INTEGRATION OF ADULT HEALTH AND SOCIAL CARE IN SCOTLAND: RESPONSE TO SCOTTISH GOVERNMENT CONSULTATION

Summary

First and foremost, we endorse the vision and the case for change articulated in the consultation paper. While the challenges presented are not unique to Scotland (e.g. see the King's Fund - http://www.kingsfund.org.uk/publications/continuity_of_care.html), these proposals do represent a potentially bold step change in approach provided that they are further clarified and strengthened. As an already fully integrated health and social care partnership, West Dunbartonshire Community Health & Care Partnership (CHCP) is strongly placed to comment on the proposals, reflective of our actual experience of working to realise the benefits of integration in practice.

The maturation of our CHCP has been aided by consideration of the available evidence-base and learning from elsewhere – and which have highlighted key issues that we have worked hard to address positively, notably the importance of:

- Clarity of vision and strategy.
- Clear decision-making and accountability structures and processes.
- Agreeing what success looks like and indicators for measuring progress.
- Implementing a system for managing and reporting on performance.
- Achieving efficiencies through sharing resources.
- Understanding and respecting differences in organisations' cultures and practice.
- Personal commitment from the partnership leaders and staff.

From these then we have identified a number of learning points that we suggest should be used to further strengthen the consultation proposals so that the new Partnerships <u>are designed for success</u> and not (inadvertently) set up to fail:

- What community health and social care services and responsibilities are integrated should be nationally consistent. The case for change is applicable across all care groups- so integration should be required across all those services spanning "the cradle to the grave".
- How integration is structured and delivered within and across these services should be determined at a local level.
- It is critical that the single Jointly Accountable Officers (and their senior teams) are entrusted with the authority and mandate to deliver what is a hugely ambitious agenda within a highly visible arena; and that they can rely on visible support - alongside robust scrutiny – from their local Committee, Council and Health Board.
- That the multi-layered accountability and performance regime proposed is further refined so that its complexity does not inadvertently stifle the new Partnerships' imperative to lead necessary transformational improvements; and to ensure that the outcomes and targets they are set are both stretching and realistically achievable so that their effectiveness can be judged fairly. This should acknowledge those "wicked" issues that the structural integration will not resolve.

Within the overall context of our consideration of the proposals, we would strongly commend a third operating model (in addition to the two options set out within the

Consultation Paper) i.e. a partnership entity that is not a body corporate (similar to how West Dunbartonshire CHCP has been established and currently operates).

Consultation Responses

Q1. 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?

1.1 While there is a pragmatic logic for the proposition of an initial focus on improving outcomes for older people, there is a real risk that a series of arrangements could be developed that would not be efficiently scaled up or transferable to other care groups.

1.2 The reality is that within the context of the Older People's Change Fund there is already considerable focus (including dedicated performance reporting and robust governance) on the *Reshaping Care for Older People's* agenda (http://www.scotland.gov.uk/Topics/Health/care/reshaping) – so in practical terms, such an initial focus as suggested would probably provide little (if any) added value to what is already being driven forward; and would possibly skew the implementation of integration more generically (as it may suggest a piecemeal approach, with different integration models devised for different care groups with complicated structures and unwieldy bureaucracies as a consequence).

1.3 This would then undermine two of the most compelling characteristics of the proposed vision for a successfully integrated system, i.e.:

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

1.4 In a similar vein, it is difficult to rationalise why an equivalent ambition should not be explicit for a successfully integrated system for children and young people's health and social care services; and for the accountabilities for such a system not to be hardwired into the responsibilities for the new partnerships. Child Protection case reviews repeatedly highlight inadequate and hesitant interagency communication and information sharing as contributing factors to significant incidents.

1.5 While it would be naïve to argue that an integrated management and governance would somehow be a "magic bullet" to resolve such behaviour, it is reasonable to view them as enabling factors for more effective risk assessment and care management. One example of this would be a single head of service for all children's services consistently articulating the same message in relation to *Getting It Right for Every Child* (GIRFEC - http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright) to both health and social care professionals. Another example of this would be a single Chief Social Work Officer for an authority area within the new Partnership consistently articulating the same message for child protection to all health and social care professionals across all services (not just children and young people's services). This would appear to be consistent with the Scottish Government's proposals in relation to the Children and Young People's Bill it is separately consulting upon (http://www.scotland.gov.uk/Publications/2012/07/7181).

1.6 We recognise that the proposals as they stand provide the scope for different areas to include more than "just" adult health and social care; and the attractiveness of providing local determination of the scope for the new partnerships (i.e. if the Council and Health Board wishes to do go beyond the *de minimis* position as expressed in legislation).

1.7 However, in our assessment this would likely undermine the above characteristics, particularly as where a given health board spans more than one local authority boundary it would be almost inevitable that unhelpful complexity would arise from the different local authorities within that health board boundary expressing a different preference for what responsibilities should rest with the partnerships for their respective areas.

1.8 Moreover, given that the Scottish Government's proposals quite rightly establish integration at Director level, it is difficult to see how any council financially could justify and sustain a distinctly separate management and professional structure for children's social care and criminal justice services; or how the role of Chief Social Work Officer could coherently by expressed and discharged in such circumstances.

1.9 We would contend that that it would be more effective and more robust to start with a coherent local framework for efficient management and integrated delivery across the totality of health and care services for all care groups/age cohorts - including children services and criminal justice social work services.

1.10 Within West Dunbartonshire, the established CHCP's status as a joint vehicle for the planning, allocation and management of WDC and NHSGGC health and social care resources (both strategically and operationally) is recognised as a clear manifestation of *community planning in practice*.

1.11 In our view, comprehensive integrated partnerships would be better placed to focus on *prevention* and *early intervention* - working with the whole family and whole community – and act as effective Community Planning Partners in the spirit of the *Christie Commission's* recommendations for the future of public service delivery (http://www.scotland.gov.uk/Publications/2011/06/27154527/0).

Q.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?

2.1 As per our response to Q.1., in our view all community health and social care services - including criminal justice and children and young people's services - should be included in the new Partnerships from the outset.

2. Social care for children focuses on vulnerable children and their families. These families are served by adult health and social care services and their children are served by specialist NHS community services and are also a core focus for NHS primary care and community services. Unified delivery of these services in a single Partnership will improve quality, efficiency and effectiveness.

3. It is important to note that we do not believe that the joint working with other Council functions – particularly Education services - in relation to children and young people would be undermined by fully comprehensive Health and Social Care

Partnerships. Indeed, just as the proposals as they currently stand recognise the importance of robust working arrangements between the new Partnerships and Council Housing services in relation to the *Reshaping Care for Older People* agenda (http://www.scotland.gov.uk/Topics/Health/care/reshaping), we see no reason why an equivalent emphasis should not be placed in terms of Education services in relation to the *Getting It Right For Every Child* agenda (http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright); and the duties on public bodies that are separately confirmed by the Children and Young People Bill that Scottish Government is currently also consulting upon (http://www.scotland.gov.uk/Publications/2012/07/7181).

4. Criminal justice social work is an adult social care service and it is not clear why the delivery of these services would not be included, not least as there are critical relationships with addictions and mental heath services (for example) which will be within the new Partnership's responsibilities.

5. Likewise, given our position that children's social care services should be mandated to be part of the new partnerships, we also see a compelling argument for the inclusion of criminal justice services given the connectivity between youth criminal justice services and adult criminal justice services. Inclusion of the social work service delivery element would strengthen the role of new Partnerships as a comprehensive and critical new partner in Community Justice Authorities (CJA) and related structures. Alternatively – and coupled with the establishment of a single Scottish Police Service - this may be an opportune moment to revisit the CJA construct within a now changed public sector landscape.

6. We recognise that the proposals as they stand provide the scope for different areas to include more than "just" adult health and social care; and the attractiveness of providing local determination of the scope for the new partnerships (i.e. if the council and health board wishes to do go beyond the *de minimis* position as expressed in legislation). However, in our assessment this would (again) likely undermine the above characteristics, particularly where a CJA spans more than one local authority boundary it would be almost inevitable that unhelpful complexity would arise from the different local authorities within a CJA boundary expressing a different preference for what responsibilities should rest with the partnerships for their respective areas. This would pose particular risks given the concerns highlighted by the recent Report by the Commission on Women Offenders in relation to the grossly cluttered partnership landscape.

7. There are also a variety of public protection concerns that Scottish Government has separately emphasised the cross-over between - and critically the importance of a joined-up approach by – health and social care services for both children and adults; and which have direct connections with criminal justice services (e.g. sexual offences; gender-based violence; forced marriage).

8. Primary care contractors in different areas would potentially need to relate to three different structures if both children's health and social care services are not included within their Partnership's area: the Local Authority; the Health and Social Care Partnership; and whatever arrangement the Health Board has to manage its children's services if they are not within Partnerships.

2.9 There is a need for further clarification on what responsibility the Partnerships will have for defined elements of NHS acute activity, not least to ensure that the

accountability that rests with the Jointly Accountable Officer is reflected in the level of authority that they and their management teams have over the relevant and specified NHS acute services. This clarification should extend to reducing the current vague reference to "some acute spend from health boards" that are suggested would be included within the mooted pooled budgets.

9. There is a need for clarification on what responsibility the Partnerships will have for other aspects of community-based territorial Health Board responsibilities (e.g. in relation to hospice funding), and similarly other Council responsibilities (e.g. in relation to social housing).

2.10 We would also commend that the new Partnerships are explicitly mandated as having a leadership (but clearly not sole) responsibility - on behalf of their respective health boards and councils – for health improvement and tackling health inequalities within the context of their local Community Planning Partnerships.

Q3.*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?*

3.1 As per our response to Q.1 and Q.2, we would suggest that the statutory partners be held jointly and equally accountable for nationally agreed outcomes for children's health and social care too.

3.2 The overall approach proposed should provide a sufficiently strong mechanism to achieve the extent of change that is required – provided that:

- Existing performance reporting and accountability regimes are revised so that new nationally agreed outcomes and accountability arrangements replace existing regimes rather than are introduced in addition to what is currently in place.
- The opportunity is taken to streamline reporting regimes – to avoid confusion and reduce unnecessary bureaucratic processes.
- A sufficient discipline is applied to the agreement of a tight number of nationally agreed outcomes.
- Indicators are reflective of those issues that are predominantly and reasonably within the sphere of control of the new Partnerships to deliver upon.
- Realistic "stretch" targets are set for those indicators so that the new Partnerships are not (inadvertently) set up to fail.

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

1. Within West Dunbartonshire, the established CHCP's status as a joint vehicle for the planning, allocation and management of WDC and NHSGGC health and social care resources (both strategically and operationally) is recognised as a clear manifestation of *community planning in practice*. In our view, comprehensive integrated partnerships would be better placed to focus on *prevention* and

early intervention - working with the whole family and whole community – and act as effective Community Planning Partners in the spirit of the *Christie Commission's* recommendations for the future of public service delivery (http://www.scotland.gov.uk/Publications/2011/06/27154527/0).

4.2 We are therefore supportive of the proposition that outcomes agreed for the new Partnerships are visible within their respective Community Planning Partnership (CPP) Single Outcomes Agreements (SOA) – provided that:

- In accordance with the negotiated spirit of an SOA, there is scope for local determination of which of the new Partnership's agreed national outcomes are incorporated within their respective SOA, e.g. those which most clearly fit the wider and shared smaller number of strategic priorities of the local CPP and/or those whose likelihood of achievement will be greatly increased by a formal contribution/support from other local Community Planning Partners. This is an approach that has already been established and been operating smoothly within West Dunbartonshire in terms of the existing CHCP. Merely seeking to include all of the new Partnership's nationally agreed outcomes would likely undermine the fundamental concept of an SOA, i.e. that it is developed and agreed on the basis of a local determination of priorities across a range of different stakeholders.
- The opportunity is taken to streamline reporting regimes rather than multiplying reporting activity and bureaucracy – e.g. so that Partnerships are not having to invest valuable expertise and resources reporting on performance on the same issues through different routes and using different formats/templates to different Boards/Committees and/or Scottish Government Directorates.
- There is clarity of the precise role of CPP Boards (or equivalent arrangements) in relation to those Partnership outcomes that are included within the local SOA so as not to either duplicate or dilute the already stringent governance and accountability arrangements that the new Partnerships are proposed to work to.

1. 4.3 We would caution against conflating the principles of community planning (which the new Partnerships would be a manifestation of) with attempts to shoe-horn accountability for the new Partnerships into the distinct CPP organisational structure.
2.
3. 4.4 The statutory responsibilities of the new Partnerships should <u>not</u> be to a CPP, primarily because not all of the members of CPP Boards (or equivalents) are individually accountable for decisions that they make that may affect the new Partnership's ability to function and/or deliver on their agreed outcomes; and because this would confuse the already stringent governance and accountability arrangements proposed for the new Partnerships.

Q.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*?*

5.1 There are a number of complex governance issues which need to be worked through once the headline basis of the Partnerships is defined.

5.2 We will want to see the new Partnerships with the maximum possible responsibilities for service delivery, and with a balance between NHS health and Council social care budgets and services.

5.3 However, at this point there is a need for clarity of what the proposals mean with reference to the Partnerships being distinct " bodies corporate" as this does not seem consistent with the proposition they will be governed by a joint Committee of the Council and the NHS Health Board (as per Chapter 4 of the Consultation Paper).

5.4 Fundamental to success here is the appointment of a sufficiently senior Jointly Accountable Officer as Partnership Director mandated to establish a fully integrated management team responsible for the management of staff and resources across the whole Partnership.

5.5 The overall governance arrangements for the Jointly Accountable Officers and their management teams are ambitious by any standard (when compared with the norm across either the public or private sectors).

5.6 There is a need for further refinement of the proposed "community of governance", especially as at present the implication is that its focus would be on holding the new Partnership's Committee to account for delivery.

5.7 The arrangements for governance, accountability and budgets set out in Chapters 4 and 5 of the Consultation Paper are inconsistent and create a degree of confusion as regards the governance arrangements which underlay the workings of local authorities. Accountability for delivery of council services and statutory functions (as delegated by Government) is to Council as a corporate body. Individual Councillors - including the Leader - have no direct power or accountability. While the Council Chief Executive reports to Council and implements their decisions, they themselves are not accountable for decisions of Council. Similarly, (Council) Committee Chairs only act as the Chair of the Committee: they do not control the business which comes to Committee nor its outcome. In short, it is Council as a corporate body, not individual officers or individual Members who hold accountability.

5.8 It should be clear that it is the Jointly Accountable Officer who is held to account and not the Partnership Committee. It is the role of the Partnership Committee to hold those senior officers to account on behalf of the NHS Health Board and the Council – and so the question is how to structure the Cabinet Secretary's additional and direct scrutiny responsibility within that context.

5.9 With that in mind, there are three primary sets of accountability relationships that would benefit from clarification:

- Accountability of the Jointly Accountable Officer to their Council and NHS Health Board Chief Executives.
- Accountability of both Chief Executives to the Council of Governance (i.e. the Cabinet Secretary, Leader of the Council and Chair of the NHS Health Board).
- Accountability of the Jointly Accountable Officer to the Council of Governance.

5.10 In terms of maintaining a regular and direct relationship between a council of governance (such as proposed) and the Jointly Accountable Officer, the solution would be for the Committee to be chaired by the Leader of the Council – the latter effectively discharging three mutually reinforcing governance responsibilities

here: i.e. on behalf of the Council (provided that mandate provided); on behalf of the NHS Health Board (provided they are a Non-Executive Director of the Health Board and mandated to do so); and on behalf of the council of governance. Although this approach is not one favoured within the consultation proposals, we would strongly contend that that position is revisited as the proposition above is worthy or serious consideration in terms of good public governance.

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

6.1 While this is admittedly possible in theory, it could be counter-productive in practice (just as it would be in reverse, i.e. if scope was provided for more than one integrated Partnership within a single local authority area).

6.2 Such a provision would run contrary to two of the fundamental principles that are meant to underpin the proposals, i.e.:

- It would complicate an already ambitious governance arrangement.
- It would complicate rather that simplify existing bodies and structures.

Q.7 Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership*?*

7.1 Within the context of our previous responses to Q. 3 and Q. 5, the proposed local Committee arrangement would be more than sufficient to ensure governance of the new Partnerships.

2. However, in addition to the legislative change required to abolish CHPs (as an amendment of the NHS Reform [Scotland] Act 2004), further revisions may need to be considered to clarify the legal basis of the delegated powers and pooled budget accountabilities of the new Partnership Committees, e.g.:

- The Local Government (Scotland) Act 1973 (with suggested consideration to Sections 56 and 57).
- The Community Care and Health (Scotland) Act 2004 (with suggested consideration to Sections 13 and 15).

7.3 We support the principle implicit within the proposals that voting members of the Committee are only those with a clear mandate and formally recognised accountability for the decisions that they make, either by being locally elected members of the Council or formally appointed Non-Executive Directors of the Health Board. Importantly, individuals within either of those roles will be subject to Nolan Committee's *Standards of Public Life* (http://www.public-standards.gov.uk/) – and in this manner, provide assurance to the public on the integrity of the Committee.

4. We support the importance of parity of membership from both Council and Health Board representatives as a manifestation of the equal responsibility being vested in the new Partnerships.

5. However the proposals as they stand need to better reconcile a structural tension in setting the "right" number of Committee members. This is because Health Boards tend to be larger than Councils territorially and yet have a relatively small

number of Non-Executive Directors (meaning it will be harder for Health Boards to appoint to Partnership Committees), whereas the democratic sovereignty of Councils lies in the collective body of elected members (and so will presumably create pressure for bigger, more representative partnership committees, especially for Councils run by coalitions).

6. There is an opportunity to recognise the enhanced leadership role of those councillors who are appointed on the Health Boards as Non-executive Directors: while they are in those positions by virtue of their part of the political administration of their Council, they are part of the broader governance arrangements of both their full Council and the Health Board – and will have a legitimately influential "voice" in both arenas unlike the other members of the new Partnership's Committee.

7. We support the identification of the Jointly Accountable Officer as being a non-voting member of the Committee, as that underlines the importance of Committee members acknowledging that senior officer's important leadership role; and recognises the importance of that senior officer having a mandate to appropriately "speak to power".

8. We support the identification of the Clinical Director and Chief Social Work Officer (where that role is not discharged by the Jointly Accountable Officer) as non-voting members, as that emphasises the key professional leadership role of both those posts (particularly in relation to matters concerning clinical and care standards); and recognises the importance of both those posts having a mandate to appropriately "speak to power".

9. We recognise that the third sector - and indeed a range of other organisations - will be vital to the work of the new Partnerships, and that constructive working relationships must be founded on mutual respect.

10. We welcome the explicit expectation that the third sector should be appropriately engaged within the strategic commissioning processes of the new Partnerships but with the clarity that the statutory responsibility for the delivery of health and social care services lies with NHS Health Boards and Local Authorities – and consequently that the decision making and governance needs to reflect that. This is in accordance with the fundamental principle that authority should only be properly exercised by those individuals who are subject themselves to a recognised accountability for their decisions and have accepted an appropriate level of liability for their consequences. This is particularly important to avoid the possibility or the perception that particular special interest groups and/or provider organisations have been able to influence the strategic decision-making in their favour (particularly in relation to funding allocations and procurement). Within West Dunbartonshire, we would offer the constructive and transparent working relationship that has been developed between the CHCP and West Dunbartonshire CVS (as an independent "broker" for engagement with the full range of local third sector organisations) as a good practice example.

7.11 We recognise the importance of effective community engagement work of the new Partnerships; and that the new Partnerships will have to fulfil whatever obligations are confirmed in the anticipated Community Engagement and Renewal Bill (http://www.scotland.gov.uk/Publications/2012/06/7786). Cross-referencing the proposals within the Community Engagement and Renewal Bill, we would welcome the introduction of an overarching duty for community

engagement on the public sector that replaces various existing agency specific arrangements within the context of a consistent approach for each new partnership; and that recognised of the role of elected members/councillors as representatives on behalf of communities.

7.12 It is important that community engagement should focus more on processes that effectively collect the views of wider communities/all residents or service users; and less on static structures that involve limited numbers of people or specific groups. Community engagement then should at least meet the National Standards for Community Engagement (http://www.scdc.org.uk/what/national-standards/) and be compliant with the requirements of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 (http://www.legislation.gov.uk/sdsi/2012/9780111016718).

7.13 We welcome the explicit expectation that the "community" should be appropriately engaged within the strategic commissioning processes of the new Partnerships, but require clarity on which individuals the term "community" refers to in terms of the work of the Committee as alluded to within the proposals (and indeed in relation to any participative duties that are expressed within the Community Engagement and Renewal Bill).

7.14 Similarly, there is a need to clarify the relationship between the "community" (as expressed within the proposals in relation to the work of the Partnership Committee) and the role of locally elected members/councillors, not least as they are mandated to represent all those resident within their constituencies and the local communities as a whole.

7.15 We also recognise the importance of constructive staff side/trade union engagement in the work of the new Partnerships, conscious that there are different traditions, customs and practice between and within different Health Boards and Councils.

7.16 As such, the new Partnerships should be required to operate within a single and consistent framework applicable across all staff that consolidates the NHS Staff Governance Framework (http://www.staffgovernance.scot.nhs.uk/what-is-staff-governance/) and the Scottish Government's Practice Governance Framework (http://www.scotland.gov.uk/Publications/2011/03/24111247/0) as it relates to local authority social care services.

Q.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?

8.1 Yes, the proposed performance management arrangements are more that sufficient - provided that:

- Existing performance reporting and accountability regimes are revised so that new nationally agreed outcomes and accountability arrangements replace existing regimes rather than are introduced in addition to what is currently in place.
- The opportunity is taken to streamline reporting regimes – to avoid confusion and reduce unnecessary bureaucratic processes.

- A sufficient discipline is applied to the agreement of a tight number of nationally agreed outcomes.
- Indicators are reflective of those issues that are predominantly and reasonably within the sphere of control of the new Partnerships to deliver upon.
- Realistic “stretch” targets are set for those indicators so that the new Partnerships are not (inadvertently) set up to fail.

Q.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?

9.1 No – as above, we would argue that Scottish Government should define all community health and social care responsibilities as being within the scope of the new Partnerships.

9.2 A key finding of Audit’s Scotland’s *Review of Community Health Partnerships* (www.audit-scotland.gov.uk/docs/health/2011/nr_110602_chp.pdf) was that CHPs had inconsistently delivered on a joined-up service agenda as the scope of partnership arrangements varied across Scotland.

9.3 Our view is that was an unfair criticism to level directly at CHPs themselves, as this was a consequence of the original legislation which explicitly emphasised the scope of such arrangements to be determined by the relevant NHS Health Board and Council on an authority-by-authority basis. There is a real risk of the new legislation effectively repeating a variation of that type of structural “mistake”.

Q.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?

10.1 Integrated governance and management arrangements that represent a single “health and social care system” at the level of a local authority represents a major and bold step in the right direction.

10.2 However, it is important to also recognise that no organisational model can provide a convenient “magic bullet” or act as a panacea for the complexity and scale of health and social care challenges - particularly within the extremely challenging financial climate that is anticipated to persist for some years to come.

10.3 For that reason, it is critical that the Jointly Accountable Officers (and their senior team) are entrusted with the authority and mandate to deliver what is a hugely ambitious agenda within a highly visible arena; and that they can rely on visible support - alongside robust scrutiny – from their local Committee, Council and NHS Health Board.

10.4 Ensuring that the opening financial allocations fully reflect current spending on health and social care is critical. This will require a consistent national guidance.

10.5 There is a need for further clarification on what responsibility the Partnerships will have for defined elements of NHS acute activity, not least to ensure that the accountability that rests with the Jointly Accountable Officer is

reflected in the level of authority that they and their management teams have over the relevant and specified NHS acute services. This clarification should extend to reducing the current vague reference to “some acute spend from health boards” that are suggested would be included within the mooted pooled budgets.

10.6 It is clear that resources allocated by the parent bodies will need to be ring fenced but this does have implications for the wider financial governance of both parent bodies. The roles of the Council Section 95 Officer and the NHS Health Board Director of Finance need to be clarified.

10.7 The proposals indicate that resources allocated to the Partnerships will lose their NHS Health Board or Council social care “identity”. While this is appropriate and welcome to ensure the Partnerships have appropriate flexibility it does raise complex issues about the governance of the respective differential statutory responsibilities of the two parent bodies. There is a need for clarification regarding the “rules” for on-going resource allocation (e.g. a scenario where one partner corporately decides to prioritise revenue allocation within a given year to another part of its system/organisation) and how year-end exigencies would be managed (e.g. if a given Partnership either substantially underspends or overspends its pooled budget).

10.8 Similarly, there is a need for clarification on the “rules” for capital planning, funding and approval, particularly if each Partnership is responsible for singular capital asset plans, and is encouraged to provide co-located services.

10.9 It will be important that the creation and early success of the new Partnerships are not hamstrung by the costs identified within the Partial BRIA at Annex E of the consultation document. Appropriate Scottish Government funding support will be required to assist with these costs, particularly as the benefits are likely to lag behind the potential costs being incurred.

10.10 In relation to the stated two options:

- Option (a) Delegation to the Health and Social Care Partnership established as a body corporate. This proposes that the integrated budget would be two contributions from the partner organisations, each managed by the Jointly Accountable Officer; and both subject to each of the parent body’s respective financial governance arrangements. This appears contrary to the stated proposition that funds would “lose their identity” and requires further clarification.
- Option (b) Delegation between the Council and NHS Health Board partners – i.e. one partner could delegate some functions to the other. This suggests the host parent body’s governance applies to the pooled budget. While this appears to be more straight-forward, there are complexities that would require further clarification (e.g. in relation to their being different VAT rules).

10.11 We would argue that the options set out within the Consultation Paper both carry their own considerable challenges. While we accept that there will not be a perfect solution, we would strongly commend a third and more practical option, i.e. a partnership entity that is not a body corporate. This is similar to how West Dunbartonshire CHCP currently operates.

Q.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?

11.1 Yes – as an existing integrated health and social care partnership, West Dunbartonshire CHCP can certainly evidence that (even within the context of having to manage two distinct ledgers) integration enables more co-ordinated and efficient use of health and social care resources.

11.2 A pooled budget would certainly aid that further – but we also recognise that it requires adjustments to the wider corporate processes of the Council and the Health Board to strike the “right” balance between consistent practice across both corporate organisations; and providing the Partnership with sufficient flexibility to innovate and streamline its approach locally.

11.3 By the same token, there will continue to be a host of challenging agendas that the new Partnerships will also have to contend with in relation to the sustainable management of financial resources, e.g. GP prescribing and self-directed support.

***Q.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*?**

12.1 The delivery of objectives will be a product of the governance arrangement, performance management regime and the provision of sufficient resources (within the overall pooled budget) rather than the minimum categories of spend.

12.2 There needs to be a recognition that the performance objectives and outcomes expected are achievable within the budgets provided.

Q.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?

13.1 As per our response to Q.10 above, there are a number of important issues in relation to financial authority and accountability that require further definition:

- There is a need for further clarification on what responsibility the Partnerships will have for defined elements of NHS acute activity, not least to ensure that the accountability that rests with the Jointly Accountable Officer is reflected in the level of authority that they and their management teams have over the relevant and specified NHS acute services. This clarification should extend to reducing the current vague reference to “some acute spend from health boards” that are suggested would be included within the mooted pooled budgets.
- There is a need for clarification regarding the “rules” for on-going revenue resource allocation and how year-end exigencies would be managed.
- Similarly, there is a need for clarification on the “rules” for capital planning, funding and approval, particularly if each Partnership is responsible for singular capital asset plans, and is encouraged to provide co-located services.

13.2 Importantly there is a need to:

- Clarify the roles of the Council Section 95 Officer and the NHS Health Board Director of Finance.
- Define the relationship and differentiate between the financial authority proposed for the Jointly Accountable Officer and the financial authority of the Council and NHS Health Board Chief Executives.

Q.14 Have we described an appropriate level of seniority for the Jointly Accountable Officer?

14.1 We fully support the proposed single Jointly Accountable Officer as being responsible for the full range of the Partnerships resources and services, reporting directly to the Council and NHS Health Board Chief Executives.

14.2 From our experience such a post is essential if the Partnerships are to function as required. It is important to recognise that as such a post would have a much greater set of accountability and reporting arrangements to work within compared to most other senior public sector leaders.

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

15.1 It is important that this be a matter of <u>local determination</u> not least as it will be important to imbue local professional ownership of those arrangements and respect the independent contractor status of not just general practice, but also general dental practitioners, community pharmacists and community optometrists.

15.2 In addition, any such direction would seem to be at odds with the duty proposed (as referred to in Q.16 below) and the stated vision of a successfully integrated system that allows “for appropriate local approaches to delivery”.

Q.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?

16.1 Yes, although this would be improved by an accompanying consideration of how national government can encourage all GPs and other external NHS contractors to constructively participate in these arrangements so that the responsibility for the effectiveness of these arrangements are mutually shared by all and indeed ensure that the Partnership’s decision making processes benefit from the widest evidence-based contributions of staff and not just the inputs of enthusiastic local clinicians/professionals.

Q.17 *What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?*

17.1 We support the development of locality planning as a transparent vehicle for engagement with local professionals in decision-making in relation to the communities we all serve.

17.2 It is important to ensure that new Partnerships enjoy legitimacy as a force for positive change amongst professional groups, including NHS external contractors; and also provide a means to ensure that those same professionals constructively discharge a wider leadership role across their respective peer groups and within their respective professional communities.

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

18.1 While there is an organisational convenience to this proposition, it would be better for the starting point to be that our arrangements (as indeed our services) be organised in a manner that is logical for the communities that we serve rather than to reflect any particular (and historical) organisation of staff or services – i.e. for locality planning to reflect natural communities.

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

19.1 While we recognise the headline appeal of this proposal, this would not be a fair position to place those different staff that attended – and create a two-tier relationship between external contractors who attend and those professionals directly managed within the new partnerships who attend.

19.2 In addition, in order for formal and consistent devolvement of decision-making it would also have to be conditional on all external contractors being represented for the purposes of representing interests of all patients/clients equitably.

19.3 Moreover, expressing the role of locality planning groups in this stark manner could actually undermine the overall governance arrangements for the new Partnerships, e.g. it would raise the question of would it then be fair for the Jointly Accountable Officer to be held to account for decisions made by locality planning groups who themselves were nor formally accountable to anybody (let alone the Partnership Committee) for those decisions.

19.4 Give that those locality planning groups and the majority of professional staff involved in them are not being proposed as being held to direct account for any such decision making or the use of resources, then we would strongly contend that it would be more constructive to frame the purpose of locality planning groups as being one of engagement and dialogue to ensure local intelligence underpins the planning and development of services.

Q.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?

20.1 No – localities within different Partnership areas should be locally determined on the basis of recognised natural communities of residents rather than an arbitrary population number.