DUNDEE CITY COUNCIL

REPORT TO: **POLICY AND RESOURCES COMMITTEE - 10TH SEPTEMBER 2012**

REPORT ON: **HEALTH AND SOCIAL CARE INTEGRATION**

REPORT BY: **CHIEF EXECUTIVE**

REPORT NO: **334 - 2012**

1.0 PURPOSE OF REPORT

The purpose of this report to the Policy and Resources Committee is: to report on the Government's consultation on Health and Social Care Integration; to seek approval for the proposed response to the questions raised in the consultation document; and to advise on the proposed governance arrangements that will be established to see through the process of transition.

2.0 RECOMMENDATIONS

It is recommended that members of the Committee:

2.1 Note the proposals for integration outlined in Health and Social Care Integration consultation document attached as Appendix 1 to this report.

2.2 Approve the response to the consultation attached as Appendix 2 to this report.

2.3 Approve the recommended arrangement for governance of transitional planning for the change outlined in paragraph 4.6 of this report.

3.0 FINANCIAL IMPLICATIONS

If, as suggested in the response, services were integrated into a Health and Social Care Partnership, that partnership would have delegated authority of NHS Tayside and Dundee City Council for an agreed amount of resource. The resource would remain subject to the respective financial governance arrangements of each partner.

4.0 MAIN TEXT

4.1 The Government first published its proposals on health and social care integration in May 2012 (Integration of Adult Health and Social Care in Scotland, Consultation on Proposals May 2012). They are attached as Appendix 1 to this report. In the consultation document the Government sets out its argument for change; its vision for the future; and its framework for improvement. Interested bodies are invited to comment on 20 questions which range over the proposals for change by the end of September 2012.

4.2 In advancing the argument for change the Government explains that demographic pressures make the current model of service delivery unsustainable. In addition, it is argued that there are aspects of the current model of service delivery that are unsatisfactory and the government would like to see them resolved by revised arrangements for integrated working. The problem with the current approach to service delivery as defined by the government is that,

"*there is too much variability of health and social care in different parts of Scotland, particularly for older people; there is no incentive to get people out of hospital quickly and back to a homely setting; and it is much easier to get people admitted to hospital than to arrange services that would keep them at home.*"

4.3 The Government's vision for the future is that people should be supported to live well at home or in the community for as much time as they can and that they should have a positive experience of health and social care when they need it.

In summary, the proposals for reform consist of:

- Nationally agreed outcomes across health and social care, with performance management focussing at first on improved outcomes for older people
- Joint accountability via the Chief Executives of the Health Board and Local Authority to Ministers, NHS Chairs, Council Leaders and the public for delivery of outcomes
- Integrated health and social care partnership arrangements set up either through the adoption of a Lead Agency Model, (Model 1) or through the delegation of agreed functions to a Health and Social Care Partnership established as a body corporate of the Health Board and Local Authority (Model 2)
- Integrated budgets, in the case of the Model 2 consisting of an amount of resource to be committed by the Health Board and Local Authority
- A Jointly Accountable Officer, responsible for the management of the committed resources and accountable for the delivery of the Partnership's delegated functions
- A Partnership Agreement which establishes the terms of the arrangement between Health and the Local Authority
- Clinical and professional leadership and engagement of the third sector in the commissioning and planning of services
- Locality service planning groups

4.4 The Government's vision and analysis of the context and the problem that the proposed changes seek to resolve resonate for Dundee City and with Dundee City Council policy. Strategy and policy statements have consistently emphasised the Council's wish to see improved outcomes for its citizens as outlined in successive Single Outcome Agreements; its concern about the relative disadvantage of some of its citizens has been taken up by the publication of a Fairness Strategy; its commitment to broad partnership working has been demonstrated through a successful community planning partnership; its recognition of the preferences of citizens to remain at home or in homely setting for as long as possible have been outlined in commissioning statements and service redesign for adults and older People; commitment to seamless service delivery has been detailed in the Dundee Change Plan for Older People; and the Council's willingness to engage with the complexities of change and performance improvement are being taken forward in its Changing for the Future Programme.

4.5 There is commonality of understanding between the Government and the Council and this is reflected in the proposed response to the consultation questions. This is particularly so in terms of vision, partnership working, a shared outcome agenda and the necessity for change and continuous improvement. There are, however, some areas where the emphasis is not as the Council would wish. These centre around, definition of partnership, democratic accountability and the need for local flexibility. The response argues therefore for: local flexibility to determine the breadth of the partnership; a strengthening of the governance framework in terms of local democratic accountability with more flexibility in relation as to which and how many councillors are members of the Health and Social Care Partnership Committee; re-ordering of the reporting arrangement and redirection of the powers of Jointly Accountable Officer towards the Health and Social Care Partnership Committee to maintain the principles of collective responsibility; flexibility to interpret the role of the Jointly Accountable Officer; and local flexibility to develop the devolution of local decision making. The response also argues that of the two models of support, the Lead Agency Model or the delegation of functions to a Health and Social Care partnership model, the second would represent the best development of our current partnership arrangements. It also describes, as requested, our experience of the flexible use of resources.

4.6 If the legislative programme follows the planned schedule it is likely that the implementation will begin in 2014. In preparation for the proposed programme of change it is necessary, therefore, that work should begin now to develop the necessary transitional arrangements. To do this the Chief Executives of Dundee City Council and NHS Tayside are recommending that an Executive group be established consisting of the Council Leader and Chief Executive, the NHS Board Chairperson and Chief Executive, the Community Health Partnership Chair, the Convenor and Vice Convenor of Health and Social Care Committee and that this group be supported by an Officer Reference Group with core membership of the Director of Social Work, the General Manager of the CHP, the Depute Chief Executive of NHS Tayside and the Head of Service for Community Care. The Executive Group will advise the NHS Board and Dundee City Council of proposed implementation plans as the detailed legislative programme unfolds.

4.7 In conclusion, the proposed arrangements for Health and Social Care Integration will have significant implications for the citizens of Dundee and for the governance arrangements of Dundee City Council and NHS Tayside. The Council will seek to use the proposals to develop partnership working to achieve improved outcomes for its citizens. The response to the proposed changes reflects such an approach.

5.0 POLICY IMPLICATIONS

As the detail of future arrangements becomes clear an appropriate risk register will be developed to ensure compliance with the Council's risk control and indemnity requirements.

6.0 CONSULTATIONS

The Chief Executive, Director of Corporate Services and Head of Democratic and Legal Services.

7.0 BACKGROUND PAPERS

None.

David Dorward DATE: 24th August 2012
Chief Executive

Integration of Adult Health and Social Care in Scotland

Consultation on Proposals

May 2012

The Scottish Government

Foreword

Scotland, like every other developed country, is experiencing radical demographic change. More people are living for longer, which is a cause for celebration, and is a sign also of the significant improvements we now enjoy in terms both of our standard of living and the success of our health and care services. We have put significant effort into preventative and anticipatory care, and to enabling self-management of a range of long-term conditions. Nevertheless, these positive changes bring with them challenges in terms of the way we plan for, organise and deliver the health and social care services that provide vital support for many people, particularly in their later years. We recognise that we cannot rest on earlier success. Reform is needed now to improve care, particularly for older people, and to make better use of the substantial resources that we commit to health and social care in Scotland.

This consultation sets out our proposals to improve the quality of the outcomes we achieve, now and in the future, via better integration of adult health and social care in Scotland. I am delighted that the development of these proposals has directly involved our partners in NHS Scotland and local government, and has benefitted from input from many stakeholders, including representatives of the professional groups and the third and independent sectors.

As we have developed these proposals, our approach has been to focus on the key questions about what matters most to people who use services. What are the improvements and outcomes they want to see, and what are the barriers in the current system that prevent professionals and staff from using their considerable skills and resources to best effect? Our objectives are to ensure that:

- Health and social care services are firmly integrated around the needs of individuals, their carers and other family members;
- That they are characterised by strong and consistent clinical and care professional leadership;
- That the providers of services are held to account jointly and effectively for improved delivery; and
- That services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve – rather than the organisations through which they are delivered.

The Scottish Government and its partners – statutory and non-statutory – are committed to putting in place a system of health and social care that is robust, effective and efficient, and which reliably and sustainably ensures the high quality of support and care that is the right of the people of Scotland.

Scotland is a small country, with a proud history of social co-operation. We are building this ambitious programme of improvement on an unrivalled foundation of professionalism, commitment and expertise, and a track record of partnership working over a number of years. We will use all of these advantages to make sure that our proposals for integrated health and social care make best use of our collective wisdom, experience and insight.

This consultation provides an opportunity for you to contribute your views on the new legislation that we are proposing to support our objectives. Legislation will be only one small part of the collective effort that will deliver on our goals, but it is an important part nonetheless. We look forward to hearing your views on our proposals.

NICOLA STURGEON MSP
CABINET SECRETARY FOR HEALTH WELLBEING AND CITIES STRATEGY

Local Government in Scotland

Scottish Local Government welcomes these proposals on the integration of health and social care and recognises that strong and effective partnership must be at the heart of driving better outcomes for the people of Scotland. The partnership we have forged at a national level between COSLA, the Scottish Government, NHS Scotland and our partners in the third and independent sectors has been instrumental in drafting a set of proposals that are both balanced and ambitious.

The road to success remains long and hard and we will doubtless confront many challenges along the way: demographic change continues to drive increasing demand, public finances are constrained, and we want to shift resources to community-based services. I have no doubt that the proposed arrangements, whatever their final form, will need time to embed, develop and demonstrate added value. But what we have with these proposals is a foundation on which to build stronger local delivery arrangements, tighter governance and accountability and better outcomes for people who require care and support.

COUNCILLOR DOUGLAS YATES
COSLA HEALTH AND WELLBEING SPOKESPERSON

Introduction

We have a great deal to be proud of in terms of health and social care provision in Scotland. The Healthcare Quality Strategy[1] underpins our commitment to deliver the highest quality healthcare services to people in Scotland and, in recent years, we have seen significant improvements in terms of standards and outcomes, with improvements in waiting times, patient safety and delayed discharges from hospital. Our introduction of a Dementia Strategy[2], our continuing commitment to Free Personal and Nursing Care[3] and our Reshaping Care for Older People[4] programme, which is supported by the significant Change Fund[5] for older people's services, all demonstrate our determination to assure innovative, high quality care and support services that improve people's lives. Our Carers' Strategy supports unpaid carers, who are themselves essential providers of health and social care, and our Self Directed Support Bill[6] seeks to put greater control into the hands of individuals using care and support services.

Nevertheless, there is widespread recognition across Scotland that we need 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.

The Scottish Government, our statutory partners in local government and NHS Scotland, and our non-statutory partners in the third and independent sectors, agree that better integration is required if we are to ensure the ongoing 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 we all work together to ensure that we are integrating services as an effective means for achieving better outcomes.

When we refer to "integrated health and social care", we mean services that 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. We have laid out our proposals for delivery of better outcomes for people via integration in this consultation to reflect what we believe are the key features of effective integration.

[1] http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf
[2] http://www.scotland.gov.uk/Resource/Doc/324377/0104420.pdf
[3] http://www.scotland.gov.uk/Resource/Doc/305166/0095748.pdf
[4] http://www.scotland.gov.uk/Topics/Health/care/reshaping
[5] http://www.scotland.gov.uk/Topics/Health/care/reshaping/changefund
[6] http://www.selfdirectedsupportscotland.org.uk/

This consultation follows on from an announcement made by the Cabinet Secretary for Health, Wellbeing and Cities Strategy on 12 December 2011, which outlined the Scottish Government's proposals for integration of adult health and social care. You can read the text of that announcement here:
http://www.scotland.gov.uk/News/Releases/2011/12/12111418

A debate was held in the Scottish Parliament on 15 December 2011, which confirmed broad cross-party support for Scottish Ministers' proposals. You can read the official report of that debate here:
http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=6627

The process of developing these proposals has included the direct involvement of the Scottish Government's partners in NHS Scotland and COSLA, and input also from many stakeholders, including representatives of professional groups and the third and independent sectors. The Scottish Government acknowledges and is grateful for the contributions made already to this important process by everyone involved so far.

What is the purpose of this consultation?

The Cabinet Secretary for Health, Wellbeing and Cities Strategy noted in her opening speech to Parliament in the debate on 15 December 2011 that, "*there should be no mistake about the extent and ambition of the changes that we seek*."

This consultation paper provides an opportunity for you to offer your views on **new legislation** that will be introduced in order to enable the changes that Ministers propose.

New legislation will not on its own achieve the improvements that Ministers are looking for. There will also be important work to carry out in terms of developing professional skills and leadership, for example. Legislation nonetheless has an important role to play – it will help to create the type of working environment that professionals and staff within the current health and social care system, and users of it, tell us is needed, and it will be used to change some arrangements that are no longer in step with society's needs. It will seek to address a number of difficulties currently faced by partners in pursuit of better outcomes for individuals and communities.

Within this consultation document, we have sought to describe the proposed new legislation in enough context to inform your answers to the questions we have asked. It is important to note, though, that this consultation does not – indeed, could not – provide a comprehensive description of every aspect of policy development, clinical improvement and practical implementation that will be part of the long-term story of effective integration of adult health and social care services in Scotland. Many of those changes and improvements will be developed locally and will build upon good practice developed over recent years.

Should the legislation proposed here pass through the Scottish Parliament, the Scottish Government will, with input from stakeholders, patients and service users, develop regulations and statutory guidance to support the changes that will be enabled by the new legislation described here. Such regulations and guidance will provide important further detail to the provisions of the Bill. There will be an ongoing, short to medium term process to give real effect to the ambitions expressed here, which will include consideration of what is required in terms of workforce development. There will of course be opportunities to contribute to that broader, ongoing process of development and improvement, which will be set within the wider context of public service reform.

Who should respond to this consultation?

Planning for, and providing, good quality health and social care services is a marker of a civilised society, and the challenges that accompany that aim affect us all, directly or indirectly. We expect that this consultation will be of interest to a wide range of people – patients, service users, carers, clinicians and other professionals working in the NHS and social care and beyond, and in the third and independent sectors, and members of the public more widely.

Equality Impact Assessment

The public sector equality duties require the Scottish Government to pay “due regard” to the need to:

- Eliminate discrimination, victimisation, harassment or other unlawful conduct that is prohibited under the Equality Act 2010;
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between people who share a relevant protected characteristic.

These three requirements apply across the “protected characteristics” of age; disability; gender reassignment; pregnancy and maternity; race; religion and belief; sex and sexual orientation.

In effect, this means that equality considerations are integrated into all functions and policies of Scottish Government Directorates and Agencies.

A key part of these duties is to assess the impact of all of our policies to ensure that we do not inadvertently create a negative impact for equality groups, and also to ensure that we actively seek the opportunity to promote equality of opportunity and to foster good relations.

In March 2012, the Scottish Government ran a scoping workshop to identify potential impacts that may or may not arise as a result of the policies described in this consultation. This workshop provided the first stage of an Equalities Impact Assessment (EQIA). A report of the findings from the workshop has been used to develop a partial EQIA, which is attached at Annex D.

We welcome your feedback regarding the equalities impact of the proposals presented in this paper, and the effect they may have on different sectors of the population.

Business Regulatory Impact Assessment

The Scottish Government is committed to consulting with all parties potentially affected by proposals for new legislation, or where any regulation is being changed significantly. All policy changes, whether European or domestic, which may have an impact upon business or the third sector should be accompanied by a Business Regulatory Impact Assessment (BRIA).

The BRIA helps policy makers to use available evidence to find proposals that best achieve the policy objectives, whilst minimising costs and burdens. Through consultation and engagement with business, the costs and benefits of the proposed legislation can be analysed. It also ensures that any impact on business, particularly small enterprises, is fully considered before regulations are made.

A partial BRIA is attached at Annex E. We welcome your views regarding the impact that the proposals presented in this paper may have on businesses, and your comments and feedback on the partial BRIA.

Structure of this consultation paper

This consultation paper is organised into chapters, as follows:

Background
Chapter 1 The case for change
Chapter 2 Outline of proposed reforms

Detailed proposals
Chapter 3 National outcomes for adult health and social care
Chapter 4 Governance and accountability
Chapter 5 Integrated budgets and resourcing
Chapter 6 Jointly Accountable Officer
Chapter 7 Professionally led locality planning and commissioning of services

Supporting information
Annex A Draft national outcomes for adult health and social care
Annex B Impact on other areas of service – beyond adult health and social care
Annex C Workforce implications

Equality Impact Assessment and Business Regulatory Impact Assessment
Annex D Partial Equality Impact Assessment
Annex E Partial Business Regulatory Impact Assessment

Responding to this consultation
Annex F Respondent Information Form
Annex G Consultation Questionnaire
Annex H How to respond

Please ensure that your response is sent to:

adulthealthandsocialcareintegration@scotland.gsi.gov.uk

Or

Integration and Service Development Division
The Scottish Government
2ER, St Andrew's House
Edinburgh
EH1 3DG

By: **31 July 2012**

Chapter 1 - The case for change

1.1. As we noted in the introduction to this consultation paper, there is a great deal to be proud of in terms of health and social care provision in Scotland. We recognise, however, that we should go further to ensure consistently good outcomes for patients, service users, carers and families. Separate – and sometimes disjointed – systems of health and social care will no longer adequately meet the needs and expectations of increasing numbers of people, particularly those living into older age, often with multiple, complex, long-term conditions, who need joined up, integrated support.

1.2. There has been very significant progress in improving pathways of care in recent years. Nevertheless, many clinicians, care professionals and managers in health and social care currently describe two key disconnects in our system of health and social care. 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.

1.3. 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, older people, and people with complex needs. Problems are also encountered at transition points, particularly as children with complex needs reach adulthood.

> "The traditional separation of health and social care – the 'fault-line of 1948' – was probably harmless at the time. In the early post-war era there was little overlap between their respective patient/client groups. Health care was still largely acute, and social care focused mainly on deprivation and 'the problem family'. Since then, as a result of improved health in youth and middle age and the dramatic ageing of the UK population, care needs have changed massively, in the direction of multiple pathology and long-term conditions, with the resultant frailty and dependency now largely compressed into the later years of life . . .
>
> "Yet the two care systems have – for various reasons – adapted only slowly, reluctantly and separately and, despite the existence of a main task in common, have broadly failed to establish and generalise reliable, effective and cost-effective means of working together on their central challenge now and for the foreseeable future: that of the care of older people, particularly those at home."
>
> **Colin T Currie**, Senior Lecturer in Geriatric Medicine, University of Edinburgh, and Honorary Consultant Geriatrician, NHS Lothian
> Journal of Integrated Care Volume 18, Issue 6, December 2010

1.4. From the perspective of people who use the system – patients, service users, carers and families – the problems we are seeking to address 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.

1.5. In terms of older people's services, we know from the public engagement exercise of Reshaping Care for Older People[7] that these are the main problems that people want us to address. We also know from clinicians and other professionals who provide health and social care support 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.

1.6. We also know from our work on Reshaping Care for Older People that[8]:

- We spend almost one third of our total spend on older people's services annually on unplanned admissions to hospital;
- There is little association between the amount spent currently on health and social care services, and the outcomes that are achieved – spending more does not necessarily result in better outcomes, or vice versa;
- We spend more annually on unplanned admissions for older people than we do 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 account of our current emphasis on improving anticipatory and preventative care, Scotland will in future experience a material increase in the number of older people who need care. The resources required to provide support will rise in the years ahead.

1.7. Despite a good track record of partnership working over many years, our 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. We need to reform the system to deliver care that is better joined up and as a consequence delivers better outcomes for patients, service users and carers.

1.8. Our 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 our commitment to a person-centred approach, which builds upon our policy on Self Directed Support and the principles of the NHS Healthcare Quality Strategy.

[7] http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/
[8] http://www.scotland.gov.uk/Resource/Doc/924/0114884.pdf

"Public service providers must be required to work much more closely in partnership, to integrate service provision and thus improve the outcomes they achieve.

We must prioritise expenditure on public services which prevent negative outcomes from arising.

And our whole system of public services – public, third and private sectors – must become more efficient by reducing duplication and sharing services wherever possible.

Experience tells us that all institutions and structures resist change, especially radical change. However, the scale of the challenges ahead is such that a comprehensive public service reform process must now be initiated, involving all stakeholders."

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

Scope – demographic considerations

1.9. Our ambitions for improving integration of 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 we recognise the importance of ensuring that better integration of health and social care services results in improvements for all patients, service users and carers.

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

1.11. Demographic change in itself also makes the case for change urgent, and suggests that we must focus 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 our more rural areas the proportion is predicted to rise to nearly one third.

1.12. Given these pressures, it might seem appropriate to focus our proposals for integration of health and social care on older people exclusively. However, we recognise a number of arguments against limiting our 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.

1.13. In terms of demographic scope, our proposal is that we will legislate to enable Health Boards and Local Authorities to integrate planning and service provision arrangements for all areas of adult health and social care. We recognise however, within that context, that assuring the ongoing provision of quality, sustainable services for older people is a priority.

1.14. We propose that the initial focus, after legislation is enacted, will in terms of performance management be on improving outcomes for older people. This consultation document includes, at Annex A, a set of draft outcomes for adult health and social care. We will work with partners and stakeholders to develop outcome measures for monitoring progress in terms of older people's services in the first instance, and also, over time, further measures to enable us to establish the impact of integrated services beyond older people's services.

1.15. These proposals also bring with them potential implications for a number of other functions, including children and families social work services and criminal justice social work. The Chief Social Work Adviser is exploring wider implications with social work professionals and a range of other stakeholders. A summary of progress to date with this work is included at Annex B. We recognise furthermore the importance of ensuring alignment and coherence between these proposals and the concurrent legislative proposals for planning, design and delivery of children's services.

Scope – enabling integration beyond health and social care

1.16. These proposals are designed to *enable* locally-implemented integration. They focus on bringing together the accountability of statutory partners – Health Boards and Local Authorities – to deliver better outcomes for patients, service users and carers. It will be important that, within local partnerships, partners beyond health and social care are also fully and appropriately involved in planning and decision making within the partnership arrangements.

1.17. Other areas of service also play a key role in the delivery of better outcomes, for people with long term conditions, complex needs and older people in particular. Housing is an important example of this. The national strategy for housing for older people[9] highlights how the right housing and related services (such as adaptations and handyperson services) can help to support independent living, and can contribute to health and social care objectives. It will be important that, in bringing primary and secondary health closer together, and health and social care closer together, partners ensure that housing services (including those provided by housing associations and the third sector, as well as by local authorities) are fully included in the integrated approach to service planning and provision, and that health and social care planning and local housing strategies are mutually supportive.

[9] http://www.scotland.gov.uk/Publications/2011/12/16091323/0

1.18. 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 we work with partners and stakeholders to deliver this agenda for integration of health and social care, it will be particularly important that we focus on building on the principles of inter-agency working enshrined in the Change Fund for Older People's Services. The fundamental purpose of our proposals for integration is to improve people's wellbeing; we will not succeed if, in bringing health and social care together, we overlook 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. The contribution of the third and independent sectors in enabling delivery of better outcomes is also a crucial factor in our wider public service reform plans.

What do we want to know from you?

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?

Chapter 2 Outline of proposed reforms

Objectives and principles of reform

2.1. Our vision of a successfully integrated system of adult health and social care for Scotland is that it will exhibit these characteristics:

- **Consistency** of outcomes across Scotland, so that people have a similar experience of services, and carers have a similar experience of support, whichever Health Board or Local Authority area they live within, while allowing for appropriate local approaches to delivery;
- A **statutory underpinning** to assure public confidence;
- An **integrated budget** to deliver community health and social care services and also appropriate aspects of acute health activity;
- Clear **accountability** for delivering agreed national outcomes;
- **Professional leadership** by clinicians and social workers; and
- It will **simplify** rather than complicate existing bodies and structures.

> "We are not starting from scratch or with a blank sheet of paper. There is already a great deal to be proud of in Scotland in health and social care provision."
>
> **Nicola Sturgeon MSP**, Cabinet Secretary for Health, Wellbeing and Cities Strategy
> 15 December 2011

2.2. In Scotland, we have long recognised that effective partnership working between the NHS, local authorities and independent contractors and professionals is a prerequisite for achieving good health and social care outcomes. For the last decade the focus has been on achieving better outcomes through partnership working, service redesign and the development of integrated clinical and care pathways.

2.3. We recognise that changes in society mean that we now need to go further. Our proposals are based on four key principles:

a) Nationally agreed outcomes will be introduced that apply across adult health and social care;
b) Statutory partners will be jointly accountable to Ministers, Local Authority Leaders and the public for delivery of those outcomes;
c) Integrated budgets will apply across adult health and social care; and
d) The role of clinicians and care professionals will be strengthened, along with engagement of the third and independent sectors, in the commissioning and planning of services.

2.4. Our proposals for reform are not based on centrally directed structural reorganisation, and will not impose a single operational delivery arrangement on partnerships. Nonetheless, we will address features of current structures that act as barriers to better integration, and result in too much focus on organisations rather than the needs of patients and service users. Examples include the difficulty of ensuring that money for health and social care services can move around between partners, and

between primary and secondary care in health, effectively; and the need to bring non-statutory partners, such as the third and independent sectors, clinicians and other professionals, and particularly GPs, into the processes of planning and commissioning services much more effectively.

2.5. Lack of centrally directed structural change should not be mistaken for lack of ambition, or determination to succeed. The proposals outlined here will require significant effort to implement, by every professional working across health and social care. Success will be characterised by strong leadership and ownership of culture change at every level, and within every contributing organisation (Health Board, Local Authority, GP practice, etc.).

Framework for integration

2.6. The chapters that follow provide greater detail on our proposed framework for integration, and invite your comments. Key features of our proposals are:

- Community Health Partnerships will be replaced by Health and Social Care Partnerships, which will be the joint and equal responsibility of Health Boards and Local Authorities, and which will work in close partnership with the third and independent sectors and with carer representation. The focus will be on making sure that people have access to the right kind of care, at the right time and in the right place.

- Health and Social Care Partnerships will be accountable, via the Chief Executives of the Health Board and Local Authority, to Ministers, Local Authority Leaders and Health Board Chairs for the delivery of nationally agreed outcomes. These outcome measures will focus, at first, on improving older people's care and will be included in all Community Planning Partnerships' Single Outcome Agreements.

- Partnerships will be required to integrate budgets for joint strategic commissioning and delivery of services to support the national outcomes. Integrated budgets will include, as a minimum, expenditure on community health and adult social care services, and, importantly, expenditure on the use of some acute hospital services. Where money comes from – health or social care, or, indeed, housing – will no longer be of consequence to the patient or service user. What will matter instead will be the extent to which partnerships achieve the maximum possible benefit for service users and patients, together and against the backdrop of shared outcomes and an integrated budget.

- A jointly appointed, senior Jointly Accountable Officer in each Partnership will ensure that partners' joint objectives, including the nationally agreed outcomes, are delivered within the integrated budget agreed by the Partnership.

- The role of clinicians, social care professionals and the third and independent sectors in the strategic commissioning of services for adults will be strengthened. Health and Social Care Partnerships will ensure that effective processes are in place for locality service planning led by clinicians and care professionals, with appropriate devolved decision-making and budgetary responsibilities.

- Proportionally, fewer resources – money and staff – will be directed in future towards institutional care, and more resources will be directed towards community provision and capacity building. This will mean creating new and potentially different job opportunities in the community.

2.7. Within this broad framework for integration, local leaders will be free to decide upon delivery mechanisms and organisational structures that best suit local needs and priorities. Partnerships can choose to delegate functions and budgets and responsibility for some aspects of service delivery to each other if there is local agreement to do so, as in the type of arrangement being implemented in Highland[10], but they will not be required to do so.

What does this mean for me as a patient, service user or carer?

2.8. We are proposing these changes because we believe they provide the most robust, effective way to deliver on our ambitions for patients, service users, carers and families:

- People should be supported to live well at home or in the community for as much time as they can;
- People should have a positive experience of health and social care when they need it; and
- Carers should be supported to continue to care and to have a life outside caring.

2.9. The changes described in this document are by nature quite technical. Much of the detail is about changing the way that our current systems of health and social care work and interact with one another – how money flows round the system to support people, how professionals are held to account for the performance of the system, and so on.

2.10. The proposals that follow are, we believe, necessary, but not sufficient by themselves, to transform health and social care in Scotland. As previously noted, there will be opportunities in the coming months and years to get involved in, and indeed to lead, the other types of improvement work that must go alongside these "system" changes to deliver truly integrated health and social care in Scotland.

What do we want to know from you?

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?

[10] http://highlandlife.net/planning_for_integration

Chapter 3 National outcomes for adult health and social care

What do we want to achieve?

3.1. Our priority is to improve people's experience of health and care services and the outcomes that services achieve, and to ensure that the substantial proportion of Scottish public services spending that supports these services is used to the very best effect. We believe that it is important to focus squarely on that priority, and on overcoming the barriers that exist in current systems – and not to take centrally directed structural change as a starting point for the transformation that is required. The many professionals who work in health and social care in Scotland must be well-placed to focus their attention fully on the shift in outcomes that is needed, and our programme of proposed reforms is designed to support that.

3.2. The underlying principle of these proposals is to provide national leadership in relation to *what* is required – the outcomes that must be delivered – and to leave to local determination *how* best to achieve those outcomes – the delivery mechanisms that will best suit different local needs.

3.3. For these reasons, we are proposing a programme of reform that takes as its starting point the introduction of a new set of nationally agreed outcome measures and standards for adult health and social care, with a particular focus initially on services for older people. From this starting point, we will work with partners to develop outcome measures covering all of adult health and social care.

3.4. The nationally agreed outcomes will apply across adult health and social care; will be transparent and accountable locally and to the Scottish Parliament via Ministers; and will provide assurance that local variation is appropriate to local needs. Providing information and evidence from across health and social care will be critical to demonstrating progress, and external scrutiny processes will be appropriately aligned to support integration of adult health and social care.

3.5. This is an ambitious and challenging approach. Success will depend in no small part on a step change in the relationship between the NHS and local government, and between both statutory partners and central government. By focussing on outcomes, we will be leaving no hiding place in which to conceal, or explain away, lack of progress. In a complicated delivery landscape like health and social care, and when tackling the very significant challenges that we face, it is important that our proposals for improvement are sufficiently ambitious to address the priorities we must tackle. We believe that an outcomes-led approach to reform is the right way to put in train the improvements we must now realise.

How will this approach be different from current arrangements?

3.6. Currently, performance management and reporting frameworks for NHS Scotland and Local Authorities are considerably different from one another.

3.7. The introduction of the Concordat 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 are now agreed between each Community Planning Partnership (CPP) and the Scottish Government.

3.8. Single Outcome Agreements provide the mechanism via which CPPs agree local strategic priorities, and demonstrate how those outcomes contribute to the National Outcomes that are part of the Scottish Government's National Performance Framework. Each Single Outcome Agreement 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.

3.9. In contrast, within NHS Scotland, management plans and decisions for the delivery of nationally applied 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 Scottish Ministers.

3.10. By introducing nationally agreed outcomes that apply across adult health and social care, we will for the first time introduce a mechanism for ensuring that Health Boards and Local Authorities are jointly and equally clear about their priorities for integrated working, and can be jointly and effectively held to account for delivery. Health Boards and Local Authorities will be free to choose locally to agree joint outcomes for other areas of service.

3.11. The specific outcomes themselves will not be written into legislation as they will be expected to change and develop over the years to come. Draft outcomes, focussing for now, as explained above, on older people's services, are currently under development and are provided at Annex A of this consultation.

How will we go about achieving this change - what will change in legislation?

3.12. Legislation will put in place a duty on statutory partners to deliver nationally agreed outcome measures for adult health and social care. The nationally agreed outcomes will apply across Health Boards and Local Authorities, which will be jointly and equally accountable to Scottish Ministers, Local Authority Leaders and Health Board Chairs for the delivery of those outcomes.

3.13. Further details on proposed governance and accountability arrangements for Health Boards and Local Authorities under these new arrangements are provided in Chapter 4.

What do we want to know from you?

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 and for support to carers. 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?

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Chapter 4 Governance and joint accountability

What do we want to achieve?

4.1. In order to ensure successful delivery of the nationally agreed outcomes that are proposed across adult health and social care, we must ensure that arrangements are in place to assure the appropriate governance and joint accountability of the statutory partners – Health Boards and Local Authorities – for achieving these outcomes. Just as the statutory partners will under these proposals be jointly and equally responsible for delivering the outcomes, they must also be held to account jointly and equally for performance.

4.2. Community Health Partnerships have taken the integration agenda as far as they can within the current legislative framework. They have demonstrated how integration can work and have provided an invaluable source of knowledge and experience in developing our integration proposals. These proposals introduce a model of integration that is based upon joint and equal governance and accountability between Health Boards and Local Authorities. This is a step change forwards from the Community Health Partnership model, in which Community Health Partnership Committees are sub-Committees of Health Boards, albeit with strong Local Authority representation.

4.3. In this chapter, we give some consideration to how governance and accountability arrangements could be organised in Health and Social Care Partnerships. Inevitably, this takes us into the territory of, for example, Committee arrangements. In keeping with the underlying theme of these proposals, it is important that, as we examine these details a little more closely, we remain focussed on the outcomes we want to achieve. A Partnership Committee is a mechanism for governing a Partnership; it is not an end in itself.

How will we go about achieving this change - what will change in legislation?

4.4. Health and Social Care Partnerships will replace Community Health Partnership Committees, which will be taken off the statute book. Health Boards and Local Authorities will jointly be required to set up a Health and Social Care Partnership. Each Partnership will cover one Local Authority area, and will replace current Community Health Partnership arrangements. Health Boards, with their partners, will have flexibility regarding whether to include the responsibilities of Community Health Partnerships that extend beyond services for adults; further detail is provided below.

4.5. The Health Board and Local Authority, via the Health Board Chief Executive and the Local Authority Chief Executive, will be required to devolve budgets made up from primary and community health, adult social care and some acute hospital spend to the Health and Social Care Partnership. These will become integrated budgets, in which the resource will effectively lose its identity – those working with it to plan and deliver services will cease to view it in constituent “health” and “social care” parts.

4.6. A duty will be placed on Health Boards and Local Authorities to appoint a senior Jointly Accountable Officer for the Health and Social Care Partnership. The Jointly Accountable Officer will report to the two Chief Executives, and through them to the Partnership Committee, which will be a Committee of the Health Board and the Local Authority.

4.7. The Jointly Accountable Officer will be responsible for commissioning and managing services to deliver the nationally agreed outcomes using the integrated budget. The Jointly Accountable Officer will have a level of delegated authority from the Health Board and Local Authority that enables them to make decisions about use of the integrated budget without needing to refer back up the line within either partner organisation (for example, by using what was previously "health" money to invest in home care services). Further information on the post of Jointly Accountable Officer is provided in Chapter 6.

4.8. A Partnership Agreement between the Health Board and the Local Authority will establish services to be delivered and outcomes to be achieved, within the context of the nationally agreed outcomes, and the financial input of each partner to an integrated budget to achieve those services. The Partnership Agreement will also describe the mechanisms to effect integration of budgets locally. A governance Committee will oversee the running of the Health and Social Care Partnership.

Accountability

4.9. The Cabinet Secretary for Health, Wellbeing and Cities Strategy, the Local Authority Leader and the Health Board Chair will together hold the Chair and Vice Chair of the Health and Social Care Partnership, and the Health Board Chief Executive and Local Authority Chief Executive, to account for the delivery of the nationally agreed adult health and social care outcomes, the integrated budget and the development of community health and social care services.

4.10. Each of these leaders will bring their own perspective and overview to ensure that the localism delivered by Health and Social Care Partnerships is intertwined with the delivery of other NHS Scotland and Local Authority services, and supports the delivery of the National Performance Framework, HEAT and Single Outcome Agreements.

4.11. The NHS Chair and Local Authority Leader will form a "community of governance" overseeing the effectiveness of the Partnership. The NHS Chair and Local Authority Leader will also ensure that the Health and Social Care Partnership delivers services that support wider community planning processes, particularly in relation to promoting early intervention and prevention, and that appropriate stakeholders have been engaged by the Health and Social Care Partnership in the planning and delivery of services.

4.12. Each Health and Social Care Partnership will be expected to produce joint commissioning strategies and delivery plans over the medium and long-term, which will be reviewed as part of the process of ongoing assurance. Further information on what we mean by "commissioning" is provided in Chapter 7. Reporting meetings to Ministers, Health Board Chairs and Local Authority Leaders, will be established and will use an agreed set of measures to support monitoring of progress towards outcomes. These meetings will build on the current regime of accountability reviews for Health Boards. Accountability to the public will be via publication of local performance data.

Composition of the Health and Social Care Partnership Committee

4.13. The Health and Social Care Partnership Committee will ensure the efficient, effective and accountable governance of the Partnerships. Our proposals for the composition and role of members of the Committee are described below.

Chair of the Committee/Casting Vote

4.14. The Health Board and Local Authority will nominate a Chair and a Vice Chair for the Health and Social Care Partnership Committee, which will rotate on an annual basis. The two roles together will form a "team" providing integrated governance for the *Partnership* on behalf of the Health Board and Local Authority, rather than "representing" the individual interests of their respective statutory partner organisations.

4.15. The Chair and Vice Chair roles will be taken by one of the NHS Non-Executive Directors (not the Chair of the Health Board), and one of the local elected members (not the Local Authority Leader). The reason for these exclusions is that both the Chair of the Health Board and the Local Authority Leader will play a governance role alongside the Cabinet Secretary – and they cannot hold themselves to account.

4.16. The Chair of the Health and Social Care Partnership Committee will have a casting vote were the Committee unable to reach a majority decision. We would hope that the circumstances in which a casting vote were needed could be kept to a minimum; guidance will be developed for good use of a casting vote by the Scottish Government, NHS Scotland and COSLA.

Voting Members

4.17. Voting members of the Health and Social Care Partnership Committee will be made up of an equal number of Health Board Non-Executive Directors and local elected members. A minimum of three representatives from each statutory partner will have a mandate to act on behalf of their parent statutory bodies. Local Partnerships will be able to increase the number of non-executive directors and local elected members where there is joint local agreement to do so, but will need to retain an equal number of each.

Non-voting members

4.18. Voting members of the Committee will be supported on the Health and Social Care Partnership Committee by a number of non-voting members. These members will represent the professional and service user perspective on the pathway of care, and will include:

- The jointly accountable officer;
- Professional advisers. A minimum requirement would be an Associate Medical Director *or* the Clinical Director of the Partnership, and the Chief Social Work Officer. From the health perspective, it will be important to ensure that the interests of both the primary and secondary aspects of the integrated budget and care pathways are represented by the clinical adviser;
- Patient/service users' representation; and
- Third sector representation of the service user and carer experience of care

Performance Management, Performance Improvement and Scrutiny

4.19. A sliding scale of improvement and performance support will be put in place to assure the delivery of national outcomes by Health and Social Care Partnerships. Improvement support will be offered to all Health and Social Care Partnerships to ensure sharing of good practice, benchmarking, leadership and organisational development, development of commissioning skills and other priority areas. Where Health and Social Care Partnerships fail to deliver nationally agreed targets, performance support will be offered and, where critical, put in place to assure the delivery of targets.

4.20. We recognise that effective collaborative working with external scrutiny partners will be important, and will work with the Care Inspectorate and Healthcare Improvement Scotland to ensure an appropriately integrated approach to reviewing the quality of service and outcomes achieved.

Other Community Health Partnership functions

4.21. Community Health Partnerships currently have responsibility for services that sit outwith the scope of these proposals; for example, they are also responsible for the delivery of children's community health services. It is important that we consider the implications for governance arrangements of "other" services as well as for adult health and social care.

4.22. We anticipate that different partnerships of Health Boards and Local Authorities may prefer to handle governance of other Community Health Partnership functions in different ways. For example, partners in some places may wish to include the budget for other services along with the budget for adult health and social care, and to apply the Health and Social Care Partnership governance arrangements to the full range of current Community Health Partnership budgets and service delivery.

4.23. Partnerships may choose not to integrate the budgets for other services along with adult health and social care, in which case the governance for other services might be provided by another Committee arrangement. Other options, and permutations on these options, are also possible; at this stage, it is our proposal that decisions about managing other areas of what are currently Community Health Partnership functions should be left to local determination. Community Health Partnerships themselves will be taken off the statute book.

4.24. It is important to note that, whether or not other Community Health Partnership functions are managed within the Health and Social Care Partnership, our proposals for accountability to Ministers and Leaders apply *only* to adult health and social care services, and the nationally agreed outcomes relating to those. The delivery of 'other' national targets that fall within the integrated budget will be the responsibility of the Jointly Accountable Officer who will report direct to the NHS and Local Authority Chief Executives for these areas.

Community Planning

4.25. A review of Community Planning is underway as part of Ministers' response to the findings of the Christie Commission. It will be important to ensure effective interaction between and across the functions of Community Planning and the functions of Health and Social Care Partnerships, in order to ensure that local planning and delivery arrangements are robust, joined up and driving forward performance improvement. Governance and accountability arrangements for Community Planning will complement the current accountability relationship between Health Boards and Ministers, which will continue.

How will this approach be different from current arrangements?

4.26. The main differences between Community Health Partnerships arrangements and the new Health and Social Care Partnerships will be:

- Health and Social Care Partnerships will be the joint and equal responsibility of the NHS and local government. Community Health Partnerships are sub-Committees of Health Boards, albeit with strong requirements for Local Authority membership. The new Health and Social Care Partnership Committees will be Committees of Health Boards and Local Authorities.
- Financial authority for achieving outcomes, and the requirement to demonstrate value for money, will be delegated to Health and Social Care Partnerships by the Health Board and the Local Authority. Currently Community Health Partnerships have no delegated financial authority beyond managing Health Board community health budgets. Local Authorities are not required to delegate budgets to Community Health Partnerships.
- Decision making authority in relation to delivering outcomes will also rest with the new Health and Social Care Partnerships, without the need to refer decisions back "up the line" to Committees within the statutory partners.
- Health Boards and Local Authorities will be jointly held to account for performance.

4.27. There are currently 34 Community Health Partnerships. New legislation will streamline those arrangements significantly, with at most one Health and Social Care Partnership per local authority area (32). This will remove the need for partners to have Community Health Partnership Committees; partners may also find that other strategic forums or Committees are no longer required.

4.28. These proposals will also for the first time draw together performance management arrangements for teams working together across the NHS and local authorities.

What do we want to know from you?

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?

Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

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?

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?

Chapter 5 Integrated budgets and resourcing

What do we want to achieve?

5.1. A key priority for these proposals is to improve the quality and consistency of care, and to put an end to the cost-shunting between the NHS and Local Authorities that too often ends up with people being delayed in hospital longer than they should be, and not benefiting from the best and most appropriate standards of care.

5.2. It is our aim to create a system of health and social care in which resources – money and people's time – can be used to best support the individual at the most appropriate point in the system – regardless of whether what is needed is "health" or "social care" support.

5.3. An important aspect of this part of our proposals is the requirement that there should be an integrated budget, which will include the budgets for community health and social care, and also the budgets for some acute hospital services. Our commitment to shifting the balance of care from institutional to community based settings, as clinically appropriate, will only be achievable when the people who are planning services can work within the entirety of the resource committed to services. A shift in the balance of care requires a shift in patterns of resource allocation and utilisation, and that can only be achieved if the integrated budget includes the full range of spend on services.

5.4. Under these proposals, Health Boards and Local Authorities will be required to integrate resources for adult services. Health Boards and Local Authorities will be free to integrate resources for other areas of service if they wish, but will not be required to by national direction under these proposals.

5.5. The new, integrated budget will be managed by the Jointly Accountable Officer on behalf of the Health and Social Care Partnership. Further information on the role of the Jointly Accountable Officer is provided in Chapter 6. This role is key to the success of the integrated budget; this post-holder must have sufficient authority over the integrated budget to make decisions about resource prioritisation without needing to refer back up the individual lines of accountability in the partner organisations.

5.6. It is our intention that the integrated resource should lose its identity in the integrated budget – so that where money comes from, be it "health" or "social care", is no longer of consequence. A practical example of the effect we are looking for is that the Jointly Accountable Officer will be able, for example, to spend what is currently categorised as "health" money – used to pay for, say, district nursing – on "social care" activity – to pay for care at home services, for example – or vice versa.

5.7. The availability of robust, trustworthy information and evidence will be particularly critical to success in terms of planning and service design, joint management of risk, benchmarking across systems and accountability for delivery. A more integrated approach to sharing information across services and local systems, within appropriate boundaries, will be required to enable and evidence improvement.

How will this approach be different from current arrangements?

5.8. Current legislation permits delegation of budgets between Health Boards and Local Authorities. Until now, however, budgets have largely been managed separately in health and social care, apart from in a few relatively small instances of pooling, such as pooled budgets for some mental health services, or shared equipment stores.

5.9. At the moment, there can be unhelpful financial consequences for Health Boards and Local Authorities that affect them both, but cannot be resolved by either on their own. For example, where someone is ready for discharge from hospital, depending upon the provision of an appropriate package of care at home, the cost of the delay falls upon the Health Board. Similarly, the consequence of any delay can be additional costs for the Local Authority, as a delay in hospital can result in a worse outcome – higher dependency and care needs – for the individual. These proposals are intended to remove that tension, so that the total cost of the care pathway is managed within the totality of the integrated budget, and there are no financial incentives or disincentives getting in the way of ensuring the best possible outcome for the individual.

5.10. Most important, of course, is the human cost within current arrangements of such tensions, in terms of wellbeing. By eliminating the distinction between “health” and “social care” budgets, we believe we can create a financial environment in which professionals can, rightly, focus their attention on what is best for the individual – without worrying about whose budget is providing which service.

5.11. These proposals are not about saving money – they are about using money more effectively in clinical and practical terms, to ensure that the support provided to people is available in an environment which will best assure their wellbeing and quality of life.

5.12. This Chapter describes in broad terms our proposals for integrating budgets between Health Boards and Local Authorities. Some of the information in this Chapter is, by its nature, quite technical. However, the principle that we describe above - that public funds should be used effectively and efficiently, and to achieve maximum benefit where need is greatest - is important to everyone.

Options for integrating budgets

5.13. We have described two options via which Health Boards and Local Authorities could integrate budgets. Under these proposals, local partnerships will be free to choose which approach they took to integrating budgets. Under each option, a Partnership Agreement will establish the nature and scope of the Partnership. Staff could move between employers to support a shift in functions, if there were local agreement to such a change.

a) <u>Delegation to the Health and Social Care Partnership, established as a body corporate</u>

   The Health Board and the Local Authority could delegate agreed functions to the Health and Social Care Partnership, which would be established as a body corporate of the Health Board and Local Authority.

The Health Board and Local Authority would agree the amount of resources to be committed by each to the integrated budget for delivery of services to support the functions delegated to the Partnership.

The integrated budget would be managed on behalf of the Partnership by the Jointly Accountable Officer, whose authority and accountability in relation to delivery of the Partnership's delegated functions would be determined by his or her statutory functions. The integrated budget would consist of the respective contributions from each partner organisation, each managed by the Jointly Accountable Officer and subject to the respective financial governance arrangements of each partner.

A Partnership Agreement would establish the terms of the arrangement between the Health Board and the Local Authority, and would establish the facility that the partners would transfer resource between the two budgets at the discretion of the Jointly Accountable Officer. Each delegating partner would retain their legislative responsibility for the functions that had been delegated to the Health and Social Care Partnership. The governance Committee referred to in Chapter 4 would form the Board of the Partnership.

Employment arrangements for the Jointly Accountable Officer are considered in Chapter 6.

b) Delegation between partners

One partner can under current legislation[11] delegate some of its functions, and a corresponding amount of its resources, to the other, which then hosts the services and integrated budget on behalf of the Health and Social Care Partnership. The financial governance system of the host partner applies to the integrated budget. A Partnership Agreement between the Health Board and the Local Authority establishes the functions and resources to be delegated between the partners.

Example

In the model currently being implemented in the Highland partnership, the Local Authority is delegating adult social care services to the Health Board, and the Health Board is delegating children's community health services to the Local Authority.

NHS Highland "hosts" the budget for adult social care, which is delegated to it by the Highland Council, and the financial governance system of NHS Highland applies to the adult health and social care budget.

Highland Council "hosts" the budget for children's community health services, which is delegated to it by NHS Highland, and the financial governance system of the Highland Council applies to the children's community health and social care budget.

[11] http://www.legislation.gov.uk/asp/2002/5/contents

In a delegated model, the delegating partner retains its legislative responsibility for the functions that have been delegated. So, in the example given above, Highland Council retains its legal obligations for the effective delivery of adult social care services, and NHS Highland retains its legal obligations for the effective delivery of children's community health services.

Who will decide what is included in the integrated budget?

5.14. The question of who will decide what is included in the integrated budget is important. It is our proposal that Ministers will provide local Health and Social Care Partnerships with direction on the categories of spend to be included as a minimum. Examples could include Local Authority spend on care at home and home care provision, along with NHS spend on appropriate acute medical specialties, primary care and prescribing, and so on.

5.15. Beyond the minimum requirements that will be defined in regulations, Health and Social Care Partnerships will be free to add other aspects of spend subject to agreement within the local Partnership Agreement.

How will we go about achieving this change - what will change in legislation?

5.16. Health Boards and Local Authorities will be placed under a duty to put in place an integrated budget for adult health and social care, using one of the models described above.

5.17. A Partnership Agreement will be required, to establish the contribution of the Health Board and Local Authority to the integrated budget, which will include, as a minimum, expenditure on community health and adult social care services, and, importantly, expenditure on the use of some acute hospital services as well.

5.18. Health Boards and Local Authorities will be required to jointly appoint a senior, Jointly Accountable Officer who will have authority over the discharge of the integrated budget to deliver the outcomes agreed nationally and within the Partnership Agreement.

5.19. Each Health and Social Care Partnership will be required to produce integrated strategic commissioning plans for use of the integrated budget over the medium and long-term. These will build on the approach taken to develop joint commissioning plans to support the Change Fund for older people's services.

5.20. To support the most effective use of resources, any existing barriers to the efficient procurement of facilities, goods and services will be considered.

What do we want to know from you?

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?

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?

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?

Chapter 6 Jointly Accountable Officer

What do we want to achieve?

6.1. In order for each Health and Social Care Partnership's integrated budget to work properly – so that it is managed without reference to whether it is "health" or "social care" money, but instead only in terms of its best use for the patient or service user or carer – it will be important for a senior Jointly Accountable Officer to manage the budget and oversee delivery of outcomes. Options for financial integration are explored in Chapter 5.

6.2. In order to ensure the level of authority and autonomy envisaged for the post, the Jointly Accountable Officer will be a senior appointment, at senior executive level or equivalent, and will report directly to the Chief Executives of the Health Board and Local Authority.

6.3. As previously discussed, the role of the Jointly Accountable Officer is central to the potential success of the approach laid out in these proposals. The post-holder must carry sufficient authority to make decisions about resource prioritisation without needing to refer back up the line within either the Health Board or the Local Authority. The effectiveness with which this aspect of delegated financial authority is achieved will be key to ensuring that resources lose their "health" or "social care" identity in the integrated budget.

How will this approach be different from current arrangements?

6.4. There are already some examples of senior joint appointments managing services across health and social care in Community Health Partnerships.

6.5. The new arrangements will be different because they will make it obligatory for every Health and Social Care Partnership to establish such a role, at a senior level, and because they will assure the financial authority of the Jointly Accountable Officer for health and social care budgets, including some acute budgets, managed as a single envelope of resources.

How will we go about achieving this change - what will change in primary legislation?

6.6. We will place a duty on Health and Social Care Partnerships to jointly appoint a senior Jointly Accountable Officer, at Executive level, reporting to the Chief Executives of the Health Board and Local Authority, to manage the integrated budget for adult health and social care and service provision to achieve the outcomes specified in the Partnership Agreement between partners.

6.7. The mechanism via which the Jointly Accountable Officer is assured the financial authority described here will depend upon the model for financial integration between the Health Board and the Local Authority that is used. Models for financial integration are discussed in Chapter 5.

6.8. If functions are delegated to the Health and Social Care Partnership, established as a corporate body, the financial authority of the Jointly Accountable Officer to manage budgets from both organisations could be established via a service level agreement between the organisations.

6.9. If functions and resources were delegated between the Health Board and Local Authority, with one partner delegating functions and resources to the other, the Jointly Accountable Officer will be employed by the host partner to account for the functions which that partner hosts. He or she will then be accountable to the Chief Executive of the host partner for use of the integrated budget and delivery of the outcomes specified by the Health and Social Care Partnership in their Partnership Agreement. Both Chief Executives will be accountable for the performance of the Health and Social Care Partnership.

What do we want to know from you?

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?

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Chapter 7 Professionally led locality planning and commissioning of services

7.1. 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. For the purposes of the reforms we propose here, we are using "commissioning" to mean the activities involved in 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.[12]

> "The [Scottish Government's] plans for bringing health and social care together mean that major changes lie ahead for these services. The self-directed support legislation should give people greater choice and control over their care packages. However, if these changes are to work well, it is essential that councils and health boards improve the planning and commissioning of services."
>
> **Robert Black**, Auditor General for Scotland, 1 March 2012[13]

7.2. We recognise the importance and potential benefits of strong clinical and professional leadership in local decision making. A criticism of some Community Health Partnerships has been the lack of perceived opportunity for professionals – including GPs, acute clinicians, social workers, nurses, Allied Health Professionals, pharmacists and others – to take an active role in, and provide leadership for, local planning of service provision. These proposals therefore include a requirement for Health and Social Care Partnerships to put in place arrangements to address this.

7.3. In particular, these proposals reflect our belief that some aspects of planning for service delivery can operate more effectively and efficiently at a layer of organisation that lies between the Health and Social Care Partnership governance Committee and individual practitioners. This is the level at which greater localism can improve outcomes for patients and service users, and at which economies of scale, and better strategic oversight, can be achieved beyond that which is available at the level of, for example, the individual GP practice.

7.4. In broad terms, we expect locality planning arrangements to deliver locally agreed strategic commissioning plans that have the support of the professionals and other care providers who will deliver services. These local plans will then form a key input to the production of the Partnership's joint strategic commissioning plan.

7.5. Effective locality planning can only take place with the full participation of the range of professionals involved in the care of patients and service users along the patient pathway, in acute care and in the community, along with managerial staff of the Health and Social Care Partnership. It will also be important to ensure the direct involvement of local elected members, representatives of the third and independent sectors, and carers' and patients' representatives.

[12] http://www.scswis.com/index.php?option=com_docman&task=doc_details&gid=181&Itemid=703
[13] http://www.audit-scotland.gov.uk/docs/health/2012/nr_120301_social_care.pdf

7.6. There are already examples of such professionally-led localism making a difference in Scotland, in particular in NHS Highland and NHS Grampian. These proposals are intended neither to stifle activity that is already underway, nor to be directive about mechanisms for locality planning that all areas should adopt. The nature of the challenge means that different local solutions will work in different localities. These arrangements must involve the full spectrum of professionals from health, social care and partners from the third and independent sectors.

7.7. We plan to work with key representative groups to build upon the experience gained to date, from within both NHS Scotland and Local Authorities, from current examples and more generally from our previous experience of locality working in Community Health Partnerships, Community Planning Partnerships and Local Healthcare Co-operatives. We will act to remove barriers that may in the past have prevented sustainable, worthwhile engagement between statutory partners (Health Boards and Local Authorities) and clinicians. We will need to ensure that locality planning groups have the right level of delegated authority, including influence over locality shares of the integrated budget, to make decisions that impact on local service provision.

How will this approach be different from current arrangements?

7.8. Community Health Partnerships (CHPs) have been criticised in some areas by GPs and other professionals for limiting their opportunities to play an active role in local service planning and provision. There has also been frustration that some CHPs were 'toothless', with decisions regularly having to be pushed upwards to the parent Health Board and with little influence in particular over acute budgets. These proposals will address those concerns, by requiring locality planning arrangements be developed and implemented in Health and Social Care Partnerships.

How will we go about achieving this change - what will change in legislation?

7.9. We will place a duty on Health Boards and Local Authorities to consult local professionals, across extended multi-disciplinary health and social care teams and the third and independent sectors, on how best to put in place local arrangements for planning service provision, at the level between Partnerships and individual GP practices. Having consulted, Partnerships will be required to put in place, and to subsequently support, review and maintain, such arrangements.

7.10. Beyond legislative change, we will also work with our partners in the NHS, local government and the professional organisations to agree the "landscape changes", such as workforce development and leadership development, that will be needed to ensure that professionals can participate effectively in locality planning as a driver for change in an integrated system of health and social care.

7.11. In terms of GP engagement, we anticipate the need to consider workload issues, and therefore availability of time to participate in locality planning, particularly in areas of high deprivation; and recruitment and retention of GPs, particularly in areas with the poorest health outcomes. We have already begun a dialogue on the scope of the GMS

Contract in Scotland, and we will continue to use that opportunity to consider how to give practical effect to these proposals for locality planning.

7.12. As with every aspect of these proposals, leadership is key. We will use our ongoing development of a leadership programme for primary care practitioners to support improvement. We will also work with stakeholders, and all relevant professions, to develop guidance to support effective development and implementation of locality planning arrangements that meet local requirements.

What do we want to know from you?

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this 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?

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?

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

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?

Annexes A - C

Additional background information

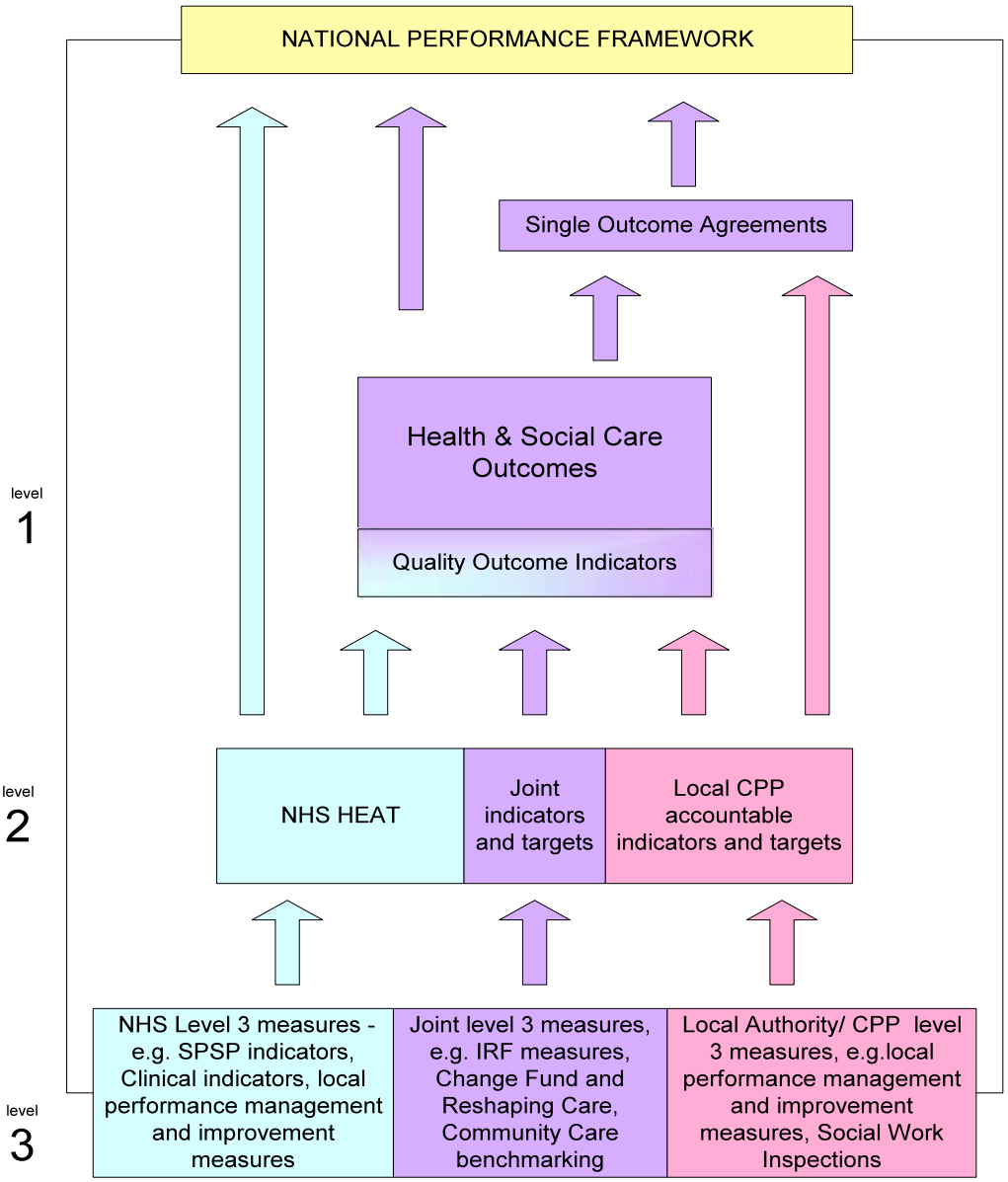
The Annexes that follow provide additional information on the changes proposed in this consultation. They are included to provide further context about *how* we believe the changes we seek can most effectively be put in place.

You are not asked to respond to questions relating to the material that follows, which is included here because we recognise that, without further context, it is difficult to comment on the legislative proposals described earlier on in this document. There will be further opportunities to contribute to the development and refinement of this detailed work described in these Annexes.

Annex A: draft national outcomes for adult health and social care

A.1. Over recent years, a significant amount of work has gone into establishing outcomes and related measures for health and community/social care. With the commitment to establish an integrated approach to planning and delivering health and social care, the Scottish Government, COSLA and other key stakeholders have agreed to develop a set of shared outcomes and related indicators/measures that will underpin the delivery of the national outcomes, which form the National Performance Framework. The National Performance Framework enables partners to jointly drive and track progress towards delivery of agreed outcomes through better integration, supported by the development of Single Outcome Agreements.

Health and Social Care Quality Measurement Framework



A.2. The diagram illustrates how various sets of outcomes and indicators/measures relate to each other. It does not represent a governance structure. The three levels of measurement are defined as follows:

Level 1 – high- level outcomes used to drive health and social care quality nationally over time, where progress is reported nationally by a small set of selected national indicators;

Level 2 - publicly accountable indicators and targets for Health Boards, Community Planning Partnerships and Health and Social Care Partnerships used to drive short to medium term improvement and agreed to impact significantly and positively on the level 1 outcomes; and

Level 3 - extensive range of indicators/measures used for local improvement and performance management, including core sets of specific indicators for national programmes.

Health and Social Care Quality Outcomes

A.3. Health and social care **quality outcomes** are high-level statements of what health and social care partners are attempting to achieve though integration and ultimately through the pursuit of quality improvement across health and social care. It is important to be explicit about these outcomes so that people can understand what they are working towards, maximise their contribution and have a clear understanding of the indicators that will be used to measure progress.

A.4. It is intended that the proposed full set of health and social care quality outcomes will eventually replace the six Quality Outcomes, which have been developed through the implementation of the Healthcare Quality Strategy – i.e. they are not intended to form an additional set of outcomes. They are also intended to be integrated and aligned within the National Performance Framework and be included in all Single Outcome Agreements.

A.5. Following a period of extensive engagement, seven proposed health and care integration outcomes have been developed to specifically reflect the outcomes, which are expected to be improved through the integration of health and social care. In order to reflect the wider priorities of health and social care, beyond those directly affected by the integration agenda, and before these outcomes can replace the current set developed through the healthcare quality strategy, further refinement will be required after consultation.

A.6. A suite of indicators and measures for integration of adult health and social care is under development. These include measures from all three levels of the proposed Health and Social Care Quality Outcomes Framework. Development of outcomes and measures will continue over time as integration takes effect across health and social care.

Health and Care Integration Outcomes

1. **Healthier living**
Individuals and communities are able and motivated to look after and improve their health and wellbeing, resulting in more people living in good health for longer, with reduced health inequalities.

2. **Independent living**
People with disabilities, long term conditions or who become frail are able to live as safely and independently as possible in the community, and have control over their care and support.

3. **Positive experiences and outcomes**
People have positive experiences of health, social care and support services, which help to maintain or improve their quality of life.

4. **Carers are supported**
People who provide unpaid care to others are supported and able to maintain their own health and wellbeing.

5. **Services are safe**
People using health, social care and support services are safe- guarded from harm and have their dignity and human rights respected.

6. **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.

7. **Effective resource use**
The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation.

Annex B Impact on other areas of service – beyond adult health and social care

B.1. This section provides a description of ongoing work to consider the potential impact – potential opportunities and risks – that integration of adult health and social care may have on other aspects of social work and social services delivery.

B.2. Further consideration of these important issues, and action to address them, will be taken forward in partnership with a wide range of stakeholders over the consultation period for integration of adult health and social care, and beyond. As noted in Chapter 1 of this consultation paper, Ministers asked the Chief Social Work Adviser to facilitate this work.

Context

B.3. At present many adult, children and family-based social services are delivered through a single social work service, although there is a varied pattern of provision across the country, depending on local circumstances and need. Social work services also work in collaboration with education, health, the third and independent sectors, and the police, to offer support and services to vulnerable children and families. In designing new approaches for adult services, it is important to ensure that services for all of those who need them, regardless of age, also continue to improve – with skilled staff and leaders, with appropriate resources, with strong local relationships and without creating new barriers to effective delivery.

B.4. As integration of adult health and social care is taken forward it will be important to identify potential risks, and then identify options for addressing and resolving these risks. We must also take the opportunity to identify how the integration proposals can offer scope for improvement to current ways of working across all service areas.

Progress to date

B.5. From January to April 2012 the Chief Social Work Adviser engaged directly with almost 200 people to discuss these issues, through written contributions, meetings and seminars.

B.6. Key issues that have been raised include:

a) Implications arising from integration of adult health and social care for social work and social care services for other categories of users, including issues of user impact, location, accountability, organisational development, performance management and regulation, and workforce practice and development.

b) Issues at the operational level, including any impact on child, adult and public protection, transitions from children's to adult services, the role of Mental Health Officers, the interface with Criminal Justice and Family Support, and the interface between addiction services and alcohol and drug mis-using parents.

c) Cross-cutting services with a role across adult and children services such as carer support, welfare rights, and advice and information, where the approach needs to emphasise avoiding duplication, wasted resources or a reduced level of service being provided to some people, from that which they currently receive.

d) Issues of professional leadership and professional support for both social work and care professionals across these service areas.

Next steps

B.7. Following the initial period of engagement in the early part of 2012, we anticipate that further work will be required to inform decisions on future actions – for example revisions to guidance, support for operational and practice changes and potentially changes to legislative provisions.

B.8. The Chief Social Work Adviser will continue to facilitate engagement around the aspect of "wider impact" during the consultation period and beyond as part of the overall programme of engagement on the integration proposals. This will ensure that the Scottish Government is able to work with key stakeholders to manage any potential risks, develop ways to address any detriment and make use of wider improvement opportunities which may arise from the integration approaches.

Annex C Workforce issues

C.1. This section provides a brief overview of the range of workforce issues that will need to be considered outside legislation as integration is taken forward. Further consideration of these important requirements will be taken forward in partnership between the Scottish Government, NHS Scotland, NHS Education for Scotland (NES), Local Authorities, the Scottish Social Services Council (SSSC), and staffside representation. In outline, we anticipate further work will be required particularly under the headings listed in this annex.

Organisational development

C.2. We anticipate further work on organisational development will be needed as listed below. This is not an exhaustive list, but is likely to include:

- Developmental work between Local Authority elected members and non-executive Directors of Health Boards.
- Developmental work between Chief Executives of Local Authorities and Health Boards and their teams.
- Jointly Accountable Officers - scoping the role, accountabilities, skills and behaviours needed for these posts, and devising a targeted programme of support on appointment.
- Developing senior professional teams including GPs and Chief Social Work Officers (building on existing developments, for example the primary care leadership initiative currently being taken forward by the Scottish Government, NES, SSSC and the Royal College of General Practitioners (RCGP); and on collaborative work being progressed by NES and SSSC).
- Support for staff working in non-statutory organisations.

Training and education of frontline staff

C.3. The success of our proposals will depend on the education, training and development of the workforce, and a set of targeted initiatives within an overall strategic framework will be essential.

C.4. In recent years, NES and SSSC have sought to ensure that the appropriate professional frameworks are in place which support national regulatory requirements. This includes scoping out the level of education, training and skills within the current workforce, compared to what will be needed in future.

C.5. Over the coming months, and beyond the immediate scope of this consultation, we will work with NES, SSSC and other stakeholders to define the priority education and training requirements within an integrated context; articulate what these will mean for individual frontline staff; and identify how to mobilise support through an education and training infrastructure which reflects a more integrated system of health and social care. In doing so, we will where possible build on existing developments and good practice (for example, the work undertaken to date by the Reshaping Care for Older People Workforce workstream).

Staff governance and partnership working

C.6. There is a well established model of industrial relations within NHS Scotland that sees employers, trade unions and professional organisations and Scottish Government working in Partnership. NHS MEL (1999) 59 sets out the partnership arrangements within which NHS Scotland employers are required to comply. The model demonstrates the extent to which good employee relations require the involvement of all stakeholders at the stage of formulating potential change or development before moving to the consultation stage.

C.7. In NHS Scotland, the principles of staff governance focus on how staff are managed, and feel they are managed. Staff governance makes up one of the 4 pillars of the governance framework (alongside clinical, financial and information governance) within which Health Boards must operate.

C.8. NHS Scotland's commitment to staff governance was given legislative underpinning by the NHS Reform (Scotland) Act 2004. The Staff Governance Standards Framework is the key policy document in support of the legislation, which aims to improve how NHS Scotland's diverse workforce is treated at work.

C.9. There are no equivalent national formal agreements on industrial relations or staff governance within Local Authorities.

C.10. Partner organisations in each Health and Social Care Partnership will need to carefully consider their approach to industrial relations and staff governance. There will be an additional requirement to review the scope of national partnership and staff governance arrangements to take into account proposals for integration.

Professional accountability

C.11. Arrangements for professional accountability of staff working within the Health and Social Care Partnerships will need to be further examined, particularly if there are to be shared management responsibilities in Partnerships.

Employment policies and procedures

C.12. There will be a requirement to examine the relationship of partner organisations' employment policies and procedures dependent on the particular model of the Health and Social Care Partnership that is implemented. Again, this will be particularly important in shared management situations, i.e. where health staff are managing social care staff, and vice versa.

Recruitment protocols and joint appointments

C.13. Further consideration will be taken forward to examine the implications of joint appointments within the context of introducing Health and Social Care Partnerships. When separate organisations develop shared staffing arrangements to recruit someone to work for all the organisations, they have created a joint appointment, with the explicit purpose of working more collaboratively and achieving shared objectives.

C.14. Full account must be taken of the impact of joint appointments on all the organisations involved, including the challenges of working across different cultures, employee relationships, pay, terms and conditions and many other factors. The importance of organisational development, training and workforce development enabling appointments to function effectively and flourish may take effect on a number of different levels.

C.15. Guidance on joint appointments was issued under the Joint Future Initiative in 2004, and this will be refreshed.

C.16. Guidance on the recruitment and contract status of Jointly Accountable Officers will also be produced.

Annex D Partial Equality Impact Assessment

Introduction

D.1. The public sector equality duty requires the Scottish Government to equality impact assess. It is a legislative requirement. More importantly, however, at the end of most policies, there are people. People are not all the same and policies should reflect the fact that different people have different needs. Equality legislation covers the characteristics of: age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

D.2. Equality impact assessment (EQIA) is all about considering how a policy (a policy can cover: activities, functions, strategies, programmes, and services or processes) may impact, either positively or negatively, on different sectors of the population in different ways.

D.3. A workshop was convened on 27 March 2012 to identify the areas of impact that the proposed Adult Health and Social Care Integration Bill, and the policy, would have on society. This report sets out the initial findings and delivers the first stage of an EQIA, which will be published alongside the consultation document and is a partial EQIA. It is being published to invite comment from those who respond to the consultation.

D.4. The workshop was the first stage of the EQIA of the policy. Findings are based on the knowledge and experience of those present at the workshop. This report is not a definitive statement or assessment of impacts but presents possible impacts that may require further consideration. This report also identifies some questions to be addressed to understand the impacts further. The purpose of further work following this scoping stage is to inform recommendations to improve any intended or consequential impacts on health and social care, enhance actions to reduce health inequalities, avoid discrimination and take action to improve equality and enhance human rights.

Rationale and aims of policy

D.5. There is a great deal to be proud of in terms of health and social care provision in Scotland. We recognise, however, that we should go further to ensure consistently good outcomes for patients, service users, carers and families. Separate, and sometimes disjointed, systems of health and social care will no longer adequately meet the needs and expectations of increasing numbers of people, particularly those living into older age, often with multiple, complex, long-term conditions, who need joined up, integrated support.

D.6. There has been very significant progress in improving pathways of care in recent years. Nevertheless, many clinicians, care professionals and managers in health and social care currently describe two key disconnects in our system of health and social care. 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.

D.7. These disconnects make it difficult to address people's needs holistically and to ensure that resources follow patients' and service users' 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, older people, and people with complex needs. Problems are also encountered at transition points, particularly as children with complex needs reach adulthood.

D.8. From the perspective of people who use the system – patients, service users, carers and families, the problems we are seeking to address can be summarised as follows:

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

D.9. Demographic change makes the case for change urgent. 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 and that around one quarter of Scotland's population will be aged 65 and over by 2033. The changes in demography will vary in scale depending on location, with predictions suggesting that rural areas will be affected to a greater degree than urban areas. We know that:

- Even allowing for the possibility that people may live longer and in better health in the future and taking into account of our current emphasis on improving anticipatory and preventative care, Scotland will in future experience a material increase in the number of older people who need care. The resources required to provide support will rise in the years ahead;
- There is little association between the amount spent currently on health and social care services and the outcomes that are achieved – spending more does not necessarily result in better outcomes;
- We spend almost one third of our total spend on older people's services annually on unplanned admissions to hospital; and
- We spend more annually on unplanned admissions for older people than we do on social care for the same group of people.

D.10. Our current system of health and social care incorporates within it barriers in terms of structures, professional territories, governance arrangements and financial management that not only often have no helpful bearing on the needs of the large, growing group of older service users, but in many cases work against general aspiration of efficiency and clinical/care quality. We need to reform the system to deliver care that is better joined up and as a consequence delivers better outcomes for patients, service users and carers.

D.11. The Scottish Government's goal for integration of health and social care is to tackle these challenges and to address the disconnects described above. We know from clinicians and other professionals who provide health and social care support 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. The integration agenda will be key in continuing to drive forward the shift in the balance of care from institutional care to services provided in the community.

Objectives

D.12. The main objectives of the integration of adult health and social care agenda are:

- Consistency of outcomes across Scotland, so that people have a similar experience of services, and carers have a similar experience of support, whichever Health Board or Local Authority area they live within, while allowing for appropriate local approaches to delivery;
- A statutory underpinning to assure public confidence;
- An integrated budget to deliver community health and adult social care services and also appropriate aspects of acute health activity;
- Clear accountability for delivering agreed national outcomes;
- Professional leadership by clinicians and social workers;
- It will simplify rather than complicate existing bodies and structures.

People present

D.13. The following were present at the workshop and contributed to the discussions:

Jo Marwaha Drew Millard Debbie Sigurson	NHS Health Scotland
Craig Bradshaw Kavita Chetty	Scottish Human Rights Commission
Tony Fitzpatrick	Carers Net
Hanna McCulloch	Capability Scotland
Milind Kolhathar	Edinburgh Voluntary Organisations Council
Elaine Torrance	Head of Social Care and Health NHS Borders
Diane White	Social Services Workforce (SG)
Fiona Hodgkiss	Analytical Services Division (SG)
Alexis Jay	Chief Social Work Adviser (SG)
Frances Conlan Alex Devoy David MacLeod Gill Scott Alison Taylor	Integration and Service Development (SG)
Chris Bruce Gerry Power	Joint Improvement Team
Gillian Barclay	Older People's Unit (SG)

Policy options (including a 'do nothing' option)

D.14. Ministers are consulting on proposals that would see new Health and Social Care Partnerships written into statutory legislation, replacing the existing Community Health Partnerships.

D.15. Evidence from the work taken forward on Reshaping Care of Older People, and from the Integrated Resource Framework, indicates that, given the changing shape of demography in Scotland, "doing nothing" is not an option. Changes are required in order to assure both the quality of outcomes for patients, service users and their carers and families, and also to assure the sustainability of service provision in the coming years. This is not a challenge that is unique to Scotland: changes in demography, and the need to change patterns of service planning and provision as a result, are common across developed countries.

D.16. Ministers' proposals will provide Health Boards and Local Authorities with some flexibility to enable them to establish local arrangements that best suit local needs. The consultation proposes options regarding the governance of Health and Social Care Partnerships, and how each Partnership manages an integrated budget, with a requirement to deliver jointly agreed outcomes.

Population groups considered

D.17. The group sought to identify potential differential impacts of the policy on different population groups. These impacts are noted below:

Population groups	**Potential differential impacts of the policy**
Older people, people in the middle years, young people and children	The consultation notes that the proposed legislation will enable Health Boards and Local Authorities to integrate planning and service provision arrangements for all areas of adult health and social care. It goes on to state that the initial focus, after legislation is enacted, will in terms of delivering outcome measures, will have a differential impact for older people because older people are high users of the health and social care system. This approach may carry a risk that other groups are overlooked, at least at first. If there is a shift in the balance of care to community care, there is likely to be an increase in the amount of health and social care services provided in the community. The point was raised that this could result in an increase in the number of individuals over 65 paying for social care support

	services. See also comments on Ageing population in rural areas below.
Women, men and transgender people (includes issues relating to pregnancy and maternity)	It is anticipated that women will be more significantly affected by this policy than men in a number of ways. Women tend to work in social care roles more than men; proportionately there tends to be more female carers (see carers section below for carer specific comments); and women are more likely to live longer and outlive male partners so they are more likely to access services in later life. Research suggests that female patients are more positive about community services, however, less positive about acute, therefore there is a positive impact on women's levels of service satisfaction.
Disabled people (includes physical disability, learning disability, sensory impairment, long-term medical conditions, mental health problems)	If there is a shift in the balance of care to health and social care partnership services provided in the community, there is likely to be an increase in the level and range of social care services commissioned. This could lead to an increase in the number of payments made on behalf of and by people who access chargeable social care services. This could negatively impact on disabled people, because they may be liable for more charges.
Minority ethnic people (includes Gypsy/Travellers, non-English speakers)	Access to language support services: will integration dilute the resources available, or make better use of existing resources? Could this lead to duplication? What are the levels of health and social care service uptake from minority ethnic communities? Current evidence indicates the numbers of minority ethnic people accessing services is low. Need to bring together workforce development on understanding of cultural outcomes.
Refugees and asylum seekers	A point was raised about accessibility: one point of access therefore individuals should find it easier to access services. There is an ongoing need for staff to have a cultural understanding of outcomes for individuals.
People with different religions or beliefs (includes people with no religion or belief)	See minority ethnic impact in terms of staff capacity and capability.

Lesbian, gay, bisexual and heterosexual people	No impacts identified.
People who are unmarried, married or in a civil partnership	No impacts identified.
People in different socio-economic groups (includes those living in poverty/people of low income)	This could impact on people from poorer areas where life expectancy is lower and the burden of disease higher. The policy could thus impact disproportionately in deprived areas in terms of the costs associated with the cared for. Ageing might be different across the population i.e. people in lower socio-economic groups being older in health but younger in age than higher socio-economic groups. This may have an impact on the age group classification.
People in different social classes	It was noted that there would be no change: that health care would continue to be free at the point of need, however, social care could be means tested.
Homeless people	It was advised that there was a developed social model for homelessness, particularly in urban areas. The question was raised over where this model would sit in an integrated system.
People involved in the criminal justice system	There were questions raised over where criminal justice health and social care will fit into an integrated system and whether any links already established would be weakened or strengthened. It was asked whether there is also a benefit from health care for prisoners, which is now delivered by NHS and therefore already in the fold in an integrated system. A question about how the policy would affect victims of crime was raised, with particular reference to the voluntary sector, given their role in this area and whether there would be an impact on any future funding.
People who have low literacy	No impacts identified.
People in remote, rural and/or island locations	The age profile of populations in remote and rural areas are increasing faster because people tend to retire to these areas and is, in some part, due to the migration of young people to urban areas for employment and educational opportunities.

	Therefore, there may be issues relating to delivery and accessibility of services for both staff and service users in these areas.
Carers	If there is a single point of access to services it will be easier and simpler for carers as they will not have to contact multiple service delivery organisations.
Staff (includes people with different work patterns, e.g. part-/full-time, short-term, job share, seasonal)	Issues relating to differing terms and conditions in Health Boards and Local Authorities were noted, with potential for consequential impact on staff and their respective representative bodies.
Others that may be relevant to the area of work (please add):	None.

Potential impacts on equality and health

D.18. The group identified the following potential impacts of the policy on equality and on health.

Example key areas of impact	Potential impacts of the policy and how the impacts may arise	Affected populations
Equality	A number of opportunities for promoting equality of opportunity were discussed when considering the differential impacts between population groups. In terms of the duty to promote good relations between groups, the policy needs to promote engagement with local organisations and co-production approaches to health and social care. The policy could also support promotion of more positive attitudes towards old age/illness/long term conditions (disability), women.	All
Lifestyles	The promotion of preventative care initiatives could have a positive impact on healthy diets/nutrition/exercise etc.	All
Social environment	Respite care for carers: Any changes or reductions to hospital facilities as a result of shifting the balance of care to the community, could have an impact on the number of facilities available which provide respite care.	Carers
Physical environment	Through promoting care in the community is it likely to be harder to control the spread of infectious diseases e.g. MRSA?	All
	Improved patient safety, with less movement from the home.	All

Potential impacts on human rights

D.19. The group identified the following potential human rights impacts.

Example article	Potential relevance	Affected populations
Life (Article 2, ECHR)	There will likely be an increase in community facilities so patients will have more options available to them, for example; to choose where they die.	Mainly adults
	Adult protection: There is a need to continue to ensure adequate provision and capacity of staff to provide support and information to enable patients to manage medication and stay safe in a homely setting.	Mainly adults
Freedom of expression (Article 10, ECHR)	No freedom of expression impacts were identified in the discussion	-
Private and family life (Article 8, ECHR)	The right to choose where you receive care, in alternative settings to hospital.	All
	There were concerns raised over the sharing and access to personal data.	All

Summary of key impacts, research questions and evidence sources

D.20. The following is a summary of the key areas of impact identified at the workshop, some possible questions to address in order to understand these, and suggested evidence sources to answer these research questions.

D.21. This is not a definitive or necessarily complete list of impacts and some may turn out, on further assessment, not to be relevant. The list is put forward as a starter to inform the next stage of the impact assessment, and is likely to be refined and explored further.

D.22. The work undertaken to explore these research questions should be proportionate to the expected benefits and any potential to make relevant and significant changes as a result.

D.23. Evidence-informed recommendations are key to a robust impact assessment; however, ‘evidence’ to support the development of recommendations can be thought of more widely than just formal research. Furthermore, a lack of available robust evidence should not lead to the impact assessment process being delayed or stopping altogether.

Often there is poor or insufficient evidence about the links between a proposal and health; there may, however, be plausible theoretical grounds to expect an impact.

Area of impact	**Research questions**	**Possible evidence sources**
Increased payments made for and by people who access these services.	Could there be an increased number of social care payments made for and by people, who access these services, particularly disabled people, and over 65s?	Explore further with appropriate stakeholders.
Accessibility to services for people from ethnic minorities.	How can workforce development teams be brought together to develop an understanding of cultural outcomes for individuals?	
Homeless people.	There is a developed social model for homeless people, particularly in urban areas, but where will these models sit in an integrated system?	
Potential implications for trade union and staff-side bodies representing health and social care staff.	How will differing terms and conditions of employment between Health Boards and Local Authorities, particularly if staff move between them or are within integrated teams, be managed?	Seek advice from relevant stakeholders including Scottish Government Health Workforce and Performance Management Director, Personnel Directors and Trade Unions. This could vary according to area, though national staff-side bodies may want to adopt particular views.
Promoting positive attitudes in communities and service users.	What evidence exists of effective approaches for promoting positive attitudes? What evidence exists to suggest that shifting care into the community promotes positive attitudes?	Census; Scottish Household Survey
Diet: better nutrition and exercise.	How will the policy positively impact on opportunities for better nutrition and exercise?	Census; Scottish Household Survey
Maximising available income for older people.	How will the policy maximise the income for older people?	Census; Scottish Household Survey

Area of impact	Research questions	Possible evidence sources
Create better networks between health and social care providers and carers.	How can data be shared between NHS, social care providers and carers?	Data sharing work under development by Scottish Government
Sharing and access to personal data.	What are the concerns of patients/staff over sharing personal data and how can they be overcome?	Examples from integration in England/elsewhere?
Improve patient safety: with minimum unnecessary movement from home. Impact of change on homecare capacity.	What are the hours of care per client or numbers of clients?	Homecare statistics publication; Scottish Health Survey .
Services would be provided in a person centred framework.	What would the experience be for the patient receiving the service?	GP/local NHS services patient experience survey
Adult protection.	Adult protection: There is a need to continue to ensure adequate provision and capacity of staff to provide support and information to enable patients to manage medication and stay safe in a homely setting.	Care home statistics; census. Scottish Health Survey
Older people.	Will the policy increase the system's ability to keep >65 year olds out of hospital?	> 65 emergency bed day rate per 100,000 population by Health Board (HEAT target) stratified by gender, age and deprivation.
Criminal justice.	What is the potential impact on reconviction rates? (age and sex breakdown where possible)	Scottish Government criminal justice datasets.
Carers.	What is the potential impact on respite care admissions?	Scottish Government health and social community care publications.

Who else needs to be consulted?

D.24. A range of key partners, relevant and interested parties were invited to the scoping workshop to support the assessment of the impacts of the policy and contribute to the development of the partial EQIA scoping report. After consultation the group identified no further parties for inclusion in the scoping workshop, or to assist with the scoping report.

Suggested initial recommendations

D.25. There were a number of suggested recommendations that emerged from the scoping workshop, these have been recorded and outlined in this document. As part of the consultation process we would welcome any comments you have on this partial EQIA.

D.26. Once the consultation closes, the scoping group will be reconvened to discuss and assess further impact aspects of the consultation responses and it is the output from this work which will contribute to the final EQIA.

Annex E Partial Business and Regulatory Impact Assessment (BRIA)

Title of Proposal

Integration of Adult Health and Social Care

Purpose and intended effect

- **Background**

There is a great deal to be proud of in terms of health and social care provision in Scotland. However, we recognise that we should go further to ensure consistently good outcomes for patients, service users, carers and families. Separate, and sometimes disjointed, systems of health and social care will no longer adequately meet the needs and expectations of increasing numbers of people, particularly those living into older age, often with multiple, complex, long-term conditions, who need joined up, integrated support.

There has been significant progress in improving pathways of care in recent years. Nevertheless, many clinicians, care professionals and managers in health and social care currently describe two key disconnects in our system of health and social care. 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.

These disconnects make it difficult to address people's needs holistically and to ensure that resources follow patients' and service users' 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, older people, and people with complex needs. Problems are also encountered at transition points, particularly as children with complex needs reach adulthood.

From the perspective of people who use the system – patients, service users, carers and families – the problems the Scottish Government are seeking to address can be summarised as follows:

- There is inconsistency in the quality of care for adults and older people across Scotland;

- People are too often unnecessarily delayed in hospital when they are clinically ready for discharge;

- The services required to enable people to stay safely at home are not always available quickly enough, which can lead to preventable and undesirable admissions to hospital.

Demographic change makes the case for change urgent. 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 and that around one quarter of Scotland's population will be aged 65 and over by 2033. The changes in demography will vary in scale depending on location, with predictions suggesting that rural areas will be affected to a greater degree than urban areas. We know that:

- Even allowing for the possibility that people may live longer and in better health in the future, and taking into account our current emphasis on improving anticipatory and preventative care, Scotland will in future experience a material increase in the number of older people who need care. Therefore, the resources required to provide support will rise in the years ahead;

- There is little association between the amount spent currently on health and social care services and the outcomes that are achieved i.e. spending more does not necessarily result in better outcomes;

- We spend almost one third of our total spend on older people's services annually on unplanned admissions to hospital; and

- We spend more annually on unplanned admissions for older people than we do on social care for the same group of people.

Our current system of health and social care incorporates within it barriers in terms of structures, professional territories, governance arrangements and financial management that not only often have no helpful bearing on the needs of the large, growing group of older service users, but in many cases work against general aspirations of efficiency and clinical/care quality. We need to reform the system to deliver care that is better joined up and as a consequence delivers better outcomes for patients, service users and carers.

- **Objective**

The Scottish Government's vision of a successfully integrated system of adult health and social care for Scotland is that it will exhibit these characteristics:

- Consistency of outcomes across Scotland, so that people have a similar experience of services, and carers have a similar experience of support, whichever Health Board or Local Authority area they live within, while allowing for appropriate local approaches to delivery;

- A statutory underpinning to assure public confidence;

- An integrated budget to deliver community health and social care services and also appropriate aspects of acute health activity;

- Clear accountability for delivering agreed national outcomes;

- Professional leadership by clinicians and social workers;

- It will simplify rather than complicate existing bodies and structures.

Building on these aspirations, our proposals for integration of adult health and social care are based on four key principles:

a) Nationally agreed outcomes will be introduced that apply across adult health and social care;
b) Statutory partners will be jointly accountable to Ministers, Local Authority Leaders and the public for delivery of those outcomes;
c) Integrated budgets will apply across adult health and social care; and
d) The role of clinicians and care professionals will be strengthened, along with engagement of the third and independent sectors, in the commissioning and planning of services.

How the Integration of Adult Health and Social Care Fits in With Other Policies

Scottish Policies:

Legislation:

The integration of adult health and social care legislation will supersede and replace the following:

- The Community Health Partnerships (Scotland) Regulations 2004;
- The Community Health Partnerships (Scotland) Amendment Regulations 2010.

In addition to the above, other legislation that will be directly affected by the integration agenda are legislation relating to the NHS and Local Authorities:

- Social Work (Scotland) Act 1968;
- National Health Service (Scotland) Act 1978;
- National Health Service Reform (Scotland) Act 2004;
- Local Government (Scotland) Act 1973;
- Local Government etc. (Scotland) Act 1994;
- Local Government in Scotland Act 2003
- Public Services Reform (Scotland) Act 2010

Policy:

The integration of adult health and social care policy will supersede and replace:

- Community Health Partnerships Statutory Guidance (2004).

These proposals for integration of adult health and social care services bring with them implications for a number of other functions, including mental health, adult protection, children and families social work services and criminal justice social work. Work is underway to ensure that the implications for other areas of service are understood and planned for. An important aspect of this programme of reform will also be ensuring that, as well as bringing primary and secondary health, and health and social care, closer together, partners fully include housing and other appropriate areas of services in the integrated approach.

We will be setting out in legislation our requirements for integration. These should be applied as a minimum to adult health and social care services. However, Partnerships will be free to integrate additional services, for example, children's services, if they wish. As such this will have implications for all policies linked to these services.

UK Policies:

Health and social care provision are fully devolved matters, therefore the integration of adult health and social care policy and legislation should not impact on any UK policy.

EU Policies:

The proposals for legislation in the consultation document and the broader integration policy will not have any EU or international implications.

- **Rationale for Government intervention**

Despite a good track record of partnership working over many years, our 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. We need to reform the system to deliver care that is better joined up and as a consequence delivers better outcomes for patients, service users and carers.

Our 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 our commitment to a person-centred approach, which builds upon our policy on Self Directed Support and the principles of the NHS Healthcare Quality Strategy.

Consultation

- **Within Government**

We have consulted with the following internal teams and will be continuing the process of consulting with these teams during the development of the integration agenda:

- ACSD: Policy for Carers
- ACSD: Self Directed Support
- DCS: Drugs Policy Unit;
- DHHI: Pharmacy and Medicines Division;
- DHSCI: Chief Dental Officer and Dentistry Division;

- DJUST: Community Justice;
- EAT: Better Regulation and Industry Engagement;
- EYSSW: Social Services Workforce;
- HCNO: CNOD Policy Unit;
- HIMD: Alcohol Delivery Unit;
- HLTHAS: Resources, Efficiency and Workforce;
- HOSD: Housing Transitions and Support;
- LG: Local Government Outcomes and Partnerships Unit;
- PCARE: Primary Care Development;
- PHARM: Pharmacy;
- PSP: Public Involvement;
- RCMHD: Older People's Unit;
- RCMHD: Protection of Rights Unit;
- TSD: Employability and Skills.

The Better Regulation and Industry Regulation and the Resource, Efficiency and Workforce teams have assisted us in planning the BRIA and assessing what we need to do to complete a robust BRIA.

The Resources, Efficiency and Workforce team have further assisted us through identifying and providing data for current social care use around Scotland (see below) and will assist us with developing cost analyses.

The remaining teams have helped us identify businesses and/or organisations to consult with and are ensuring that the integration agenda fits with other policies across the health and social care directorate.

- **Public Consultation**

A full public consultation is scheduled to be held at the beginning of May 2012. It will be a 12 week consultation.

Informal Consultation:

In 2010, the Scottish Government carried out a wide public and professional engagement exercise for the Reshaping Care for Older People policy. From this we know that there are three main problems with the current system that people want us to address. These are:

- Inconsistency in the quality of care for adults and older people across Scotland;
- People are too often unnecessarily delayed in hospital when they are clinically ready for discharge;
- The services required to enable people to stay safely at home are not always available quickly enough, which can lead to preventable and undesirable admissions to hospital.

In 2011, following the Scottish elections and as preparation for developing these proposals for legislation, the Scottish Government engaged with a wide range of stakeholders including the statutory partners, third and independent sectors and professional and staff organisations. The ideas that form the basis for these proposals were developed through this period of engagement, culminating in the Cabinet Secretary for Health, Wellbeing and Cities Strategy's announcement to the Scottish Parliament on 15 December 2011 of her plans. The text of that announcement can be found here:

http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=6627

Following the Cabinet Secretary's announcement in December 2011, while the formal consultation document was prepared for publication in May 2012, we have continued the process of engagement with a wide range of appropriate groups, including:

- Allied Health Professional Directors;
- Association of Directors of Social Work (ADSW);
- British Medical Association (BMA);
- Carers Scotland;
- Convention of Scottish Local Authorities (COSLA);
- Directors of Pharmacy;
- NHS Regulators;
- Patient Focus and Public Involvement Directors;
- Royal College of General Practitioners (RCGP);
- Scottish Care;
- Scottish Council for Voluntary Organisations (SCVO);
- Scottish Executive Directors of Nursing;
- Scottish Health Council;
- Scottish Partnership Forum (SPF);
- Women's Royal Voluntary Service (WRVS)

The process of engagement will continue during the formal consultation process.

- **Business**

With the assistance of Scottish Government policy colleagues, we have identified the following organisations to contact:

- Association of Community Health Partnerships;
- Association of Directors of Social Work (ADSW);
- Association of Local Authority Chief Housing Officers (ALACHO);
- Chartered Institute of Housing (CIH);
- Coalition of Care and Support Providers in Scotland (CCPS);
- Community Pharmacy Scotland;
- Convention of Scottish Local Authorities (COSLA);

- Directors of Pharmacy;
- Glasgow and West of Scotland Forum (GWSF);
- Long Term Conditions Alliance Scotland (LTCAS);
- Mental Health Tribunal for Scotland;
- Mental Welfare Commission;
- National Pharmacy Association;
- Royal Pharmaceutical Society;
- Safeguarding Communities – Reducing Offending (SACRO);
- Scottish Care;
- Scottish Council for Voluntary Organisations (SCVO);
- Scottish Federation of Housing Associations (SFHA);
- Scottish General Practitioners Committee (SGPC; part of the BMA);
- Society of Local Authority Chief Executives and Senior Managers (SOLACE);
- Voices of Experience Scotland (VOX Scotland)
- Voluntary Health Scotland (VHS).

We will begin consulting with the identified organisations/businesses once the public consultation is underway.

Options

The formation of Health and Social Care Partnerships will be written into statutory legislation. Partnerships will be required to form a Health and Social Care Partnership following the guidance issued by the Scottish Government.

The consultation proposes that Health and Social Care Partnerships should replace Community Health Partnership committees, which will be taken off the statute book. Health Boards and Local Authorities will jointly be required to set up a Health and Social Care Partnership. Each Partnership will cover a single Local Authority area, and will replace current Community Health Partnership arrangements.

Partnerships may choose not to integrate the budgets for other services along with adult health and social care, in which case the governance for other services might be provided by another Committee arrangement. Other options for the ongoing management of CHP responsibilities, and permutations on these options, are also possible; at this stage, it is our proposal that decisions about managing other areas of what are currently CHP functions should be left to NHS Boards to determine.

Partnerships will also be required to put in place arrangements for locality planning to deliver locally agreed joint strategic commissioning plans that have the support of the professionals and other care providers who will deliver services.

The aim is to create a system of health and social care in which the 'care pound' can be used to best support the individual at the most appropriate point in the system, regardless of whether health or social care support is required. It is the Scottish Government's intention that the integrated resource should lose its identity within the integrated budget, i.e. it will no longer be of consequence whether monies come from a health or a social care budget.

The consultation describes two options via which Health Boards and Local Authorities could integrate budgets to achieve this aim. Under these proposals, local Partnerships will be free to choose which approach they take to integrate budgets. Under each option, a Partnership Agreement will establish the nature and scope of the Partnership. Staff could move between employers to support a shift in functions, if there were local agreement to such a change.

Option 1: Delegation Between Partners

One partner can under current legislation delegate some of its functions, and a corresponding amount of its resources, to the other, which then hosts the services and integrated budget on behalf of the Health and Social Care Partnership. The financial governance system of the host partner applies to the integrated budget.

A Partnership Agreement between the Health Board and the Local Authority establishes the functions and resources to be delegated between the partners. Each delegating partner retains their existing legislative responsibility for delivery of functions.

Option 2: Delegation to the Health and Social Care Partnership, established as a body corporate

The Health Board and the Local Authority could delegate agreed functions to the Health and Social Care Partnership, which would be established as a body corporate of the Health Board and Local Authority. The Health Board and Local Authority would agree the amount of resources to be committed by each to the integrated budget for delivery of services to support the functions delegated to the Partnership.

The integrated budget would be managed on behalf of the Partnership by a Jointly Accountable Officer, whose authority and accountability in relation to delivery of the Partnership's delegated functions would be determined by his or her statutory functions. The integrated budget would consist of the respective contributions from each partner organisation, each managed by the Jointly Accountable Officer and subject to the respective financial governance arrangements of each partner.

A Partnership Agreement would establish the terms of the arrangement between the Health Board and the Local Authority, and would establish the facility that the partners would transfer resource between the two budgets at

the discretion of the Jointly Accountable Officer. Each delegating partner would retain their legislative responsibility for the functions that had been delegated to the Health and Social Care Partnership.

Do nothing option

The proposals for the integration of adult health and social care will be primary legislation and as such Partnerships will not have the option of doing nothing.

Locality Planning

Community Health Partnerships (CHPs) have been criticised in some areas by GPs and other professionals for limiting their opportunities to play an active role in local service planning and provision. There has also been frustration that some CHPs were 'toothless', with decisions regularly having to be pushed upwards to the parent Health Board and with little influence in particular over acute budgets. These proposals will address those concerns, by requiring locality planning arrangements be developed and implemented in Health and Social Care Partnerships.

The consultation will propose a duty on Health Boards and Local Authorities to consult local professionals, across extended multi-disciplinary health and social care teams and the third and independent sectors, on how best to put in place local arrangements for planning service provision, at the level between Partnerships and individual GP practices. Having consulted, Partnerships will be required to put in place, and to subsequently support, review and maintain, such arrangements.

- **Sectors and Groups Affected**

  The groups that we anticipate will be affected by this are as follows:

  - clinical/professional/support health and social care workforce;
  - carers;
  - service users;
  - health and social care providers (NHS, local authority and independent e.g. care homes);
  - statutory bodies.

- **Benefits**

  The main objectives behind both options are twofold: first, to achieve better outcomes for service users; and second, to address the pressures created by the projected demographic change in Scotland. In addressing these objectives, the Scottish Government is aiming to ease fiscal pressures (see figure 1), deliver a more effective and cohesive service, and better meet the needs of individuals in the system. This will, in turn, benefit health and social care providers.

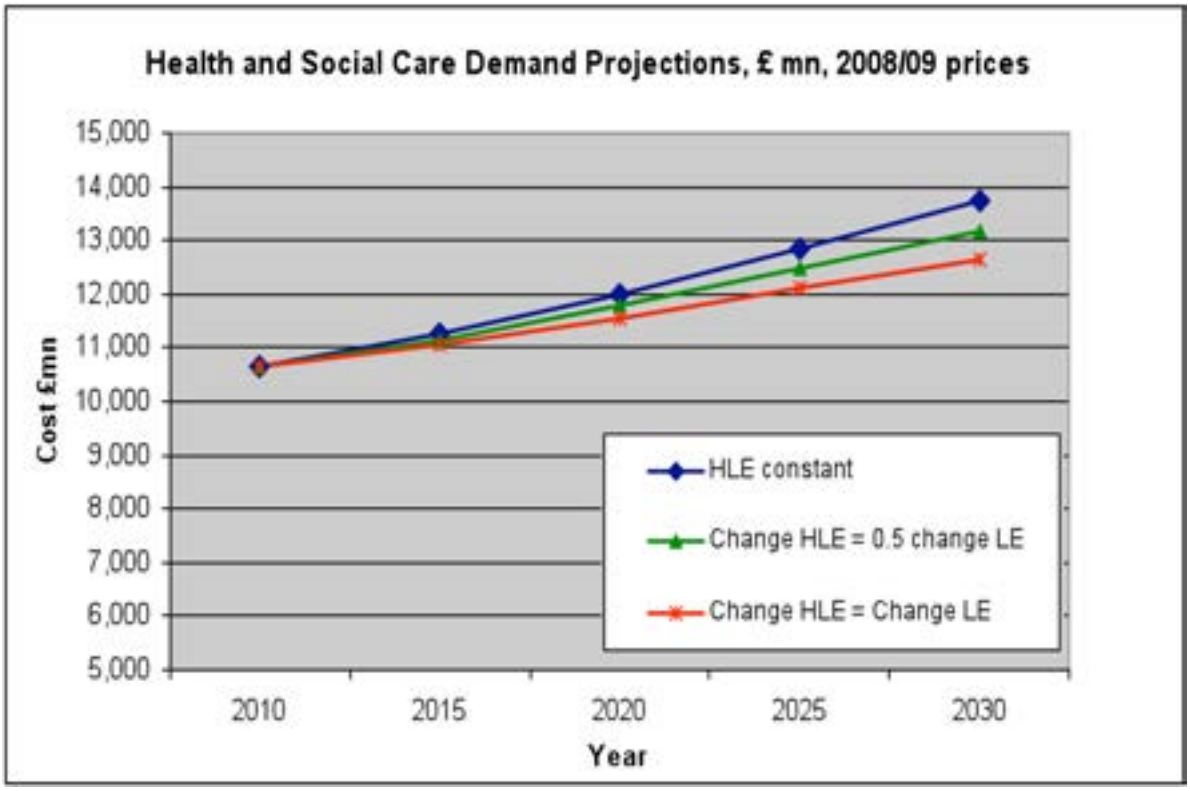


Figure 1: Graph showing the projected increase in costs for social care up to 2030 for three variables. The dark blue line shows the increase in cost assuming that the healthy life expectancy doesn't change i.e. people are healthy until, say, 68 and live until 70 now; and the line projects people who are healthy until 68 but live until, say, 75. The green and red lines show variations of the above idea, with the ideal situation being the red line: healthy life expectancy increases as does life expectancy to give the same time in the 'unhealthy' bracket. This still indicates that the projected increase in costs will be untenable. HLE= healthy life expectancy; LE= life expectancy.

Produced by Scottish Government, Analytical Services Division (Health)

- **Costs**

We have identified the following areas which we expect will have potential costs or potential savings/benefits as a result of implementing the agenda:

Potential Costs:

- Provision of more health and social care in communities;
- Costs associated with enabling GPs to participate in locality planning;
- Transitional non-recurrent double running costs as changes are made to current arrangements;
- Employment costs of Jointly Accountable Officers;
- Non-recurrent costs of producing Partnership Agreements;
- Costs of financial management of the integrated budget e.g. reporting activity and unit costs;
- Costs associated with IT and data sharing;
- Training and workforce development costs.

Potential benefits/savings:

- Reduction in rates of acute bed use, and length of stay, as care moves into communities and anticipatory services are improved, particularly for the frail elderly population;
- Efficiency savings arise from better understanding of activity, unit costs and reduced variation;
- Savings from reduced cost shunting e.g. reduced delayed discharges;
- Cost savings from potential reduction in number of committees and the removal of all CHPs.

In addition to the above, with the shift in the balance of care from acute care to community care, we expect that the amount of commissioned social care will increase and therefore the amount spent on social care will increase.

Currently expenditure on adult social care in each local authority is as follows:

Local Authority Expenditure on Adult Social Care*, 2009-10, £ thousands

Aberdeen City	79,974
Aberdeenshire	93,118
Angus	41,349
Argyll & Bute	37,387
Clackmannanshire	16,780
Dumfries & Galloway	55,482
Dundee City	57,351
East Ayrshire	45,038
East Dunbartonshire	29,879
East Lothian	36,358
East Renfrewshire	30,707
Edinburgh, City of	177,337
Eilean Siar	17,476
Falkirk	53,832
Fife	137,401
Glasgow City	252,828
Highland	82,487
Inverclyde	37,581
Midlothian	28,328
Moray	32,033
North Ayrshire	52,674
North Lanarkshire	144,394
Orkney Islands	13,185
Perth & Kinross	54,309
Renfrewshire	63,157
Scottish Borders	52,920
Shetland Islands	20,546
South Ayrshire	51,273
South Lanarkshire	113,008
Stirling	31,258
West Dunbartonshire	47,040
West Lothian	47,343

Note: * Social work (excluding children, asylum seekers and refugees and criminal justice services) Net Revenue Expenditure with ring-fenced revenue grants added back.

Source: Local Financial Returns, LFR 3

Scottish Firms Impact Test

Throughout the consultation and the development of the integration agenda, the policy team with responsibility for the integration of adult health and social care will meet directly with a range or organisations, businesses and users affected by the proposals. This will enable us to better assess the costs and/or benefits to each organisation, business or user. The final BRIA will contain details of engagement with a minimum of six businesses, to better assess the impacts of this agenda on them.

Businesses affected:

Following discussions with Scottish Government policy colleagues, we anticipate that businesses associated with social care will be affected to a greater extent than those associated with healthcare. This is because there is far greater plurality of provision in social care in Scotland than in healthcare (with the NHS providing almost all healthcare), and because the process of commissioning social care is likely to be different in different Local Authority areas.

The level of health and social care provided in communities is expected to increase under these proposals. There may be a greater impact on social care businesses, because of the plurality of providers noted above, but there will also be an impact on, for example, pharmacies – we will consider the impact on businesses across health and social care to take account of the range of interests involved. This is reflected in the organisations that we have identified to consult with for the full Business Regulatory Impact Assessment (see above).

- **Competition Assessment**
  The proposals outlined above propose a shift to community provision and anticipatory care. Therefore, it is likely that services will need to be redesigned to better meet the needs of individuals and achieve better quality of outcomes; however, it is anticipated that this is unlikely to substantially impact on competition within the current market.

  To ascertain whether the proposals will impact on competition, we will be conducting competition assessments using the Office of Fair Trading Guidelines (2007) as part of the process of consulting with businesses. The results of these assessments will be published in the full BRIA.

- **Test run of Business Forms**
  No new business forms will be brought in with the implementation of the proposed legislation.

Legal Aid Impact Test

We have discussed the integration agenda with the Scottish Government Legal Aid Team. We have determined that as we are not creating any new offences/penalties etc and there is nothing to suggest that there will be an increase on individuals seeking legal advice as a result of the proposals, a legal aid impact test does not need to be carried out.

Enforcement, sanctions and monitoring

The consultation will propose that Community Health Partnerships should be replaced by Health and Social Care Partnerships. These will be the joint and equal responsibility of Health Boards and Local Authorities. They will be required to work in partnership with the third and independent sectors with a focus on making sure that people have access to the right kind of care, at the right time and in the right place.

Accountability:

Health and Social Care Partnerships will be accountable, via the Chief Executives of the Health Board and Local Authority, to Ministers, NHS Chairs, Council Leaders and the public for the delivery of nationally agreed outcomes. Outcomes measures will focus initially on improving older people's care and will be included in all Community Planning Partnerships' Single Outcome Agreements.

The nationally agreed outcomes will apply across health and social care; will be transparent and accountable locally and to the Scottish Parliament via Ministers; and will provide assurance that local variation is appropriate to local needs. Providing information and evidence from across health and social care will be critical to demonstrating progress, and external scrutiny processes will be appropriately aligned to support integration of adult health and social care.

Monitoring:

A sliding scale of improvement and performance support will be put in place to assure the delivery of national outcomes by Health and Social Care Partnerships. Improvement support will be offered to all Health and Social Care Partnerships to ensure sharing of good practice, benchmarking, leadership and organisational development, development of commissioning skills and other priority areas. Where Health and Social Care Partnerships fail to deliver national targets, performance support will be offered and, where critical, put in place to assure the delivery of targets.

We recognise that effective collaborative working with external scrutiny partners will be important, and will work with the Care Inspectorate and Healthcare Improvement Scotland to ensure an appropriately integrated approach to reviewing the quality of service and outcomes achieved.

As work progresses on this agenda, we will be considering further methods of monitoring the progress of integration.

Sanctions for non-compliance:

Current Ministerial sanctions for failure to deliver under legislative requirements will be amended to reflect the new Partnership arrangements.

Implementation and delivery plan

May – August 2012:

- Public consultation;
- Publish partial BRIA and EQIA with the consultation paper;
- Consult with businesses identified.

August – September 2012:

- Assess public and business consultation responses.

September 2012 onwards:

- Development of legislation.
- Publish complete BRIA and EQIA in support of the integration agenda (date to be confirmed).

- **Post Implementation Review**
  Each Health and Social Care Partnership will be expected to produce joint commissioning strategies and delivery plans over the medium and long-term, which will be reviewed as part of the process of ongoing assurance. Reporting meetings to Ministers, Health Board Chairs and Local Authority Leaders, will be established and will use an agreed set of measures to support monitoring of progress towards outcomes. These meetings will build on the current regime of accountability reviews for Health Boards. Accountability to the public will be via publication of local performance data.

Summary and recommendation

Summary:

The Scottish Government is proposing plans to integrate adult health and social care across Scotland. These have been developed in collaboration with partners. Furthermore, the proposals have cross party support and we have garnered support with external agencies through engagement events.

We are proposing that as a minimum, adult health and social care services should be integrated and Partnerships would be able to integrate additional services if they agree to do so.

The integration of adult health and social care will be driven forward through the formation of Health and Social Care Partnerships. These will be the joint and equal responsibility of Health Boards and Local Authorities.

The consultation will propose two options for the governance of the Health and Social Care Partnerships: delegation between partners; and delegation to the Health and Social Care Partnership, established as a body corporate.

Recommendation:

The options, outlined in the consultation document and above, provide Partnerships with two possible options for Governance arrangements. It will be up to Partnerships to decide which option suits them best, based upon the local scenario. The proposals for the integration of adult health and social care will be primary legislation and as such Partnerships will not have the option of doing nothing.

- **Summary costs and benefits**

  We have identified potential costs and potential benefits/savings (see above) and will be seeking additional quantification of these for the full BRIA. We will be using information from the Highland model of integrated health and social care, which went live in April 2012, to begin the assessment of these aspects.

Declaration and publication

I have read the BRIA and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options. I am satisfied that business impact will be assessed with the support of businesses in Scotland.

Signed:

Date: 30 April 2012

Nicola Sturgeon
Cabinet Secretary for Health, Wellbeing and Cities Strategy

Scottish Government Contact point:

David MacLeod
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0131 244 2653

Annex F Respondent Information Form

Integration of Adult Health and Social Care in Scotland

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

Title Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Dr ☐ ***Please tick as appropriate***

Surname

Forename

2. Postal Address

Postcode	**Phone**	**Email**

3. Please indicate which category best describes your role/group or interest in health and social care integration. (Tick one only)

NHS Health Board	☐
Other NHS organisation	☐
General Practitioner	☐
Local Authority	☐
Other statutory organisation	☐
Third sector care provider organisation	☐
Independent/private care provider organisation	☐
Representative organisation for professional group	☐
Representative organisation for staff group e.g. trade union	☐
Education/academic group	☐
Representative group for patients/care users	☐
Representative group for carers	☐
Patient/service user	☐
Carer	☐
Other, please state	☐

5. 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** ☐ **No**

Annex G Consultation Questionnaire

The case for change

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 ☐

Comments

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 ☐

Comments

National outcomes for adult health and social care

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 ☐

Comments

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 ☐

Comments

Governance and joint accountability

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 ☐

Comments

Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

Yes ☐ No ☐

Comments

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

Yes ☐ No ☐

Comments

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 ☐

Comments

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 ☐

Comments

Integrated budgets and resourcing

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 ☐

Comments

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 ☐

Comments

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 ☐

Comments

Jointly Accountable Officer

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 ☐

Comments

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Yes ☐ No ☐

Comments

Professionally led locality planning and commissioning of services

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

Yes ☐ No ☐

Comments

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 ☐

Comments

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?

Comments

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 ☐

Comments

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

Comments

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 ☐

Comments

Do you have any further comments regarding the consultation proposals?

Comments

Do you have any comments regarding the partial EQIA? *(see Annex D)*

Comments

Do you have any comments regarding the partial BRIA? *(see Annex E)*

Comments

Annex H How to respond

The Integration and Service Development Team welcomes responses to this consultation paper by **31 July 2012.** Please send your response with the completed Respondent Information Form to:

adulthealthandsocialcareintegration@scotland.gsi.gov.uk

or

Integration and Service Development Division
(Consultation)
The Scottish Government
2ER, St Andrew's House
Edinburgh
EH1 3DG

We would be grateful if you would **use the consultation questionnaire provided in the consultation document or clearly indicate in your response which questions or parts of the consultation paper your are responding to** as this will aid our analysis of the responses received.

This consultation, and all other Scottish Government consultation exercises, can be viewed online on the consultation web pages of the Scottish Government website at http://www.scotland.gov.uk/consultations .

The Scottish Government now has an email alert system for consultations SEconsult: http://www.scotland.gov.uk/consultations/seconsult.aspx This system allows stakeholder individuals and organisations to register and receive a weekly email containing details of all new consultations (including web links). SEconsult complements, but in no way replaces, SG distribution lists, and is designed to allow stakeholders to keep up to date with all SG consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We would encourage you to register.

Handling your response

We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please complete and return the **Respondent Information Form** which forms part of the separate consultation questionnaire as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential and treat accordingly. All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

If you tell us we can make your response public, we will put it in the Scottish Government Library and on the Scottish Government consultation web pages. We will check all responses where agreement to publish has been given for any wording that might be harmful to others before putting them in the library or on the website. If you would like to see the responses please contact the Scottish Government Library on 0131 244 4565. Responses can be copied and sent to you, but a charge may be made for this service.

What happens next?

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us reach a decision on the Legislation on the Integration of Adult Health and Social Care. We will issue a report on this consultation process in the Autumn of 2012, which will be published on the Scottish Government's website at:

http://www.scotland.gov.uk/Publications/Recent

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to:

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APPENDIX 2

INTEGRATION OF ADULT HEALTH AND SOCIAL CARE IN SCOTLAND
DUNDEE CITY COUNCIL RESPONSE

QUESTION 1 - THE CASE FOR CHANGE

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?

COMMENTS

We agree that the achievement of improved outcomes should be the purpose and driver of change and the basis upon which performance is judged. We also agree that there is a compelling case for change. Local experience tells us that achieving improvement not only involves reorganising the complex interdependencies that are around the system, but also involves analysing how and why it has been resistant to improvement. Cultural influences feature strongly in the process of change. This is ambitious and challenging and cannot be a short term objective - it will require sustained effort over time.

Whilst locally we have demonstrated improvement in outcome measures like delayed discharge and in rebalancing care, we have not managed to make an impact on inequalities. The gap between the life circumstances of our most and least deprived citizens has grown in the last ten years and we have 29% percent of people living in the 15% most deprived communities. The Council is giving priority to inequalities and has recently published a Fairness Strategy. One obvious implication of the deprivation of our population is that, not only do we have an ageing population, but we also have the characteristics of ageing featuring in a much younger population with the resultant impact on demand for health and social care services.

Whilst we understand and appreciate the demographic imperatives that come from an ageing population we think inequalities are our most significant overall challenge. We would want, therefore, to be able to keep our partnership approach flexible and open to approaches that would allow us to give health improvement priority. This would mean in practice, that we would want to be able to segment our population and give priority to those in the greatest need, identify evidenced approaches that are likely to deliver the most significant improvement for individuals and prioritise resources beyond health and social care on these evidenced approaches. To do this effectively we expect to draw on and recognise a broad concept of partnership.

These factors aside, analysis of how our local system impacts on the needs of older people resonates with the Government's in that: we have unexplained variation in our services which is experienced as inconsistency by service users and carers; we have not sufficiently rebalanced care in favour of care at home; we have too many unplanned admissions; there are people delayed in hospital beyond their fit date for discharge; and some services are not delivered quickly enough. We know that much of this involves the health and social care interface and that there is capacity for improvement. We also know, however, that at all levels of service delivery, hospital, care home, or home, we are observing increased dependency and that consequently there is increased demand.

Local experience of the Integrated Resource Framework (IRF) has demonstrated that those with the highest dependency consume a significantly disproportionate level of resource. It is recognised, therefore, that we have much to gain from ensuring we have the most effective approach to service response in terms of improving individual and collective outcomes. This will not be sufficient, however, to deal with future demand. This will require a scale and pace of change beyond that which we have achieved to date.

Whilst we support the notion of the application to adults of the proposition that lies behind the integration proposal in general terms, we have a couple of observations that we would wish to make. Firstly, other adults are not a homogeneous group. Secondly, the interface issues are different, so for

example, links with education training and employment are much more significant for people with mental illness and learning disability and the acute services interface much less, people with drug and alcohol problem interface much more with children's services and criminal justice services. In addition, there are cross cutting aspects of service delivery like adult protection that apply to all categories of need.

The identified disconnects, between primary and secondary care and between health and social care apply most directly to older people. The proposed changes self evidently do much less to deal with the first identified disconnect than the second. We believe this disconnect is critical to the shift in the balance of care . We return to the pre-eminence of this issue in response to later questions.

In summary, and in response to question 1, we would want to retain the flexibility to adopt the approach that best meets the needs of our population and best sustains the achievements we have already made in partnership working. We agree, however, that it would be reasonable to focus initially on outcomes for older people.

QUESTION 2 - OUTLINE OF PROPOSED REFORMS

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?

COMMENTS

We believe the objectives of the reform should be;

- improved outcomes for our citizens, particularly those who are relatively disadvantaged with a concept of partnership that extends explicitly beyond health and social care and into the wider community;

- flexible deployment of resources by all partners in the achievement of these outcomes;

- improved experience of service delivery by the citizen;

- to support early intervention and prevention;

- explicit recognition of the positive contribution people and communities have to make; and

- strong democratic accountability.

Locally we have a mature community planning partnership with good community participation combined with a developing Fairness Strategy that is designed to focus priority on narrowing the gap between our most and least advantaged citizens. We have similarly mature partnership working arrangements in adult services and we have a Total Place initiative in place for children's services.

Drawing on these experiences confirms to us that a clear policy direction; strong public and professional engagement; a common strategic direction with clear strategic leadership; an explicit focus on improved outcomes; the development and cultivation of positive working relationships and a supporting partnership machinery with an integrated commissioning and management framework have been constant factors where we have achieved most success.

The focus from the proposed framework on strengthening partnership working within a single commissioning direction is welcome and would do well to be matched nationally. We do not believe, however, that this framework in itself will necessarily bring the improvement sought. In particular, the identified disconnect, between primary and secondary care is occurring at present within a single organisation. The proposed structural arrangements could sharpen rather than smooth this boundary and consequently inhibit the process of the shift in the balance of care.

In conclusion, we support the objectives for the framework and the enhancement of the mechanisms available to support integrated working. We do not think they are an automatic prescription for

success. We believe we will develop our partnership most effectively if we retain the flexibility to determine locally how, to what extent, and over what time period we apply the proposed mechanisms. More specifically, our local objectives of improving health and wellbeing and reducing inequalities would be enhanced if Public Health was included explicitly within the framework and if the mechanisms offered by Community Planning Partnerships were recognised as a key feature of the framework. Finally, we think the possibility should be open but not required to include Criminal Justice Services within the framework.

NATIONAL OUTCOMES FOR ADULT HEALTH AND SOCIAL CARE

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 and for support to carers. 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?

QUESTION 4

Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

COMMENTS

Q3 - We believe a successfully integrated system needs to be, and should be, grounded on a common set of outcomes and should be accountable for achievement against these outcomes. The public policy significance of the integration agenda argues for strong accountability. We agree that placing a legislative duty on statutory partners would contribute to this. It would not, however, deal adequately with the interdependencies and broader interrelationships that are a necessary component of the change. The health and social care outcomes should be applied through all aspects of partnership and should and be incorporated directly into the Local Single Outcome Agreement. This would in turn form the logical basis for the proposed Local Partnership Agreement. As well as in this context, consideration should be given to this as part of the National Review of Community Planning.

Q4 - In line with the answer to three above we agree the nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements.

GOVERNANCE AND ACCOUNTABILITY

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?

QUESTION 6

Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

QUESTION 7

Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

COMMENTS

Our position on governance and joint accountability is informed by our wish to have an open and transparent governance framework that recognises the strength of public accountability that comes with democratically appointed elected representatives and also respects the necessity for clear lines of accountability for non elected representatives. We also recognise that a balance has to be struck between local and national accountabilities. The proposals do not however, position the roles of Chief Executives of Local Authorities, or Local Authority Leaders comfortably for us in this respect. Local Authority Leaders do not hold committees of the Council to account. The full Council holds committees to account. The Chief Executive is not accountable to the Council Leader but to the whole council. This hierarchy should be respected in the revised agreements. The democratically accountable bodies should be held to account through their roles and duties with the Chief Executives and Council Leaders providing leadership and direction. The Chief Executives should be accountable to the Council and the Health Board Chief Executive to the Health Board and Cabinet Secretary. They should, however, be held jointly accountable for achieving the nationally agreed outcomes and

indicators in line with views outlined above. The public accountability should come through the mechanisms of the Single Outcome Agreement and Community Planning Partnerships.

The arrangements for the Partnership Committee will operate most satisfactory if they have the full and explicit support of the parent bodies. We recognise that to achieve a qualitative change in joint commissioning the Partnership Committee will need the proper delegated authority to undertake its responsibilities. We do not think the proposed committee arrangements are supportive to this. This is because the ambition and consequent scale and social reach of the responsibility of the proposed committee is very significant. It therefore demands proportionate membership in terms of the authority and membership numbers and balance between elected and non elected representatives. Specifically, we do not think the members of non elected representatives should be prescribed; we do not think that Council leader or Boards should be excluded from membership; and, whilst we think principles of equity should be applied, the availability of non executive board members should not determine the size of the committee.

The duties and delegated powers of the committee should, however, be defined better. Accountability for the resource should be with the committee and not to the Jointly Accountable Officer. Officers should be subject to an agreed scheme of delegated powers as defined by the Partnership Committee and its parent bodies. This approach would be most consistent with our understanding of proper standards of public and democratic accountability.

GOVERNANCE AND ACCOUNTABILITY

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?

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?

Q8 - The focus of performance on integrated outcomes and national standards is sound and consistent with the overall proposals. We think, however, that further consideration should be given to how separately constituted scrutiny bodies will operate in the integration environment.

Q9 - We have indicated above that partnerships should have the flexibility but should not be required to include other functions that support local arrangement like, for example, Public Health and Criminal Justice.

INTEGRATED BUDGETS AND RESOURCING

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?

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?

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?

COMMENTS

Of the two models of support our preferred route would be Model 2 - it would be a natural development of our current partnership arrangements. We think the potential advantages of pooling over aligning may be overstated, but we are committed to the provision of seamless service delivery, and to reducing duplication and unexplained variation in our service delivery.

Locally, we have aligned our community adult budget and reported on budgeting performances against this aligned budget through a joint management team. Commissioning frameworks are developed through joint strategic planning groups which have brought partnership involvement. We have drawn on this background and experience to develop successfully our stakeholder monitoring and performance arrangement for our Older People Change Plan. We have extended these arrangements into a single management arrangement for learning disability. We have pooled our budgets and/or resources in certain discrete circumstances.

We have found it helpful to have aligned budgets across all adults and older people expenditure. This has enabled joint scrutiny of performance and enhanced flexibility for service development, so for example we have been able to use health resource to fund intermediate care development and local authority resource to increase care at home and enablement against an agreed objective of reducing reliance on care homes and long stay hospital care for older people. In the case of learning disability, this approach has allowed us to jointly analyse our cost pressures and agree a common management approach to the management and development of resources. The learning disability experience has also been instructive in developing our understanding of the limitations of such an approach. The application of differential human resource policies and terms and conditions of employment are challenging in both time and effort. Budget cycles, reporting arrangements, and financial regulations are all different so understanding of a dual system is required and is similarly challenging in time and effort since any budget that is aggregated has to remain capable of disaggregation.

As we interpret the situation at present altering this would require changes to primary legislation. The proposals as described at present to not specifically address how, or if, it intended to develop legislative and/or technical solutions to resolve these matters.

The attribution of acute resource has been a particular challenge for us in terms of budgetary alignment. Our efforts to advance plan a shift in the balance of care in our change plan for older people has drawn this into sharp focus. This is in part due to the fact that our local evidence and experience does not demonstrate a reduction in demand for acute care in the short medium or long term, leading health board commissioners to conclude that the strategic objective should be to stop further growth in acute beds but not to reduce it significantly below the current level of provision. The financial planning of implication of this has been that we have had to push shifts in resource from acute to community to the later periods of our financial planning cycle. In addition, attribution of resource has not been entirely transparent.

The debate and discussion about this combined with our experience of the IRF process have also revealed that we have very different approaches to unit costing and confirmed that there are significant issues about the application fixed costs that arise for the acute sector. We would conclude that detailed guidance and advice will be required about how acute resources can be disaggregated and attributed across the system flexibly or otherwise. In addition, our experience of managing programmes of change also tells us that buildings have a very potent political resonance with the public. Following through on the flexible deployment of resource will require strong and consistent political leadership both locally and nationally.

We have found that actual pooling of budget has been most useful in situations where we have different funding sources paying for exactly the same thing like for example occupational therapy equipment and some buildings.

In conclusion we recognise that both lateral and horizontal integration of resources could help us deploy our resources to better effect in the interests of our population. We do not think we should be required to do this for groups beyond older people but we think the flexibility to do so should be available.

JOINTLY ACCOUNTABLE OFFICER

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?

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

COMMENTS

The role of the Jointly Accountable Officer (JAO) should be of leadership and management. The powers of the officer are argued above should be those delegated from the Partnership Committee

which should provide democratic scrutiny. This approach provides necessary check and balance between the role of an officer, the Committee and elected representatives on the Committee. The management accountability should be to the Chief Executives of the Health Board and Council and we would expect that within such a system the JAO would be given the power to flexibly deploy resources and would in turn have the authority of the Partnership Committee and its parent bodies in this respect. We believe such an approach would strengthen accountability.

Account should also be taken of the role and responsibilities of the local authority Chief Social Work Officer. Very little consideration is given to this role within the consultation framework.

We think consideration should be given to how failure would be dealt with and how it should be resolved. We would expect this to be a matter that would feature in the Partnership Agreement and lie with the Cabinet Secretary and Council Leader for ultimate resolution.

We think as with other aspects of the proposals that local partnerships should be able to interpret the role of the JAO flexibly into their own situation.

PROFESSIONALLY LED LOCALITY PLANNING AND COMMISSIONING OF SERVICES

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this 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?

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?

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

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?

We have a strong view that locality planning should be left to local determination. We think that understanding of how local communities of interest, for example people with learning disability, geographical communities, and administrative boundaries, e.g. GP patient boundaries interact is best understood locally. In addition, we already have quite a complicated community engagement landscape. We would want to be free to co-ordinate our community engagement to make best use of machinery that is already in place. In addition and as indicated above we are locally we are also exploring a total place approach for children's services and are considering how we could segment our population focus for adults differently to increase the scale and pace of change. We do not think, therefore, that the definition of sub-localities for service delivery for procurement purposes by the Scottish Government would be helpful or effective in improving local outcomes.

We think we should use community planning mechanisms and involvement strategies to ensure both professional and public participation in our macro planning or commissioning and also in our service redesign. We note that micro commissioning as it is being developed through the self directed support legislation is inconsistent care services social move to with the integration policy. We think this should be revisited.

We do not think, proposals as outlined provide a sufficient range of incentives the guarantee the active participation of GP's or other frontline staff. Our IRF experiences supports this assertion. In this respect, we think consideration needs to be given to aligning the GP contract to reward activities that support the broad direction of change for older people and other adult groups. This should include the importance of time for participation in local commissioning processes, Social Workers and Social Care staff should also see direct benefit from their involvement and all need standardised information with support from through training and learning to interpret and use data that tells them about activity and cost.

We do not think it is practicable to locate locality planning around GP practices for service delivery purposes because; a) with few exceptions in Dundee their population bases are dispersed and would

be difficult to match administratively, b) their patient populations do not form a community engagement, c) their independent contractor status means they do not operate representatively limiting their capacity to drive planning at a local level, and d) locality based planning should be based on a much broader construct of partnership than the organisation of GP practices.

We think the segmentation of the population and devolution of authority for the organisation and delivery of services should take account of the lessons learned from tests like Total Place and evidence gathered through initiatives like IFR. We recommend, therefore, that there should be flexibility to allow the devolution of responsibility to locality partnership groups but no prescription around range of responsibility or the size of the population.