheme under subsection (1) in relation to staff, the Scottish Ministers must consult in respect of each group mentioned in subsection (1B), such persons appearing to be representative of the group as the Scottish Ministers think fit.

(1B) The groups mentioned in subsection (1A) are—

(a) health professionals,
(b) social care professionals,
(c) such other groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

(2) An integration scheme falls within this subsection if it sets out that the integration model in section 1(4)(b), (c) or (d) is to apply.

(3) Before making a scheme under subsection (1), the Scottish Ministers must consult—
(a) the person who is to delegate functions under an integration scheme falling within subsection (2), and
(b) the person to whom the functions are to be delegated.

16 Integration joint monitoring committees: further provision

(1) The Scottish Ministers may by order make provision about—
(a) the establishment of integration joint monitoring committees,
(b) the membership of integration joint monitoring committees,
(c) the proceedings of integration joint monitoring committees,
(d) any other matter relating to the operation of integration joint monitoring committees that the Scottish Ministers think fit.

(2) Without prejudice to section 49(1)(a), an order under subsection (1) may make different provision in relation to different integration joint monitoring committees.

17 Payments to Health Boards in respect of delegated functions

(1) Subsection (2) applies where—
(a) an integration scheme sets out that the integration model in section 1(4)(b) or (d) is to apply, and
(b) the scheme is approved by the Scottish Ministers under section 7.

(2) The local authority must make a payment to the Health Board of the amount determined in accordance with the method that is set out in the scheme in relation to each function delegated to the Health Board.

18 Payments to local authorities in respect of delegated functions

(1) This section applies where—
(a) an integration scheme sets out that the integration model in section 1(4)(c) or (d) is to apply, and
(b) the scheme is approved by the Scottish Ministers under section 7.

(1A) Where an integration scheme contains provision of the type mentioned in section 1(3)(ca), the Health Board must set aside for use by the local authority an amount determined in accordance with the method set out in the scheme in relation to each function delegated to the local authority.

(2) Where an integration scheme contains provision of the type mentioned in section 1(3)(d), the Health Board must make a payment to the local authority of the amount determined in accordance with the method set out in the scheme in relation to each function delegated to the local authority.
(3) Each local authority which delegates functions to another local authority (the “lead authority”) under the scheme must make a payment to the lead authority of the amount determined in accordance with the method set out in the scheme in relation to each function delegated by the authority to the lead authority.

18ZA  Power of Scottish Ministers to make provision giving effect to integration scheme

The Scottish Ministers may by regulations make such provision as they think fit for the purpose of giving effect to provision included by virtue of section 1(3)(e) in integration schemes approved by them under section 7.

19  Transfer of staff: effect on contract of employment

(1) This section applies where by virtue of section 12(3), 15(1) or 36(3) a person is to be transferred from the employment of one person (“the original employer”) to another (“the new employer”).

(2) If, before the day of the transfer, the person informs the original employer that the person does not wish to become an employee of the new employer, the person’s contract of employment is terminated on the day before the day of the transfer.

(3) Otherwise—

(a) the contract of employment between the person and the original employer has effect on and after the day of the transfer as if originally made between the person and the new employer,

(b) the rights, powers, duties and liabilities of the original employer under or in connection with the contract of employment are by virtue of this section transferred to the new employer on the day of the transfer, and

(c) anything done before the day of the transfer by or in relation to the original employer in respect of the contract of employment or the person is to be treated on and after that day as having been done by or in relation to the new employer.

(3A) Nothing in subsection (3)—

(a) transfers to the new employer any liability for a share in any deficit in a pension scheme of the original employer that—

(i) is attributable to the person’s membership of the scheme, and

(ii) accrued before the day of the transfer, or

(b) transfers to the new employer any right in respect of a share in any surplus in such a pension scheme that is so attributable and that so accrued.

(4) A person is not to be treated for any purpose as being dismissed by reason of the operation of any provision of this section in relation to the person.

(5) Nothing in this section affects any right of a person to terminate the person’s contract of employment if a substantial detrimental change in the person’s working conditions is made.

(6) No such right arises by reason only that, by virtue of this section, the identity of the person’s employer changes.
20 Co-operation

(1) This section applies where the Scottish Ministers approve under section 7 one or more schemes prepared by virtue of section 2(3) or (4) in relation to the same Health Board.

(2) The persons mentioned in subsection (3) must co-operate with each other in relation to the efficient and effective use of their resources (including in particular buildings, staff and equipment) in pursuance of the scheme or schemes.

(3) The persons are—
(a) each local authority,
(b) the Health Board.

20A Carrying out of functions conferred on officers of local authorities

(1) This section applies where—
(a) a prescribed function conferred by or by virtue of an enactment on an officer of a local authority relates to a function delegated to an integration authority under an integration scheme, and
(b) any prescribed conditions are satisfied.

(2) Where the integration authority is an integration joint board, the prescribed function is deemed to have been conferred also on an officer of the Health Board and any other local authorities that are the constituent authorities of the integration joint board.

(3) Where the integration authority is a local authority or Health Board or (as the case may be) a local authority and Health Board acting jointly, the prescribed function is deemed to have been conferred also on an officer of the Health Board and any other local authority which prepared the integration scheme.

20B Carrying out of functions conferred on officers of Health Boards

(1) This section applies where—
(a) a prescribed function conferred by or by virtue of an enactment on an officer of a Health Board relates to a function delegated to an integration authority under an integration scheme, and
(b) any prescribed conditions are satisfied.

(2) Where the integration authority is an integration joint board, the prescribed function is deemed to have been conferred also on an officer of the local authority or authorities that are the constituent authorities of the integration joint board.

(3) Where the integration authority is a local authority or Health Board or (as the case may be) a local authority and Health Board acting jointly, the prescribed function is deemed to have been conferred also on an officer of the local authority or authorities which prepared the integration scheme.

Carrying out of delegated functions

21 Effect of delegation of functions

(1) This section applies where a function is delegated in pursuance of an integration scheme.
part 1

functions of local authorities and health boards

(2) The integration authority to which the function is delegated is to carry out the function.

(3) The integration authority has all of the powers and duties from time to time applying in connection with the carrying out of the function.

(4) Despite subsection (2), the delegation of the function in pursuance of an integration scheme does not prevent the carrying out of the function by the person by whom the delegation is made.

(5) The Scottish Ministers may by order provide that an integration authority which is an integration joint board must or must not exercise a power of the type mentioned in subsection (3) in connection with the carrying out of a function specified in the order.

22

directions by integration authority

(1) Where the integration authority is an integration joint board, it must give a direction to a constituent authority to carry out each function delegated to the integration authority.

(2) Where the integration authority is a local authority or a Health Board, it may give a direction to the Health Board or local authority which prepared the integration scheme by virtue of which it is the integration authority to carry out any function delegated to the integration authority.

(3) A person to whom a direction under this section may be given must provide the integration authority with such information as the integration authority may reasonably require for the purpose of its deciding—

(a) whether to give the direction,
(b) the content of the direction.

(4) A direction under this section may be given to more than one person in relation to the same function.

(5) If a direction such as is mentioned in subsection (4) is given, the direction may—

(a) require the persons to carry out the function jointly or only in so far as is specified in the direction,
(b) require each person to carry out the function in relation to an area specified in the direction,
(c) require each person to do particular things in relation to the function.

22a

section 22: supplementary

(1) A direction under section 22—

(za) must, where provision of the type mentioned in section 1(3)(ca) is included in the integration scheme in relation to the function to which the direction relates, set out the amount which has been set aside by the Health Board for the use of the person who is to carry out the function,

(a) must, in any other case, set out, or set out a method of determining, payments that are to be made by the integration authority to the person who is to carry out the function,

(aa) must specify how such an amount or, as the case may be, such a payment is to be used,

(b) may—
(i) regulate the manner in which the function is to be carried out,

(ii) make such supplementary, incidental or consequential provision as the integration authority considers appropriate.

(2) The provision referred to in subsection (1)(b)(ii) may include in particular the imposition on the person who is to carry out the function of requirements—

(a) to provide information to the integration authority,

(b) to take action to enable the integration authority to comply with any order of a court made against it in connection with the carrying out of the function.

(3) The integration authority must make payments in accordance with any provision included in the direction by virtue of subsection (1)(a).

(4) A person to whom a direction under section 22 is given must comply with the direction.

(5) A direction under section 22—

(a) may vary or revoke an earlier direction under that section given by the same integration authority,

(b) must be in writing.

(6) If the conditions in subsection (7) are met, the Scottish Ministers may by order provide that an integration authority which is an integration joint board may decide not to give a direction under section 22 in relation to the carrying out of a function specified in the order.

(7) The conditions are—

(a) that the Scottish Ministers receive a written application from the constituent authorities requesting that an order be made in relation to the functions specified in the application, and

(b) that the Scottish Ministers consider that the making of an order in relation to some or all of those functions would improve compliance with the integration delivery principles and contribute to achieving the national health and wellbeing outcomes in relation to the carrying out of the functions.

(8) If the Scottish Ministers do not consider under subsection (7)(b) that the making of an order under subsection (6) would improve compliance with the integration delivery principles or contribute to achieving the national health and wellbeing outcomes in relation to the carrying out of any functions, they need not include those functions in the order.

### 18A Health funding: further provision

(1) This section applies where under section 13(2A) or 18(1A) a Health Board is required to set aside an amount in respect of certain functions delegated to an integration authority.

(2) The integration authority may by direction require a Health Board—

(a) to carry out a function delegated to the integration authority by the Health Board and in relation to which amounts have been set aside, and

(b) to use an amount of the set aside amount specified in the direction (the “specified amount”) for that purpose.
(3) If the integration authority gives a direction under subsection (2) and, despite the
direction, the Health Board does not use all of the specified amount, the integration
authority may require the Health Board to pay to it the unused amount of the specified
amount.

(4) If the integration authority gives a direction under subsection (2) and, despite the
direction, the Health Board requires to use more than the specified amount, the Health
Board may require the integration authority to reimburse it for the additional amount
used.

(5) The Health Board must give reports to the integration authority about such matters
relating to the amounts set aside as the integration authority may specify.

(6) Reports under subsection (5) must be given at such times and in relation to such periods
as the integration authority may specify.

Strategic planning etc.

23 Requirement to prepare strategic plans

(1) The integration authority for the area of a local authority must prepare strategic plans in
accordance with this section.

(2) A strategic plan is a document—
   (a) setting out the arrangements for the carrying out of the integration functions for
       the area of the local authority over the period of the plan,
   (b) setting out how those arrangements are intended to achieve, or contribute to
       achieving, the national health and wellbeing outcomes, and
   (c) including such other material as the integration authority thinks fit.

(3) The provision required to be included in a strategic plan by virtue of subsection (2)(a) is
to include provision—
   (a) dividing the area of the local authority into two or more localities, and
   (b) setting out separately arrangements for the carrying out of the integration
       functions in relation to each such locality.

(3A) If the functions of the integration authority are to be delegated to the authority before the
day prescribed under section 9(3) or, as the case may be, section 14(1A), the first
strategic plan must specify the day on which functions are to be delegated to the
authority.

(4) The first strategic plan of an integration authority is to be prepared before the integration
start day.

(6) In this section, “integration start day” means—
   (a) in relation to an integration authority which is an integration joint board, the day
       on which functions are delegated to the authority by virtue of subsection (3A) or,
       as the case may be, section 9(3),
   (b) in relation to any other integration authority, the day on which functions are
delegated by virtue of subsection (3A) or, as the case may be, section 14(1A) to,
or to the constituent authorities of, the integration authority.
24 Considerations in preparing strategic plan

(1) This section applies where an integration authority in relation to the area of a local authority is preparing a strategic plan.

(2) The integration authority must have regard to—

   (a) the integration delivery principles (see section 25), and

   (b) the national health and wellbeing outcomes (see section 5).

(3) The integration authority must have regard to the effect which any arrangements which it is considering setting out in the strategic plan in pursuance of section 23(2)(a) may have on services, facilities or resources—

   (a) used in relation to arrangements set out in pursuance of that section in a strategic plan prepared by another integration authority,

   (b) which would be used in relation to arrangements which another integration authority is considering setting out in pursuance of that section in a strategic plan which it is preparing.

(4) The references in subsections (3)(a) and (b) to a strategic plan are to a strategic plan relating to the same period as, or relating to part of the same period as, the strategic plan which is being prepared by the integration authority.

25 Integration delivery principles

(1) The integration delivery principles are—

   (a) that the main purpose of services which are provided in pursuance of integration functions is to improve the wellbeing of service-users,

   (b) that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible—

      (i) is integrated from the point of view of service-users,

      (ii) takes account of the particular needs of different service-users,

      (iii) takes account of the particular needs of service-users in different parts of the area in which the service is being provided,

      (iiiza) takes account of the particular characteristics and circumstances of different service-users,

      (iiizb) respects the rights of service-users,

      (iiia) takes account of the dignity of service-users,

      (iiib) takes account of the participation by service-users in the community in which service-users live,

      (iiic) protects and improves the safety of service-users,

      (iid) improves the quality of the service,

      (iv) is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care),

      (v) best anticipates needs and prevents them arising, and

      (vi) makes the best use of the available facilities, people and other resources.
(2) In subsection (1), “service-users” means persons to whom or in relation to whom the services are provided.

26 Establishment of strategic planning group

(1) Before preparing its first strategic plan, an integration authority in relation to the area of a local authority is to establish a group (its “strategic planning group”) comprising—

(a) where the integration authority is an integration joint board—

(i) at least one person nominated by the Health Board which is a constituent authority in relation to the integration joint board,

(ii) where one local authority is a constituent authority in relation to the integration joint board, at least one person nominated by the local authority,

(iii) where two or more local authorities are constituent authorities in relation to the integration joint board, at least one person nominated by the local authorities,

(b) where the integration authority is a Health Board, at least one person nominated by the local authority or authorities with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its functions,

(c) where the integration authority is a local authority, at least one person nominated by the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its functions,

(d) one person in respect of each of the groups mentioned in subsection (2), being a person who the integration authority considers to be representative of that group, and

(e) such other persons as the integration authority considers appropriate.

(2) The groups referred to in subsection (1)(d) are such groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

(2A) The integration authority is to determine—

(a) the number of members of its strategic planning group,

(b) so far as not set out in this section, the processes for appointment, removal and replacement of members.

(2B) The integration authority may—

(a) appoint members of its strategic planning group from persons nominated under subsection (1),

(b) in such circumstances as the authority considers appropriate, remove persons appointed under paragraph (a) from membership of the group,

(c) appoint members in place of members who resign or are removed from membership of the group.

(2C) A constituent authority may—

(a) remove from a strategic planning group a member appointed to represent it,

(b) nominate under subsection (1) another person in place of a member of the group appointed to represent it.
(2D) A member of a strategic planning group may resign at any time.

(2E) During the period to which any strategic plan of an integration authority relates, its strategic planning group is also to comprise a person to represent the interests of each locality set out in the plan in pursuance of section 23(3)(a).

(2F) It is for the integration authority to—

(a) decide which persons are suitable to represent the interests of a locality, and
(b) select the representative.

(2G) An integration authority may under subsection (2F)(b) select a single person in respect of two or more localities.

(2H) The validity of anything done by an integration authority’s strategic planning group is not affected by any vacancy in its membership.

(3) The procedure of an integration authority’s strategic planning group is to be such as the authority determines.

(4) An integration authority may pay to members of its strategic planning group such expenses and allowances as the authority determines.

27 Preparation of strategic plan

(1) This section applies where an integration authority in relation to the area of a local authority is preparing a strategic plan.

(1A) The integration authority is to—

(a) prepare proposals for what the strategic plan should contain, and
(b) seek the views of its strategic planning group on the proposals.

(2) Taking account of any views expressed by virtue of subsection (1A)(b), the integration authority is then to—

(a) prepare a first draft of the strategic plan, and
(b) seek the views of its strategic planning group on the draft.

(3) Taking account of any views expressed by virtue of subsection (2)(b), the integration authority is then to—

(a) prepare a second draft of the strategic plan,
(b) send a copy to—

(i) the persons mentioned in subsection (4), and
(ii) such other persons as it considers appropriate, and
(c) invite the recipients to express views (within such period as the integration authority considers appropriate) on the draft.

(4) The persons referred to in subsection (3)(b)(i) are—

(a) where the integration authority is an integration joint board, each constituent authority,
(b) where the integration authority is a local authority, the Health Board with which the local authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions,
Part 1—Functions of local authorities and Health Boards

19

(c) where the integration authority is a Health Board, the local authority with which
the Health Board prepared the integration scheme in pursuance of which the
integration authority acquired its delegated functions, and

(d) persons who the integration authority considers to be representative of each of the
groups mentioned in subsection (5).

(5) The groups referred to in subsection (4)(d) are such groups of persons appearing to the
Scottish Ministers to have an interest as may be prescribed.

(6) In finalising the strategic plan, the integration authority must take account of any views
expressed by virtue of subsection (3)(c).

27A Provision of information for purpose of preparing strategic plan

(1) A constituent authority must provide an integration authority which is an integration
joint board with such information as the authority may reasonably require for the
purpose of preparing a strategic plan.

(2) The person mentioned in subsection (3) must provide an integration authority which is a
Health Board or a local authority with such information as the integration authority may
reasonably require for the purpose of preparing a strategic plan.

(3) That person is the local authority or the Health Board with which the integration
authority prepared the integration scheme in pursuance of which the integration
authority acquired its delegated functions.

29 Publication of strategic plans

(1) As soon as practicable after the finalisation of the plan under section 27, an integration
authority must publish its strategic plan.

(3) At the same time as publishing a strategic plan, an integration authority must also
publish a statement of the action which it took in pursuance of section 27.

30 Significant decisions outside strategic plan: public involvement

(1) This section applies where the integration authority for the area of a local authority—
(a) proposes to take a significant decision about the arrangements for the carrying out
of the integration functions for the area of the authority, and
(b) intends the decision to take effect other than by virtue of revising its strategic plan
under section 30A.

(2) In subsection (1)(a), “significant decision” means a decision which the integration
authority considers might significantly affect the provision of a service provided in
pursuance of the integration functions in the area of the local authority.

(3) The integration authority must—
(a) seek and have regard to the views of its strategic planning group, and
(b) take such action as it thinks fit with a view to securing that persons mentioned in
subsection (4) are involved in and consulted on the decision.

(4) Those persons are users of the service which is being or may be provided.
30A  Review of strategic plan

(1) An integration authority—

(a) must before the expiry of the relevant period review the effectiveness of its strategic plan,

(b) may from time to time carry out such a review.

(2) In carrying out a review under subsection (1), the integration authority must—

(a) have regard to—

(i) the integration delivery principles, and
(ii) the national health and wellbeing outcomes, and

(b) seek and have regard to the views of its strategic planning group on—

(i) the effectiveness of the arrangements for the carrying out of the integration functions in the area of the local authority, and
(ii) whether the integration authority should prepare a replacement strategic plan.

(3) Following a review under subsection (1), an integration authority may prepare a replacement strategic plan.

(4) Subject to subsection (2), the process of such a review is to be such as the integration authority determines.

(5) A constituent authority must provide an integration authority which is an integration joint board with such information as the integration authority may reasonably require for the purpose of carrying out a review under subsection (1).

(6) The person mentioned in subsection (7) must provide an integration authority which is a Health Board or a local authority with such information as the integration authority may reasonably require for the purpose of carrying out a review under subsection (1).

(7) That person is the local authority or the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions.

(7A) Sections 24, 27, 27A and 29 apply in relation to a strategic plan prepared by virtue of subsection (3) as those sections apply in relation to a strategic plan prepared by virtue of section 23.

(8) A strategic plan prepared in pursuance of this section must specify a day on which the period of the plan is to begin.

(9) In subsection (1), “relevant period”, in relation to an integration authority, means—

(a) the period of 3 years beginning with the integration start day (as defined in section 23(6)), and

(b) each subsequent period of 3 years beginning with—

(i) where a replacement strategic plan is prepared following a review under subsection (1), the day specified under subsection (8),
(ii) where no replacement strategic plan is prepared following such a review, the day on which the integration authority decides not to prepare a replacement strategic plan.
30B  Requirement to prepare replacement strategic plan

(1) This section applies where the integration authority in relation to the area of a local authority is an integration joint board.

(2) If it appears to a constituent authority that the strategic plan is preventing, or is likely to prevent, the constituent authority from carrying out any of its functions appropriately or in a way which complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, the constituent authorities acting jointly may direct the integration authority to prepare a replacement strategic plan.

(3) A direction under subsection (2) must—
   (a) be in writing,
   (b) include a statement summarising the reasons for giving it.

(4) A direction under subsection (2) must specify—
   (a) a day by which the replacement strategic plan must be prepared, and
   (b) a day on which the period of the plan is to begin.

(5) The constituent authorities acting jointly may by direction substitute a different day for a day specified under subsection (4).

(6) An integration authority must comply with a direction given to it under subsection (2).

(7) Sections 24, 27, 27A and 29 apply in relation to a strategic plan prepared by virtue of subsection (2) as those sections apply in relation to a strategic plan prepared by virtue of section 23.

30C  Strategic plan: annual financial statement

(1) Each integration authority must publish an annual financial statement—
   (a) when it publishes its first strategic plan, and
   (b) each year after that.

(2) An annual financial statement must set out in relation to the strategic plan to which it relates the amount that the integration authority intends to spend in implementation of the plan.

Carrying out of integration functions

31  Carrying out of integration functions: general

In carrying out an integration function for the area of a local authority, a person must have regard to—
   (a) the integration delivery principles, and
   (b) the national health and wellbeing outcomes.

32  Carrying out of integration functions: localities

(1) This section applies where—
an integration authority carrying out an integration function for the area of a local
authority proposes to take a decision which the integration authority considers
might significantly affect the provision in a locality of the area of a service
provided in pursuance of the function, or

(b) a person carrying out an integration function for the area of a local authority
proposes to take a decision which the person considers might significantly affect
the provision in a locality of the area of a service provided in pursuance of the
function.

(2) In subsection (1), “locality” means a locality of an area as set out in the strategic plan in
pursuance of section 23(3)(a).

(3) The integration authority or, as the case may be, person must take such action as the
authority or person thinks fit with a view to securing that the groups mentioned in
subsection (4) are involved in and consulted on the decision.

(4) The groups referred to in subsection (3) are such groups of persons appearing to the
Scottish Ministers to have an interest as may be prescribed.

(5) The integration authority may pay to members of groups consulted under subsection (3)
such expenses and allowances as the authority determines.

33 Integration authority: performance report

(1) Each integration authority must prepare a performance report for the reporting year.

(2) A performance report is a report setting out an assessment of performance during the
reporting year to which it relates in planning and carrying out the integration functions
for the area of the local authority.

(3) The Scottish Ministers may by regulations prescribe the form and content of
performance reports.

(3A) An integration authority must—

(a) publish each performance report before the expiry of the period of 4 months
beginning with the end of the reporting year, and

(b) provide a copy of it to the persons mentioned in subsection (3B).

(3B) Those persons are—

(a) where the integration authority is an integration joint board, each constituent
authority,

(b) where the integration authority is a local authority and a Health Board acting
jointly, the integration joint monitoring committee,

(c) where the integration authority is a Health Board or a local authority—

(i) the integration joint monitoring committee, and

(ii) the other authority.

(3C) A constituent authority must provide an integration authority which is an integration
joint board with such information as the authority may reasonably require for the
purpose of preparing a performance report.

(3D) The other authority must provide an integration authority which is a Health Board or a
local authority with such information as the integration authority may reasonably require
for the purpose of preparing a performance report.
In this section—

“other authority” means the local authority or the Health Board with which the integration authority prepared the integration scheme in pursuance of which the integration authority acquired its delegated functions,

“reporting year”, in relation to an integration authority, means—

(a) the period beginning with the date prescribed under section 9(3) or, as the case may be, 14(1A) and ending on the first anniversary of that date, and

(b) each subsequent period of a year.

33A Reports

(1) An integration joint monitoring committee may give reports to the integration authority on any aspect of the carrying out of the integration functions for the area of the local authority for which the integration joint monitoring committee is established.

(2) A report may include recommendations as to how those integration functions should be carried out in future.

(3) Where a report is given to an integration authority under subsection (1), the integration authority must—

(a) have regard to the report and any recommendations included in it,

(b) take such action as the authority considers necessary, and

(c) if the report includes recommendations, give the integration joint monitoring committee a response to them in writing as soon as is reasonably practicable after the authority is given the report.

(4) An integration joint monitoring committee may publish—

(a) reports given under subsection (1),

(b) responses given under subsection (3)(c).

(5) The local authority and the Health Board which prepared the integration scheme by virtue of which the integration joint monitoring committee is established must provide the committee with such reports, information or other assistance as the committee may reasonably require for the purpose of preparing a report under subsection (1).

Review of integration scheme

33B Review of integration scheme

(1) This section applies where an integration scheme has been approved by the Scottish Ministers under section 7.

(2) The local authority and the Health Board must carry out a review of the scheme before the expiry of the relevant period for the purpose of identifying whether any changes to the scheme are necessary or desirable.

(3) Sections 3 and 6 apply to a review of an integration scheme under subsection (2) as they apply to the preparation of an integration scheme (but as if the words “Before submitting the integration scheme for approval under section 7,” in section 6(2) were omitted).
After taking account of any views of persons consulted under section 6 (as applied by subsection (3)), the local authority and the Health Board must decide whether any changes to the scheme are necessary or desirable.

In subsection (2), the “relevant period” means—

(a) the period of 5 years beginning with the day on which the scheme was approved under section 7, and
(b) each subsequent period of 5 years beginning with—

(i) where the local authority and the Health Board vary the scheme under section 34, the day specified under subsection (5) of that section,

(ii) where the local authority and the Health Board decide no changes to the scheme are necessary or desirable, the day on which that decision is made.

33C Requirement to review integration scheme

(1) This section applies where an integration scheme has been approved by the Scottish Ministers under section 7.

(2) On the request of the local authority or the Health Board, the local authority and the Health Board must jointly carry out a review of the scheme for the purpose of identifying whether any changes to the scheme are necessary or desirable.

(3) On each occasion on which the Scottish Ministers exercise the power conferred by section 1(3)(e), the Scottish Ministers may require the local authority and the Health Board jointly to carry out a review of the integration scheme for the purpose of identifying whether any changes to the scheme are necessary or desirable.

(4) Sections 3 and 6 apply to a review of an integration scheme under subsection (2) or (3) as they apply to the preparation of an integration scheme (but as if the words “Before submitting the integration scheme for approval under section 7,” in section 6(2) were omitted).

(5) After taking account of any views of persons consulted under section 6 (as applied by subsection (3)), the local authority and the Health Board must decide whether any changes to the scheme are necessary or desirable.

34 Revised integration scheme

(1) This section applies where a local authority and a Health Board decide under section 33B or 33C that changes to an integration scheme are necessary or desirable.

(2) The local authority and the Health Board may vary the scheme by jointly preparing a revised integration scheme.

(3) A revised integration scheme may—

(a) set out additional functions that are to be delegated under the scheme as mentioned in section 1(3)(b),
(b) set out functions that are delegated by virtue of the integration scheme approved under section 7 that are no longer to be delegated,
(c) if the integration scheme delegates functions in accordance with the integration model mentioned in section 1(4)(b), (c) or (d), set out functions that are to be carried out in conjunction with the delegated functions,
(d) if the integration scheme delegates functions in accordance with the integration model mentioned in section 1(4)(b), (c) or (d), set out functions that are no longer to be carried out in conjunction with the delegated functions,

(da) change the method of determining amounts to be made available as mentioned in section 1(3)(ca),

(e) change the method of determining payments as mentioned in section 1(3)(d),

(f) change or remove any information included in the scheme by virtue of section 1(3)(e).

(3A) Before complying with subsection (4), the local authority and the Health Board must jointly consult—

(a) such persons or groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed, and

(b) such other persons as the local authority and the Health Board think fit.

(3B) In finalising the revised integration scheme, the local authority and the Health Board must take account of any views expressed by virtue of subsection (3A).

(4) The local authority and the Health Board must jointly submit the revised scheme to the Scottish Ministers for approval under section 7.

(5) A revised integration scheme takes effect on such day as may be specified by the Scottish Ministers.

(6) As soon as practicable after a revised integration scheme takes effect, the local authority and the Health Board must publish it.

35 New integration scheme

(1) This section applies where a local authority and a Health Board decide under section 33B or 33C that changes to an integration scheme are necessary or desirable.

(2) If the local authority and the Health Board wish to change a matter mentioned in subsection (3) they must prepare a new integration scheme under section 1 or (as the case may be) 2(2).

(3) The matters are—

(a) the local authority which prepared the integration scheme,

(b) the integration model.

(4) This Act applies in relation to a new integration scheme prepared by virtue of subsection (2) as it applies in relation to an integration scheme which requires to be prepared by section 1 or (as the case may be) 2(2).

36 Power to make provision in consequence of new integration scheme

(1) This section applies where the Scottish Ministers approve an integration scheme which has been prepared by virtue of section 35.

(2) In consequence of the replacement of an integration scheme by a new integration scheme, the Scottish Ministers may by order provide for the winding-up of an integration joint board.
(3) In consequence of the replacement of an integration scheme by a new integration scheme, the Scottish Ministers may by scheme make such provision about the transfer of staff, property, rights, liabilities or obligations of an integration joint board, a local authority or a Health Board as they consider necessary.

(4) Before making a scheme under subsection (3), the Scottish Ministers must consult—
   (a) the person from whom it is proposed to transfer staff, and
   (b) the person to whom it is proposed that the staff be transferred.

(5) Before making a scheme under subsection (3) in relation to staff, the Scottish Ministers must consult in respect of each group mentioned in subsection (6) such persons appearing to be representative of the group as the Scottish Ministers think fit.

(6) The groups mentioned in subsection (5) are—
   (a) health professionals,
   (b) social care professionals,
   (c) such other groups of persons appearing to the Scottish Ministers to have an interest as may be prescribed.

Supplementary

37 Information-sharing

(1) Where a local authority and a Health Board are jointly preparing an integration scheme, each of them may disclose information to the other for or in relation to the purpose of preparing the scheme.

(2) Where two or more local authorities and a Health Board are jointly preparing an integration scheme, each of them may disclose information to any of the others for or in relation to the purpose of preparing the scheme.

(3) A person mentioned in subsection (4) may disclose information to any other person mentioned in that subsection for or in relation to any of the purposes mentioned in subsection (5).

(4) The persons are—
   (a) a local authority,
   (b) a Health Board,
   (c) an integration joint board.

(5) The purposes are—
   (ba) the carrying out of integration functions,
   (c) the preparation of a strategic plan.

(6) Subsections (1) to (3) apply despite any duty of confidentiality owed to any person in respect of the information by the person disclosing the information.

38 Grants to local authorities

(1) The Scottish Ministers may make a grant to a local authority in respect of costs incurred by the authority by virtue of this Part.
(2) The payment of a grant under subsection (1) may be made subject to such conditions (including conditions as to repayment) as the Scottish Ministers may determine.

39 Default power of Scottish Ministers

(1) Subsection (2) applies where a local authority and a Health Board fail before the day prescribed for the purposes of section 7, or the day specified under subsection (4)(c) of that section, to submit an integration scheme for the approval of the Scottish Ministers under that section.

(2) The Scottish Ministers may—

(a) specify functions of the local authority and the Health Board which are to be delegated to an integration joint board,

(b) by order establish the integration joint board to which the functions are to be delegated,

(c) require the local authority and the Health Board to delegate the specified functions to the integration joint board before the prescribed day,

(d) require the local authority and the Health Board to make such payments to the integration joint board as the Scottish Ministers may specify, and

(e) require the local authority and the Health Board to comply with such other requirements in relation to the functions as the Scottish Ministers may specify.

40 Directions

(1) The Scottish Ministers may give directions to a local authority in relation to the carrying out of—

(a) functions conferred on it by this Act,

(b) functions delegated to it in pursuance of an integration scheme,

(c) functions specified in the scheme that are to be carried out in conjunction with those functions.

(2) The Scottish Ministers may give directions to a Health Board in relation to the carrying out of—

(a) functions conferred on it by this Act,

(b) functions delegated to it in pursuance of an integration scheme,

(c) functions specified in the scheme that are to be carried out in conjunction with those functions.

(3) The Scottish Ministers may give directions to an integration joint board in relation to the carrying out of—

(a) functions conferred on it by this Act,

(b) functions delegated to it in pursuance of an integration scheme.

(4) A local authority, a Health Board or an integration joint board must comply with a direction given to it under this section.

(5) Directions under this section—

(a) may vary or revoke earlier directions under this section,
Part 1—Functions of local authorities and Health Boards

(b) must be in writing.

(6) The Scottish Ministers may not under subsection (1) or (2) give a direction requiring a local authority or Health Board to make a written application of the type mentioned in section 22A.

41 Guidance

(1) A person mentioned in subsection (2) must have regard to any guidance issued by the Scottish Ministers about its functions under or in relation to this Act.

(2) Those persons are—

(a) a local authority,
(b) a Health Board,
(c) an integration joint board,
(d) an integration joint monitoring committee.

41A Social Care and Social Work Improvement Scotland

In section 53 of the Public Services Reform (Scotland) Act 2010 (inspections by Social Care and Social Work Improvement Scotland)—

(a) in subsection (1), after paragraph (b), add—

“(c) where social services, services provided under the health service or services provided by an independent health care service are provided in pursuance of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 (‘the 2014 Act’), the planning, organisation or co-ordination of those services.”,

(b) in subsection (2)—

(i) for “this section” substitute “subsection (1)(a) or (b)”,

(ii) after paragraph (e), add—

“(f) reviewing and evaluating the extent to which the social service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(g) reviewing and evaluating the extent to which the planning, organisation or co-ordination of social services, services provided under the health service and services provided by an independent health care service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(h) reviewing and evaluating the effectiveness of a strategic plan prepared under section 23 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(i) encouraging improvement in the extent to which implementation of a strategic plan prepared under section 23 of the 2014 Act complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, and
Part 1—Functions of local authorities and Health Boards

(j) enabling consideration as to the need for any recommendations to be prepared as to any such improvement to be included in the report prepared under section 57.

(ba) after subsection (2), insert—

“(2A) The purposes of an inspection under subsection (1)(c) may include any of those mentioned in subsection (2)(f) to (j).”, and

(c) after subsection (6), add—

“(7) In this section—

“independent health care service” has the meaning given by section 10F(1) of the National Health Service (Scotland) Act 1978;

“integration delivery principles” has the meaning given by section 25 of the 2014 Act;

“national health and wellbeing outcomes” has the same meaning as in section 5(1) of the 2014 Act.”.

41B Healthcare Improvement Scotland

(1) The National Health Service (Scotland) Act 1978 is amended as follows.

(2) In section 10I (Healthcare Improvement Scotland: inspection of services provided under the health service)—

(za) for subsection (1), substitute—

“(1) HIS may inspect any service provided under the health service—

(a) in pursuance of its general duty of furthering improvement in the quality of health care in Scotland, or

(b) for any of the purposes mentioned in subsection (1B).”,

(a) after subsection (1), insert—

“(1A) Where a service provided under the health service and social services are provided by virtue of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 (“the 2014 Act”), HIS may inspect the planning, organisation or co-ordination of those services for any of the purposes mentioned in subsection (1B).

(1B) The purposes are—

(a) reviewing and evaluating the extent to which the service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(b) reviewing and evaluating the extent to which the planning, organisation or co-ordination of services provided under the health service and social services is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(c) reviewing and evaluating the effectiveness of a strategic plan prepared under section 23 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,
(d) encouraging improvement in the extent to which implementation of a strategic plan prepared under section 23 of the 2014 Act complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, and

(e) enabling consideration as to the need for any recommendations to be prepared as to any such improvement to be included in the report prepared under section 10N.”, and

(b) after subsection (2), insert—

“(3) In this section—

“integration delivery principles” has the meaning given by section 25 of the 2014 Act;

“national health and wellbeing outcomes” has the same meaning as in section 5(1) of the 2014 Act;

“social services” has the meaning given by section 46 of the Public Services Reform (Scotland) Act 2010.”.

(3) In section 10J (inspections of independent health care services)—

(a) in subsection (1), after paragraph (b), add—

“(c) where services provided by an independent health care service and social services are provided in pursuance of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 ("the 2014 Act"), the planning, organisation or co-ordination of those services.”,

(b) in subsection (2)—

(i) for “this section” substitute “subsection (1)(a) or (b)”;

(ii) after paragraph (e), add—

“(f) reviewing and evaluating the extent to which the independent health care service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(g) reviewing and evaluating the extent to which the planning, organisation or co-ordination of services provided by an independent health care service and social services is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(h) reviewing and evaluating the effectiveness of a strategic plan prepared under section 23 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes,

(i) encouraging improvement in the extent to which implementation of a strategic plan prepared under section 23 of the 2014 Act complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, and

(j) enabling consideration as to the need for any recommendations to be prepared as to any such improvement to be included in the report prepared under section 10N.”,
(ba) after subsection (2), insert—

“(2A) The purposes of an inspection under subsection (1)(c) may include any of those mentioned in subsection (2)(f) to (j).”, and

(c) after subsection (7), add—

“(8) In this section—

“integration delivery principles” has the meaning given by section 25 of the 2014 Act;

“national health and wellbeing outcomes” has the same meaning as in section 5(1) of the 2014 Act;

“social services” has the meaning given by section 46 of the Public Services Reform (Scotland) Act 2010.”.

41C Joint inspections of health services and social services

(1) The Public Services Reform (Scotland) Act 2010 is amended as follows.

(2) In section 115(11) (meaning of “confidential information”), for “section”, where it second occurs, substitute “sections 116A(4) and”.

(3) After section 116, insert—

“116A Joint inspections of social services and health services

(1) Social Care and Social Work Improvement Scotland (“SCSWIS”) and Healthcare Improvement Scotland (“HIS”) may jointly conduct an inspection in relation to—

(a) any social services, services provided under the health service or services provided by an independent health care service which are provided in pursuance of an integration scheme approved under section 7 of the Public Bodies (Joint Working) (Scotland) Act 2014 (“the 2014 Act”), or

(b) a local authority, Health Board or integration joint board (as defined in section 1(4)(a) of the 2014 Act) which is required by section 23 of the 2014 Act to prepare a strategic plan.

(2) The purposes of an inspection under this section may be any of those mentioned in section 10I(1) or (1B) or 10J(2) of the National Health Service (Scotland) Act 1978 or section 53(2) of this Act.

(2A) On the request of SCSWIS and HIS, any other person or body mentioned in section 115(6) may conduct an inspection under subsection (1) jointly with SCSWIS and HIS.

(3) In conducting an inspection under this section, SCSWIS and HIS must have regard to any code of practice or practice note issued by the Scottish Ministers for the purpose of—

(a) giving practical and general guidance on matters relating to such an inspection (including, without prejudice to that generality, such matters as access to confidential information and the holding, sharing and destruction of such information),

(b) promoting what appear to them to be desirable practices with regard to such matters.
(4) After conducting an inspection under this section, SCSWIS and HIS must—

(a) prepare a report, and

(b) give any person to whom the report relates an opportunity to comment on the report.

(5) SCSWIS and HIS must—

(a) give the report to the Scottish Ministers,

(b) give copies of the report to any person to whom the report relates, and

(c) make copies of the report available at their offices for inspection by any person at any reasonable time.

(6) In this section—

“independent health care service” has the meaning given by section 10F of the National Health Service (Scotland) Act 1978;

“social services” has the meaning given by section 46.”.

(4) In section 117 (regulations relating to joint inspections), after subsection 5, add—

“(6) In this section, “joint inspection” means an inspection conducted under section 115 or 116A.”.

41D Amendments of section 56 of Local Government (Scotland) Act 1973

In section 56 of the Local Government (Scotland) Act 1973 (arrangements for discharge of functions by local authorities)—

(a) after subsection (7), insert—

“(7A) A local authority is not to make arrangements under this section for the discharge of any functions conferred on it by the Public Bodies (Joint Working) (Scotland) Act 2014 by any other local authority.”, and

(b) after subsection (15), add—

“(16) In this section, “Act” includes an Act of the Scottish Parliament.”.

41E Children’s services planning

In section 7(1) of the Children and Young People (Scotland) Act 2014 (which makes provision for introductory matters relating to children’s services planning), in the definition of “other service provider”, after paragraph (e), insert—

“(f) an integration joint board established by order under section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014.”.

42 Meaning of “integration authority”

For the purposes of this Part, the “integration authority” for the area of a local authority is—

(a) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(a), the integration joint board established in pursuance of the scheme,
(b) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(b), the Health Board to which the functions are delegated,

(c) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(c), the local authority to which the functions are delegated,

(d) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(d), the local authority and the Health Board to which the functions are delegated, acting jointly.

43 Meaning of “integration functions”

(1) For the purposes of this Part, the “integration functions” for the area of a local authority are—

(a) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(a), the functions delegated to the integration joint board in pursuance of the scheme,

(b) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(b)—

(i) the functions delegated to the Health Board in pursuance of the scheme,

(ii) the functions to be carried out in conjunction with those functions,

(c) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(c)—

(i) the functions delegated to the local authority in pursuance of the scheme,

(ii) the functions to be carried out in conjunction with those functions,

(d) where in pursuance of the integration scheme for the area functions are delegated in accordance with the integration model mentioned in section 1(4)(d)—

(i) the functions delegated to each of the Health Board and the local authority in pursuance of the scheme, and

(ii) the functions to be carried out in conjunction with those functions.

(2) In subsection (1), the references to the functions which are to be carried out in conjunction with delegated functions are to the functions set out in the integration scheme in pursuance of section 1(3)(c).

43A Meaning of “constituent authority”

For the purposes of this Part, each local authority and the Health Board which prepared the integration scheme in pursuance of which an integration joint board was, or is to be, established is a “constituent authority” in relation to that board.
PART 2

SHARED SERVICES

44 Shared services

(1) The Common Services Agency for the Scottish Health Service (the “Agency”) may, with the consent of the Scottish Ministers, enter into arrangements with a person mentioned in subsection (2) under which the Agency provides, or secures the provision of, any goods or services for the person.

(2) The persons are—

(a) the Scottish Ministers,
(b) any other office-holder in the Scottish Administration,
(c) any Scottish public authority,
(d) any Scottish public authority with mixed functions or no reserved functions,
(e) any government department,
(f) any cross-border public authority,
(g) any body corporate formed by a Health Board or by the Agency, or in the formation of which a Health Board or the Agency participated, by virtue of a delegation of the power in section 84B(1) of the National Health Service (Scotland) Act 1978 (joint ventures).

(3) Services which may be provided under subsection (1) include in particular—

(a) administrative services,
(b) technical services,
(c) legal services,
(d) other professional services,
(e) accommodation services.

(4) The power to make arrangements under subsection (1) is without prejudice to any other power of the Agency to provide goods or services to other persons.

(4A) The Scottish Ministers may by order amend subsection (2) so as to add or remove a person, or a description of a person, for the time being mentioned in or falling within that subsection.

(5) In this section—

“cross-border public authority” has the meaning given by section 88(5) of the Scotland Act 1998 (c.46),
“government department” has the meaning given by section 126(1) of that Act,
“office-holder in the Scottish Administration” is to be construed in accordance with section 126(7) of that Act,
“Scottish public authority” has the meaning given by section 126(1) of that Act except that it does not include—

(a) a Health Board,
(b) a Special Health Board (constituted under section 2(1)(b) of the National Health Service (Scotland) Act 1978), or
(c) Healthcare Improvement Scotland,

“Scottish public authority with mixed functions or no reserved functions” means persons, bodies and office-holders (other than the Agency) listed in schedule 5 to the Public Services Reform (Scotland) Act 2010 (improvement of public functions: listed bodies) under the heading “Scottish public authorities with mixed functions or no reserved functions”.

44A Section 44: consequential provision

(1) The National Health Service (Scotland) Act 1978 is amended in accordance with subsections (2) and (3).

(2) In section 10 (Common Services Agency)—
   (a) in subsection (1), the words from “which” to the end are repealed, and
   (b) after that subsection, insert—

   “(1A) The Agency has the functions conferred on it by—
   (a) this Act, and
   (b) section 44 of the Public Bodies (Joint Working) (Scotland) Act 2014.”

(3) In section 15 (supply of goods and services to local authorities etc.)—
   (a) in subsection (1)—
      (i) for “, a Health Board or the Agency”, in the first two places where it occurs, substitute “or a Health Board”, and
   (ii) in paragraph (e), the words “or the Agency” are repealed,
   (b) after that subsection, insert—

   “(1ZA) Paragraph (a) of subsection (1) applies to the Agency as it applies to a Health Board.”,
   (c) in subsection (2), after “including” insert “paragraph (a) as applied by subsection (1ZA) and”, and
   (d) subsections (2A) to (2D) are repealed.

(4) In section 17(2) of the Patient Rights (Scotland) Act 2011, for “that Act” substitute “the 1978 Act”.

44B Common Services Agency for the Scottish Health Service: residual liabilities

In section 2(1) of the National Health Service (Residual Liabilities) Act 1996 (certain Scottish health bodies: duty to transfer residual liabilities on ceasing to exist), for “or a Special Health Board” substitute “, a Special Health Board or the Common Services Agency for the Scottish Health Service”.

45 Extension of schemes for meeting losses and liabilities of health service bodies

(1) Section 85B of the National Health Service (Scotland) Act 1978 (schemes for meeting losses and liabilities of health service bodies) is amended as follows.

(2) In subsection (2)—
   (a) the word “and” immediately after paragraph (ea) is repealed,
(b) after paragraph (f) add—

“(g) local authorities; and
(h) integration joint boards established by order under section 9(2) of the 2014 Act.”.

(3) After subsection (2A) insert—

“(2B) The reference—

(a) in paragraph (a) of subsection (1) to property of a local authority is to be construed as a reference to property held by a local authority in connection with the exercise of its relevant functions;
(b) in paragraph (b) of that subsection to the functions of a local authority is to be construed as a reference to the relevant functions of a local authority.

(2C) In subsection (2B), “relevant functions” means—

(a) integration functions; and
(b) such other functions as the Scottish Ministers may by order specify.

(2D) In subsection (2C)(a), “integration functions” means functions which in pursuance of an integration scheme under the 2014 Act are—

(a) delegated to the authority;
(b) to be carried out in conjunction with functions delegated to the authority (that is, functions set out in the integration scheme in pursuance of section 1(3)(c) of that Act); or
(c) to be carried out by the authority by virtue of a direction under section 22 of the 2014 Act.”.

(4) After subsection (4) insert—

“(4A) Subsection (4)(a) does not apply in relation to a local authority.”.

(5) After subsection (5) insert—

“(6) In this section, “the 2014 Act” means the Public Bodies (Joint Working) (Scotland) Act 2014.”.

PART 3

HEALTH SERVICE: FUNCTIONS

46 Scottish Ministers: power to form companies etc.

In section 84B of the National Health Service (Scotland) Act 1978 (joint ventures)—

(a) in subsection (1), for “companies”, wherever it occurs, substitute “bodies corporate”;

(aa) after subsection (1), insert—

“(1A) The Scottish Ministers may do any (or all) of the following—

(a) form or participate in forming bodies corporate for any of the purposes mentioned in subsection (1B),
Part 4—General

47 Health Boards: carrying out of functions

After section 12J of the National Health Service (Scotland) Act 1978, insert—

“12K Power of Health Board to carry out other Health Board’s functions

A Health Board may, with the agreement of another Health Board and the Scottish Ministers, carry out on behalf of that other Health Board any function of that other Health Board.”.

PART 4

GENERAL

48 Interpretation

(1) In this Act—

“Health Board” has the meaning given by section 1(7),
“health care” has the same meaning as in section 10A(1)(b) of the National Health Service (Scotland) Act 1978,

“health professionals” means persons of such description engaged in the provision of health care as may be prescribed,

“integration delivery principles” has the meaning given by section 25,

“integration joint board” has the meaning given by section 1(4)(a),

“integration joint monitoring committee” has the meaning given by section 14(2),

“integration scheme” has the meaning given by section 1(3),

“national health and wellbeing outcomes” has the same meaning as in section 5(1),

“prescribed” means prescribed by the Scottish Ministers by regulations,

“social care” means—

(a) social services (having the same meaning as in Part 5 of the Public Services Reform (Scotland) Act 2010), and

(b) such functions of local authorities relating to the provision of accommodation for persons who are homeless as may be prescribed,

“social care professionals” means persons of such description engaged in the provision of social care as may be prescribed,

“strategic plan” has the meaning given by section 23(2).

For the purposes of this Act, a provider of a service is a “commercial” provider if the aim of the person in providing the service is or includes making a profit.

References in this Act (other than sections 2(3), 11(5)(a)(i), 12(2A)(a)(i), 33C(2) (first occurrence only), 37(1) and 43A)—

(a) to a local authority include, in the case where the integration scheme is being or has been jointly prepared under section 2(4), references to both or all the authorities which are preparing or have prepared the scheme, acting jointly,

(b) to the area of a local authority mean, in a case where the integration scheme is being or has been jointly prepared under section 2(4), the combined area of the local authorities which are preparing or have prepared the scheme.

References in this Act to a function include references to a function so far as exercisable in relation to persons or matters of a particular class or description.

Subordinate legislation

Regulations and orders under this Act may—

(a) make different provision for different purposes,

(aa) make different provision for different cases or classes of case,

(b) include such supplementary, incidental, consequential, transitional or transitory provision, or savings, as the Scottish Ministers consider appropriate.

Regulations under sections 1(3)(e), (4C), (4D) and (4H), 5(1) and 18ZA are subject to the affirmative procedure.

An order under section 44(4A) is subject to the affirmative procedure.
(3) An order under section 50 containing provision which adds to, replaces or omits any part of the text of an Act is subject to the affirmative procedure.

(4) Otherwise, regulations and orders under this Act are subject to the negative procedure.

(5) This section does not apply to an order under section 52(2).

50 Ancillary provision

(1) The Scottish Ministers may by order—
   (a) make such supplementary, incidental or consequential provision as they consider appropriate for the purposes of, in consequence of, or for giving full effect to, any provision of this Act,
   (b) make such transitional or transitory provision or savings as they consider appropriate for the purposes of, or in connection with, the coming into force of any provision of this Act.

(2) An order under this section may modify any enactment (including this Act).

51 Repeals and revocation

(A1) Section 5A of the Social Work (Scotland) Act 1968 (which makes provision about local authority plans for community care services) is repealed.

(1) Sections 4A and 4B of the National Health Service (Scotland) Act 1978 (c.29) (which make provision about community health partnerships) are repealed.

(2) Sections 15 to 17 of the Community Care and Health (Scotland) Act 2002 (asp 5) (which make provision about joint working among local authorities and certain health bodies) are repealed.

(3) Section 2 of the National Health Service Reform (Scotland) Act 2004 (asp 7) (which inserts sections 4A and 4B into the National Health Service (Scotland) Act 1978) is repealed.

(3A) Section 17(1) of the Patient Rights (Scotland) Act 2011 is repealed.

(4) Section 20 of the Social Care (Self-directed Support) (Scotland) Act 2013 (asp 1) (which amends section 15(4) of the Community Care and Health (Scotland) Act 2002) is repealed.

(5) The Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013 (S.S.I. 2013/220) is revoked.

52 Commencement

(1) Sections 1(3) to (7), 5, 37 and 41 and this Part (other than section 51) come into force on the day after Royal Assent.

(2) The other provisions of this Act come into force on such day as the Scottish Ministers may by order appoint.

(3) An order under subsection (2) may contain transitory or transitional provision or savings.
53  **Short title**

The short title of this Act is the Public Bodies (Joint Working) (Scotland) Act 2014.
SCHEDULE
(introduced by section 1(4A))

FUNCTIONS OF LOCAL AUTHORITIES WHICH MAY BE DELEGATED

PART 1

FUNCTIONS CONFERRED BY ENACTMENTS

Sections 22, 26, 45 and 48 of the National Assistance Act 1948.
Sections 1, 4, 5, 6B, 8, 10, 12, 12A, 12AZA, 12AA, 12AB, 13 to 14, 27, 27ZA, 28, 29, 59, 78A, 80, 81, 83, 86 and 87 of the Social Work (Scotland) Act 1968.
Sections 34, 39, 40 and 50 of the Children Act 1975.
Section 24 of the Local Government and Planning (Scotland) Act 1982.
Sections 21, 22 and 23 of the Health and Social Services and Social Security Adjudications Act 1983.
Sections 3, 5, 6, 8, 9 and 10 of the Foster Children (Scotland) Act 1984.
Sections 2, 3, 7 and 8 of the Disabled Persons (Services, Consultation and Representation) Act 1986.
Sections 4, 5 and 5A and Part II of the Housing (Scotland) Act 1987.
Sections 17, 19 to 27, 29 to 32, 36, 38 and 76 of the Children (Scotland) Act 1995.
Sections 10, 12, 37 and 39 to 45 of the Adults with Incapacity (Scotland) Act 2000.
Sections 1, 2, 5, 6, 8 and 92 of the Housing (Scotland) Act 2001.
Sections 5, 6 and 14 of the Community Care and Health (Scotland) Act 2002.
Sections 17, 25 to 27, 33, 34, 228 and 259 of the Mental Health (Care and Treatment) (Scotland) Act 2003.
Sections 10 and 11 of the Management of Offenders etc. (Scotland) Act 2005.
Section 71 of the Housing (Scotland) Act 2006.
Sections 1, 4, 5, 6, 9, 10, 11, 12, 19, 26, 45, 47, 48, 49, 51, 71, 80, 90, 99, 101 and 105 of the Adoption and Children (Scotland) Act 2007.
Sections 4 to 11, 14, 16, 18, 22, 40, 42 and 43 of the Adult Support and Protection (Scotland) Act 2007.
Sections 35, 37, 42, 44, 48, 49, 60, 131, 144, 145, 166, 167, 180, 183 and 184 of the Children’s Hearings (Scotland) Act 2011.
Sections 3, 5 to 13, 16 and 19 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Public Bodies (Joint Working) (Scotland) Bill

Schedule—Functions of local authorities which may be delegated

Part 2—Functions conferred by virtue of enactments

PART 2

FUNCTIONS CONFERRED BY VIRTUE OF ENACTMENTS

Section 4 of the Community Care and Health (Scotland) Act 2002.

Section 153 of the Children’s Hearings (Scotland) Act 2011.
Public Bodies (Joint Working) (Scotland) Bill
[AS PASSED]

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

Introduced by: Alex Neil
Supported by: Derek Mackay
On: 28 May 2013
Bill type: Government Bill