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
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.
Annex A

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.