

Health and Social Care Integration

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2. **Section 1: Overview**
3. Public services in Scotland face an unprecedented challenge: to improve outcomes for the people of Scotland and reduce inequalities at a time of increased demand, by ensuring the best use of increasingly limited resources.
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5. Local government has invested significantly in arguing that effective and sustainable reform requires public agencies to be empowered to work together to improve lives across Scotland's communities. We have also argued that Community Planning and Single Outcome Agreements are at the heart of this agenda. These views have gained considerable traction, and both the Christie Commission, and the Government's response to it, have recognised the need to build on and strengthen those processes.
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7. Scottish local government is therefore committed to delivering real change for the communities it serves and is jointly accountable to communities, along with its community planning partners, for delivering local outcomes as set out in SOAs. We therefore need to recognise community planning as the context for health and social care integration. In many ways this is a simple proposition. After all, the broad aim of community planning is to improve life outcomes for people and communities across Scotland by ensuring that public services work in a more integrated and effective way. Above all, our views on integration are therefore built on a fundamental objective to ensure that the relationship between Health and Social Care Partnerships and Community Planning Partnerships is well-defined and clearly articulated at both the national and local levels. We are clear that a focus on health and social care outcomes for communities, and ensuring partnership arrangements that are fit-for-purpose to deliver these, should guide this relationship, and we make a number of suggestions in this context. We are also clear that the Scottish Government must account for these issues in the reform of community planning with the same energy and commitment as it has approached the integration of health and social care.
8. In considering the public service reform agenda more broadly, COSLA has expressed general support for an agenda that develops outcomes-based approaches; uses resources flexibly; promotes co-production, early intervention and prevention; facilitates service integration; and enhances local democratic scrutiny. The overall thrust of the Scottish Government proposals on health and social care integration would seem to align with these general principles. COSLA would argue, however, that the proposals are at times too prescriptive and too detailed, and as a general rule there should be more flexibility at a local level to determine the shape and governance of the proposed partnership arrangements. The pace and scope of integration should be determined at a partnership level, accepting that there will be a statutory minimum defined in legislation. We would also maintain that health and social care partnership arrangements should be subject to effective democratic oversight, with well-defined governance lines being drawn between partnership structures and the parent council and NHS Board. However, the current governance proposals, while well-intentioned, fall short of describing effective arrangements in support of this principle.
9. COSLA's response is not limited to the particular questions raised in the formal consultation. In general terms, we take the view that the proposals in themselves are not sufficient to effect change, especially if our commonly defined policy objective is to keep more

people living independently in their own home. In particular, we believe that the outcomes agenda needs to be iteratively developed, with a strong fit to SOAs and community planning processes. Furthermore, work needs to be done at a national level to ensure that resources become as flexible and fluid as possible in order to achieve the policy objective of shifting the balance of care. This has significant implications for the harmonisation of the management of resources (human and financial) across local government and the NHS. If this enterprise is to succeed we cannot shy away from challenging issues like shifting resources out of secondary care, or taking strategic decisions to re-shape the workforce.

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11. COSLA has worked closely with Scottish Government colleagues, and other key stakeholders, to begin to address these wider issues – both through the review and ongoing reform of community planning, and through the range of strategic groups set up to support the integration project. We welcome this approach and would emphasise the importance of ensuring local government is properly represented across the various strategic and working groups tasked with taking integration forward. **We also seek full engagement in the process of drafting the health and social care integration bill and ask that the draft bill be subject to full public consultation prior to it entering Parliament.** The Scottish Government's proposals for health and social care integration represent arguably the most significant change to social work services since the 1968 Social Work (Scotland) Act. We believe the potential impact of legislation, coupled with the level of comment on initial proposals, mean consultation on the draft bill itself is required.

Section 2: COSLA's Position on Public Service Reform

12. In terms of the current performance of public services in Scotland, there is a strong connection between improved outcomes for particular population groups and reduced costs over the longer term. Conversely, a failure to improve outcomes for whole population groups can cause a failure to tackle rising demand and control costs. In short, poor outcomes for a relatively small proportion of the population drive very large amounts of public spending.

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14. The improvement of outcomes demands an integrated approach to service delivery. Because outcomes are themselves mutually interdependent – for instance, a person's well-being is defined not just by their overall health but also their safety, their independence, and so on – our approach to the improvement of outcomes must be similarly defined. In other words, only by integrating public services will we begin to truly nurture an outcomes ethos.

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16. COSLA is also clear that public sector reform must be guided by values and principles. In this regard, we point to the primacy of local democratic accountability as a first principle of good governance. Local populations should be able to have a direct say on who governs local services – this principle is both a means to end (the accountabilities built-in to democratic governance structures provide incentives for better decision making) and an end in itself (government of the people, by the people, for the people).

17. In general terms then, COSLA supports a public service reform agenda which:

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19. is focused on the improvement of outcomes, co-ordinated through community planning;

20. asks community planning partners to use their total resource flexibly in support of those outcomes;

21. maximises the potential of co-production, early intervention and prevention;

22. is focused on greater integration of local services in order to achieve a seamless service to citizens;

23. puts local democracy and accountability at the heart of the reform process to ensure full and effective accountability for decision making.

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25. On the face of it, the Scottish Government's proposals on health and social care integration satisfies these general principles. The prospectus set out in the consultation document envisages nationally agreed outcomes that all partnerships will pursue; a locally integrated system based on local authority boundaries; integrated budgets, which will give us - for the first time - the levers to shift the balance of care from secondary care and deliver real community benefit; and a governance structure that puts elected members and Health Board Non-Executive Directors in control of Health and Social Care Partnerships.
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27. The Scottish Government's proposals have much to commend them and we find that, with some adjustment to allow for a more flexible use of different models, they would sit well within the broader ambitions we have in respect of public services reform. As such, this response should be taken for what it is: a constructive attempt to move that agenda forward; to identify where the challenges lie, or where the proposals fall short of what we would want, and, where relevant, to suggest alternative arrangements. **While there are a number of issues within the consultation document with which we disagree, it does not alter our general view that the integration of health and social care should be supported as a matter of principle, and will form a corner-stone of the public service reform agenda into the future.**

Defining the Health and Social Care Problem

28. The improvement of outcomes needs to be the methodological driver of change and the touchstone for assessing success. Population outcomes for older people are generally improving: life expectancy and healthy life expectancy are both increasing, and many 'system' outcomes evidence a success story over the last decade: the number of people with social care needs being cared for in their own homes has increased and delayed discharges of over six weeks have fallen from a high of over 2000 in March 2002 to zero in March 2008. At the same time, it is recognised that the impact of demographic change will be significant, not just in its impact on general demand for health and social care services, but also in terms of health outcomes (more people will be living with dementia, for example). Similarly, it is clear that other 'system' other outcomes are not improving quickly enough – emergency admissions to hospital being a case in point.
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30. We would maintain that the Scottish Government's analysis of how the health and social care system responds to the needs of older people is broadly accurate. The Scottish Government estimates that around a third of the £5bn spent on health and social care for older people every year goes on unplanned admissions, many of which could be avoided. It is true that there is unexplained variation in the quality of care and support; that people are too often unnecessarily delayed in hospital when they are clinically ready for discharge; and that the services required to enable people to stay safely at home are not always available quickly enough. However, the size and nature of these challenges varies across Scotland
31. COSLA would also want to point out that while public services need to be able to respond to the growing number of older people presenting with health and social care needs, that is not all they will need to do. As such, we should be careful about defining a public policy problem too tightly, lest we beget a political or structural response that lacks the flexibility to engage with other complex challenges.
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33. To cite a case in point: the report of the Commission on Public Service Reform was supportive of an agenda founded on the principles of coproduction, assets-based approaches to health improvement and early intervention. It is important that any new partnership arrangements not only allow for these principles to be built in, but are actually founded on them. In doing so, we can position partnerships to look not just at seamless service delivery for older people, but we can also deliver good and effective support for

people with disabilities or long-term conditions; and we can begin to make inroads into unjustifiable levels of health inequalities. Our starting point should be to engender the preconditions of good health.

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35. We also need to be careful not to assume the same set of problems exist for all population groups. The proposals will require that services for adults as well as older people should be integrated. However, we need to be mindful that the interface issues can be slightly different for the adult populations. For instance, for people experiencing mental ill-health or who have a learning disability, the interface with employment is crucial, where access to supportive employability services, good public transport and the benefits system becomes crucial.

36. Or again, for people with drug or alcohol addictions, oftentimes a complex relationship exists within the family unit, and interface issues here are as focused as much on the criminal justice system, or the housing system, as any relationship between community care and acute hospital provision.

37. Finally, although the legislation won't require it, many partnerships will want to be thoughtful about integrating children's services, and again, another set of interface issues emerge. The education system is particularly important in this respect: children with disabilities, with long-term conditions, or who are formally looked after by the state need clear opportunities to engage with the education system in order that their future is determined by their potential rather than their circumstances. Furthermore, for our most vulnerable children, oftentimes decision making is carried out within multi-agency settings (for example, child protection committees), which attempt to provide the best support to children despite different organisational and professional governance arrangements.

38. We make these points to illustrate that it is not just the interface between health and social care which is at stake in these reforms. One of the reasons that public service reform is challenging is that whatever organisational boundaries exist, interface issues will continue to require management.

39. **This leads us to draw two general conclusions:**

40. **Appropriate levels of local flexibility needs to be given to partnerships, in order that services can be correctly positioned within a highly complex system of public services;**

41. **The over-arching vehicle that can take a strategic view of these interface issues is community planning – and we need to ensure that the reform of community planning provides the foundation for effective partnership working within which wider reform initiatives take place, and involves the same energy and commitment as the integration of health and social care.**

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44. NHS/Local Government Partnership Issues

45. Contrary to much of the rhetoric expressed on the relationship between Scottish Local Government and NHS Scotland, COSLA would hold that the last ten years has witnessed the steady improvement of partnership working at both local and national levels.

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47. Beginning with large scale hospital closure programmes for people with disabilities, through the development of Joint Futures and the development of Community Health Partnerships to the position today, we would maintain that it is possible to trace steady improvement in the quality of partnership working and – importantly – the quality and cohesion of service delivery.

48. That is not to say that we have achieved as much as we can; and it is clear that some partners have experienced significant strain on their relationship across this timespan – but we are building from a position of strength and that should be remembered.
49. One of the key factors that has shaped this progress has been an emerging consensus on public policy. This has been most recently expressed in the high level outcomes crafted in support of the integration agenda: we want people with disabilities, long term conditions or who become frail in their old age to live as safely and independently as possible in the community, and have control over their care and support. However, the simplicity of this idea sometimes gets lost amidst the difficult task of managing large bureaucracies like NHS Boards or councils, and under the pressure of significant financial constraints and different performance arrangements, too often organisational behaviours have driven activity in different directions. COSLA agrees therefore, that changes in governance, performance management, resourcing and commissioning have the potential to further improve the partnership agenda.
50. Indeed, despite the successes of the last decade, it is fair to say that the integration of the three major blocks of health and social care activity has been limited: the delivery of social care; primary care and secondary care services do not often flow from a single strategic plan. The Scottish Government's proposals to correct that through the joint commissioning agenda are entirely welcome.
51. Other proposals set out in the consultation deserve to be read with a more critical eye – which isn't to say that COSLA does not support the thrust of what is set out, only that the move to improve outcomes by changing the management and financial structure of health and social care services is predicated on an incomplete evidence base.
52. Furthermore, it is clear to us that even if the proposed changes are necessary, that does not mean they will be sufficient to deliver success. To cite a case in point: given that the NHS has a single managerial, performance and governance structure and a single funding arrangement, we need to explore why the integration of primary and secondary care has been limited. We need to understand the blockages that have existed – whether professional, financial or cultural – in order that we can overcome these as we set out on a bigger agenda to integrate health and social care services.
53. Finally, we would highlight that partnership needs to be national as well as local. Over the past five years in particular, the partnership agenda at a national level has delivered a shared strategic vision and has allowed the Scottish Government, COSLA and NHS Scotland to innovate and make progress. We have created a national partnership board in the Ministerial Strategy Group and associated Delivery Group; we have used this structure to develop policies together, beginning with 'Reshaping Care for Older People' through the Change Fund and now to integration; we have used our collective energies to remedy old sores like resource transfer; and we have benefited from a partnership focus in driving performance improvement in areas like hospital discharge. Additionally, the recently established National Group on Community Planning is intended to provide the forum for local and national government to drive forward the effectiveness of the Community Planning/SOA framework across Scotland. **It is important that we build on these partnership arrangements nationally over the coming years, recognising that further thought will need to be given to how this national capacity engages with challenging issues like performance improvement and management and strategic joint commissioning.**

Section 3: Community Planning, National Outcomes and SOAs

Community Planning

54. Proposals for health and social care integration represent a key plank of public sector reform; as such, they need to be grounded in the principles identified by the Christie Commission, which place partnership working and a focus on outcomes at the heart of public service delivery.
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56. COSLA's position on public service reform embraces these principles supports an agenda that enhances local democratic accountability, develops an outcomes based approach to service delivery and facilitates greater integration of local services.
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58. This joint accountability through community planning exists as a back-drop to integration and the proposals for health and social care integration describe a range of complementary accountabilities under which the new partnership committees will operate. Although COSLA is proposing amendments to these arrangements, we would support the principle of shared and multiple accountabilities as a necessary condition for delivering outcomes that cannot be achieved by one partner acting alone. This requires us to recognise community planning as the context for integration and to ensure that the relationship between Health and Social Care Partnerships and Community Planning Partnerships is well-defined and clearly articulated at both the national and local levels.
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60. COSLA and the Scottish Government are currently implementing the proposals of the joint review of community planning and SOAs as part of the response to the Christie Commission, and there is a helpful opportunity to ensure that the interface with health and social care is fully effective.
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62. We would highlight two key principles to illustrate the essential nature of this relationship. Firstly, the unique strength of the CPP is its ability to capture the sum of its partners' contributions, and so while Community Planning covers all public services that have a role to play in improving outcomes, the CPP will not itself run health and social care services. At one level, the work of HSCPs should therefore be considered to be an example of community planning in practice, namely, a focused attempt to use the total spending power of partners to improve outcomes for service users through a locally integrated service delivery model.
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64. Secondly, Community Planning Partnerships are not intended to alter or undermine proposed lines of accountability for health and social care partnerships. Rather, the intention is to reinforce and make those accountabilities as effective as possible through a strategic approach to the planning, targeting and coordination of partner contributions, including the Health and Social Care partnership, to agreed outcomes. Indeed, it is unlikely that the organisational objectives of councils and health boards will be fulfilled by the new health and social care partnership committees alone. For instance, most Community Planning Partnerships will want to reduce health inequalities, and to do so will need to work effectively with other partners at the CPP level. In other words, the community planning function will be required to take responsibility for coordinating areas of work not directly undertaken by the Health and Social Care Partnership or the two statutory bodies alone.
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66. These are important factors because with the exception of councils, the existing framework has essentially been voluntary across public services; public bodies have no statutory duty to agree, deliver and resource improved outcomes, either singly or within a partnership setting. A key recommendation of the community planning review has therefore been to introduce new duties on partners to work together to improve outcomes for local communities, and to ensure that CPPs operate as genuine Boards. For COSLA, these are the building blocks of a stronger, more joined up, and more extensive approach to partnership working. COSLA looks forward to on-going joint work to clarify how these duties and accountabilities fit with the new governance and accountability arrangements proposed for health and social care, and to ensure the development and effective

organisation of nationally agreed outcomes can be taken forward as part of that task.

67. Overall, **we would stress that we need to do more collectively to knit together the various strands of legislation being proposed on community planning, community empowerment, and health and social care integration.** Should this work become fragmented, it will be a retrograde step in our efforts to reform public services in Scotland to deliver better outcomes.

National outcomes

68. For these multiple accountabilities to operate effectively, there needs to be a strong agreement on what partnerships are to be held to account for. To this end, the development of national outcomes for health and social care is welcome. The integration proposals acknowledge that these national outcomes will be developed over time as part of an iterative process and this approach is also welcomed.

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70. We will want to make sure that outcomes reflect the priorities of the NHS, Scottish Government, local government, and our partners in the third and independent sectors, and achieve a strong strategic fit with SOAs. The Scottish Government and COSLA need to be confident of achieving three primary goals in this respect:

71. that the nationally agreed health and social care outcomes are used by every partnership to direct progress;
72. that these link in appropriate ways to community planning arrangements and the SOA; and
73. that the SOA is positioned as a strategic document which describes the contribution that all community planning partners make to the improvement of outcomes within a given locality.

74. If all of these principles are upheld, **COSLA would envisage a tiered approach to the management of outcomes, whereby every partnership would be required to report against the nationally agreed outcomes, with the relevant population based outcomes being imported into the SOA, recognising that all community planning partners should be contributing to these.** We therefore recognise that the relationship between these nationally agreed outcomes and the SOA will be crucial and believe that the nationally agreed outcomes should be reported at different levels and classified in different ways.

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76. For example, the proposed national outcome around an 'engaged workforce' should clearly only apply at the Health and Social Care Partnership level, since it is specific to the bilateral relationship between the NHS board and council and does not involve other community planning partners. On the other hand, the outcome on 'independent living' should be imported into the SOA because its fulfilment cannot be achieved unless we consider the role of other service areas like housing, community justice or transport. In other words, the population based outcomes have relevance at CPP level, whereas the system outcomes should apply at HSCP level. We offer some detailed suggestions about how the full range of outcomes might be categorised in Annex 1.

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Single Outcome Agreements

78. More generally, we would argue that the governance and accountability arrangements in place for community planning and SOAs, and those proposed for health and social care, should complement each other through the strategic alignment of outcomes.

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81. In operating these complementary governance and accountability structures, it will be important to maintain a focus on how partners are held to account for delivery of the agreed outcomes, whilst also ensuring sufficient flexibility and autonomy in terms of how those

outcomes are achieved. CPPs would therefore not take direct responsibility for delivery of outcomes or integration of services where specific arrangements, such as HSCPs, are being developed. This strategic focus will help to ensure that partnership arrangements operate efficiently, and that reporting arrangements between CPPs and the new health and social care partnerships are focused on outcomes, with appropriate additional arrangements being agreed locally and with a clear purpose.

82. Similarly, there needs to be room for additional local outcomes and indicators to reflect local democratic priorities or particular needs within a locality, and in recognition of the fact that some of the health and social care outcomes will also require action by a broader range of partners. For instance, in order to make progress towards outcome one on healthier living and reduced health inequalities, health and social care partnerships will need to work effectively with other partners at the CPP level to influence the wider determinants of health.

83. It is also important to recognise that both councils and the NHS may be further tasked by CPPs with delivering wider outcomes in support of the SOA, not just those pertaining to health and social care. **By signing up to the SOA, partners are committing to supporting the delivery of the SOA in all possible ways compatible with their duties and responsibilities, whether that be in a lead role, or through a 'value added' role. This will require strong commitment to both enterprises by both partners, and from the Scottish Government to help drive a whole-systems approach to outcomes and community planning.**

84. Performance Management

85. A fundamental component of this commitment to delivering outcomes is a joint approach to performance assessment and improvement. For multiple accountabilities to operate effectively, a single set of jointly agreed outcomes are necessary, but not sufficient. There must also be agreement on what constitutes success (and therefore failure) and how this will be measured and assessed. Disparate performance management cultures have historically pulled the NHS and councils in different directions. The NHS in Scotland is performance managed by the Scottish Government through ministers, with a high degree of prescription on target setting and performance monitoring, coupled with centre-facing reporting arrangements. Councils, however, are performance managed through democratic scrutiny by local elected members, with locally-agreed targets and performance monitoring systems, coupled with community-facing reporting through duties on public performance reporting.

86. Despite these differences, we need to ensure performance management and improvement arrangements clearly set out what is to be achieved and by when, how success will be measured and how failure will be dealt with. COSLA would suggest that councils and their partners set individual local targets for achieving the national outcomes and agree those with Ministers.

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88. Within this framework, self-assessment and benchmarking (within and between partnerships) should be the starting point of performance assessment and we have offered further comment on this in the section on outcomes.

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91. **Section 4: Models of Integration**

92. The Scottish Government has set out two primary models by which health and social care services should be integrated: the Lead Agency Model; and the Integrated Partnership Model.

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94. In the survey work carried out by COSLA in preparation of our consultation response, very few of our member councils indicated that the Lead Agency model was being considered locally. As such, we have spent more time reflecting on the Health and Social Care Partnership Model. It is also true to say that despite the obvious short-term upheaval that comes with the implementation of the Lead Agency Model, at one level it avoids some of the more complicated relationship and governance issues that are inherent in the Integrated Partnership Model. So that is another reason for limiting our analysis of this model.
- 95.
96. As indicated above, COSLA believes that we need to be careful not to narrowly define delivery arrangements for integrated services. There is no question that the move towards integrated arrangements is overdue but we should allow more flexibility at a local level to determine the shape of the proposed partnerships. We come to this view in light of a strong evidence base which indicates that there is at best a weak relationship between organisational structure and the delivery of quality outcomes. As expressed in the recent work of the Institute for Research and Innovation in Social Services, “the journey towards integration needs to start from a focus on service users and from different agencies agreeing a shared vision for the future, rather than from structures and organisational solutions.”¹
97. That is not to say COSLA believes that the integration project does not need to be defined or indeed set out in legislation; only that we need to provide maximum flexibility in the interpretation of that legislation, such that partnerships can design arrangements that optimally respond to local needs and service arrangements. The detail and nature of that flexibility is considered below. This includes a recognition that, for a minority of partnerships, neither option 1 nor option 2 would represent the best approach to delivering integration locally. We therefore suggest that legislation should be permissive enough to allow the Scottish Government to explore alternative routes with those partnerships, provided they comply with mutually agreed principles and are subject to agreement with the Scottish Government.
- 98.
99. Option 1: Delegation / Lead Agency Arrangements
100. As described in the consultation, the Lead Agency model involves one partner delegating 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.
- 101.
102. COSLA believes that the Lead Agency model described in the consultation document, and in particular the specific arrangements being implemented by the Highland Partnership, is a radical and exciting development in the formation of more outcome focused and integrated service delivery models. We would support any of our member councils who choose to adopt this approach.
- 103.
104. At the same time, in the survey work carried out by COSLA in preparation of our consultation response, very few of our member councils indicated that the Lead Agency model was being considered locally. Some councils may wish to explore the use of this model for key services (e.g. mental health) but few indicated that they would take on the population based approach adopted by the Highland Partnership.
105. COSLA is also seeking clarification over the scope of the Lead Agency model. **In particular, we would want the lead agency option to be open to public health arrangements (where one partner could carry out that function on behalf of both).** There are already

¹ IRISS, ‘An Evidence Base for the Delivery of Adult Services’, p.9

examples of NHS Boards and councils adopting an integrated approach to public health and we therefore believe that the mechanisms laid down in legislation should open up the possibility of lead agency arrangements being devised for public health. This may allow for a more focussed approach to tackling health inequalities, along with other key public health issues such as tackling obesity or the misuse of alcohol.

106. Similarly, in respect of health and social care services, we would want to explore whether the model is capable of being deployed in a way that could see the flow of functions from the NHS to local government. While we appreciate that this has been demonstrated within the Highland Partnership (with the council taking the lead on children's healthcare), **we would argue that in principle there is no reason that the council could not lead on appropriate elements of adult or older people's health care services.** It is therefore crucial that the legislation is genuinely open to these possibilities.
107. Option 2: Integrated Budget managed by Jointly Accountable Officer
108. The other option to integrate services would be through the delegation of agreed functions to a 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.
- 109.
110. In the survey work carried out by COSLA in preparation of our consultation response, this option was clearly identified as being the one that most councils were interested in pursuing. However, while it offers significant scope to drive forward the integration project, there are nonetheless issues of detail that need to be altered or amended. COSLA would therefore like to raise issues in respect of the scope of the partnership, the governance arrangements and some of the issues that flow from integrating the resource through the body corporate.
- 111.
112. Scope of Partnerships
113. COSLA believes that local flexibility will be important in determining the scope of the partnership beyond the statutory minimum. There are many variables, including the nature of local structures, the size of the local authority area, and the needs of the local population, which make this principle important.
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115. We recognise that other respondents might take a different view, namely, that the scope of service provided should be the same in all partnership areas, or at least that all partnership areas should deliver this consistent approach by a specific end-date. However, we think that this misses a crucial point highlighted above: interface issues in the public sector exist in different directions and therefore have to be managed. The way these interfaces are managed should be reflective of the particular challenges within an area, rather than moulded to a national blue-print.
- 116.
117. We do recognise, however, that the Scottish Government has committed to a legislative agenda and is therefore committed to adopting a statutory minimum. We are persuaded

that it does not make sense from a legislative point of view to restrict the scope of integrated services to older people alone and that from an equalities perspective, it would be better to write enabling legislation that could involve other service groups. However, we accept this with three caveats:

- **The scope of the partnership should be determined locally, accepting that the formal integration of adult health and social care services will be statutorily required;**
- **The pace of integration needs to be phased and locally determined, and for those partnerships who wish to begin with older people's services alone, that is a legitimate position to adopt; and**
- **The delivery of adult services has to engage a number of distinct interface issues and will therefore require flexibility to get management arrangements and delivery structures right. Indeed, the very notion of 'adult services' serves only administrative purposes: for instance, the needs and preferences of people with learning disabilities, physical disabilities, addictions and mental ill-health can be very different.**

118. We appreciate that partnerships will engage risk whatever the scope of the partnership agreed locally. For instance, if children's social work services are *not* brought into partnerships, thought will need to be given to how social work services can deliver integrated support, particularly in those areas where outcomes are tied to complex family relationships (e.g. families with drug/alcohol problems). However, if children's services *are* brought in, care will need to be taken to preserve the relationship with the education system.

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120. Similarly, thought will need to be given to how much of the residual CHP is brought into the new arrangements. Our sense is that matching the range and depth of services across the council and Health Board will be important to the balance and equity of the partnership. That is why **COSLA would argue that the determination of what NHS community health services are brought into the partnership needs careful agreement between the two parent bodies.** We further recognise that the shared services agenda within the NHS complicates these discussions, with some CHPs hosting services intended to serve the entire Health Board area. It will be important to give partnerships the flexibility locally to decide how to deal with these issues.

121. We are aware that some partnerships currently choose to host criminal justice social work services within their CHCPs. COSLA believes that this flexibility and choice should remain and would therefore argue **the option to bring criminal justice social work into the proposed Health and Social Care Partnerships should be available but not required.** Indeed, other partnerships may see a case for criminal justice social work to operate within the context of their CPP, given the breadth of services required to support ex-offenders and to prevent offending. It is timely that the Scottish Government is progressing a review of community justice structures at the same time as developing proposals for the integration of health and social care. COSLA would argue that these reforms, along with the review of community planning, should be considered as part of a whole-systems approach to public service reform rather than distinct work streams, so as to avoid any unintended consequences or barriers to pursuing our joint ambitions in this area.

122.

123. We also recognise that the interface with housing will be crucial to the success of the integration agenda. We believe that it is therefore vital that strategic commissioning plans link effectively to the strategic housing needs assessments carried out by local authorities; and that capacity planning for the health and care system within a locality should involve housing input.

124. COSLA is more sceptical about the case to formally bring housing resource into the integrated resource framework of the Health and Social Care Partnership. Significant challenges will exist for those partnerships who would want to formally integrate housing resource into new partnership arrangements, not least because the Housing Revenue Account is ring-fenced, which is at odds with an ambition to create more fluid resource within Health and Social Care Partnerships. That point notwithstanding, we would support those partnerships who decide in favour of formally integrating the housing resource if that is deemed to improve outcomes for the local population. In any event, it will be important that local innovation in respect of how the housing interface is managed can be shared among partnerships.

125.

126. Governance and Accountability

127. In bringing together NHS Boards and councils to deliver a partnership, there is a recognition that two separate systems of governance and accountability will need to be fused together. Constitutionally, the NHS in Scotland is primarily accountable to – and performance managed by – Scottish Ministers. By contrast, councils are self-governing organisations controlled by elected members. There will therefore be inevitable tensions to overcome between national and local accountabilities in the delivery of partnership arrangements. While COSLA would argue that more public services in Scotland should be accountable to locally elected members, we recognise that there is a need to balance local and national accountabilities in devising NHS/local government partnership arrangements.

128.

129. However, while there is a genuine attempt to reflect the balance between ‘the national’ and ‘the local’ in the proposed governance arrangements, COSLA feels that the arrangements do not adequately accommodate the collective accountability of the full elected membership of councils. In particular, the Scottish Government’s proposals ascribe too much responsibility to the Council Leader, which is not a constitutionally or legally defined position. This has two important consequences for the arrangements as set out:

- The Council Leader, as an individual, cannot be asked to hold a formal council (or partnership) committee to account. It is the job of the full council to hold any committees to account;
- The council Chief Executive is not accountable to the Council Leader per se, but to the whole council;

130. COSLA would therefore ask that the Scottish Government reflects these principles in the governance arrangements designed to oversee Health and Social Care Partnerships. We believe that if these principles are taken on board, it will have the following implications:-

- **The primary accountability of the Health and Social Care Partnership should be to the full council and the full Health Board, rather than to individuals (e.g. Cabinet Secretary, Council Leader and Health Board Chair). This will be important in order to retain the principle of collective responsibility within councils.**
- **The trio of Cabinet Secretary/Council Leader/Health Board Chair should be recast as a trouble-shooting / leadership function to be drawn down as required rather than incorporated into *de facto* reporting arrangements.**
- **The two Chief Executives should be jointly responsible for performance against nationally agreed outcomes and indicators. However, the Chief Executive should be accountable to the council and the Health Board Chief Executive to the Health Board and Cabinet Secretary. COSLA believes that this will actually strengthen accountability and remove ambiguity. This does not prevent, in the event of problem or leadership issues emerging, the trio of Cabinet Secretary/Health Board Chair/Leader engaging with both CEOs.**

131. By embedding the arrangements set out above, formal reporting against the agreed outcomes could be taken forward through the SOA process, thereby developing public accountability for performance. Equally, Scottish local government would be happy to engage in NHS-style public accountability meetings, if that was deemed to assist with open and transparent accountability to members of the public.

132.

133. Role of Parent Bodies

134. By defining the accountability of the Health and Social Care Partnership to the parent organisations, it will be extremely important to define the duties of the parent bodies in sustaining and nurturing the partnership. We would agree with the Scottish Government that it will be important to develop and sign-off on a Partnership Agreement, in order to deal with the range of governance, strategic, legal, financial and technical arrangements that will require to be put in place in support of the partnership. It will be important that these agreements set out a clear vision of what the partnership intends to achieve.

135.

136. The parent bodies will have a particularly challenging role in respect of agreeing the partnership budget, accommodating any efficiency requirements and managing spending pressures. These points are picked up in more detail later in this paper.

137. In configuring these new partnerships, we need to fully commit to them, providing them with the requisite autonomy to fulfil their duties and deliver against the agreed outcomes. To cite a case in point: the partnerships will be asked to produce long-term commissioning plans. While these will of course have to be worked up with the two parent bodies and while we would expect the commissioning plans to be subject to endorsement from the council, Health Board and Scottish Government, thereafter we have to allow partnerships to deliver on those strategic plans. Service redesign initiatives should be developed through this medium, thus limiting the need for Ministerial call-in powers to be used.

138. The Partnership Committee

139. The principle of equity between council and NHS representation on the partnership committee is accepted. One of the reasons that Community Health Partnerships did not achieve full legitimacy in all parts of the country is that they were conceived as sub-committees of the Health Board. If we are therefore to avoid a similar challenge, the principle of equity would need to hold.

140.

141. At the same time, we believe that the arrangements as set out in the consultation proposals are too detailed, restrictive and prescriptive. One proposal that COSLA would strongly oppose is to prescribe a limit on the elected membership of the partnership committee. Applying such a simple arithmetic approach will rarely be capable of delivering the structures required locally. This issue is problematic for some of our larger member councils in particular. The effect of the current position might be to:

142. Create, in some circumstances, a democratic deficit. The elected council is accountable for the discharge of its legal duties and the use of its resources. However, in some areas, under these proposals, we could see as little as 5% of the elected membership overseeing 30% of the council budget. COSLA maintains that the public would want stronger local accountability than that;

143. Create a lack of political balance, especially where council administrations are formed as a coalition;

144. Constrain options to develop larger partnerships involving more than one council area, since the representativeness would be diluted across several councils

145.

146. As such, **the proposals as set out need to be altered. Democratic representativeness should not be constrained by a prescribed minimum number of elected members.**

We would identify four main possibilities as a means of redressing this:

147.

148. That NHS Boards recruit additional Non-Executive Directors to allow for a larger number of elected members while maintaining the principle of equity;
149. That NHS Boards require existing Non-Executive Directors to undertake additional duties (i.e. sit on more than one partnership committee);
150. That a weighted system of voting is introduced, which would allow the number of elected members to expand but not offend against the principle of equity (e.g. the vote of 12 elected members would be the equivalent of 4 NHS non-Executive Directors);
151. That we remove the principle of equity and accept an imbalance between councillors and non-Executive Directors
- 152.
153. While all of these options would be acceptable to COSLA, we understand that the final point would create challenges and disturb the equity of the partnership. Of the options listed above, we feel that the first or second options would deliver the most representative partnership committees.
- 154.
155. A further matter needs to be explored in respect of direct elections to Health Boards. While this creates a more democratic process around the appointment of Non-Executive Directors, it does not confer full democratic accountability, which in the case of the NHS continues to rest with Scottish Ministers. That point notwithstanding, elected Board members would bring an added level of accountability when compared with the status quo.
156. More generally, the proposals are too restrictive – and too prescriptive – in setting out the suggested membership of the partnership committee. We have significant amounts of evidence from the literature which suggests that **strong and effective local leadership is a vital component of successfully integrated partnership with a record of improving outcomes. It therefore makes little sense to exclude the Leader of the Council or the Health Board from Chairing the Committee. The proposed exclusions should therefore be removed.**
157. The composition of non-voting members is equally too prescriptive. The precise make-up of the non-voting members should be determined locally. It is highly likely that the proposed membership set out in the consultation document would be adopted locally but that flexibility should nonetheless exist.
158. During the consultation period, we have heard much about NHS staff relations and the fact that staff representatives have a voice and vote at Board level. While we have no objection to staff representatives being involved in a partnership committee in a non-voting capacity if that is agreed locally, we *would* hold that **the current distinction between voting and non-voting members of the committee should be retained – and that only Councillors and NHS Non-Executive Directors should have a vote.** The fundamental virtue of democratic accountability is that the public can remove their elected representatives via the ballot box. It would weaken accountability and the importance of local democracy if this principle were to be overlooked. We would adopt the same stance in respect of third sector voices who would wish to see formal voting and accountability mechanisms conferred on their representatives.
159. Finally, it is important that the function of the partnership committee is well-defined. In particular, the partnership committee has to be responsible for the overall use of resources, including any commissioning decision to disinvest in one part of the system in order to reinvest in another. **The Scottish Government should clarify that the accountability for these types of decisions lie with the Partnership Committee rather than with accountable officers.**
160. Role and Governance of Jointly Accountable Officer

161. For those councils who wish to appoint a Jointly Accountable Officer, it will be important that the post-holder has the authority to shift resources into those services or activities which best deliver against the outcomes of the partnership. Most of our member councils agree, therefore, that the JAO should therefore be accountable in line management terms to the Chief Executives of the Council and Health Board.
- 162.
163. However, given the size of the budget and the more general aim to effect a strategic shift in resources, it is crucial that the JAO is fully accountable to the Partnership Committee. This means that there should be appropriate checks and balances in the system to prevent the JAO making decisions that should rightly be taken at committee level. While **the precise detail of the powers to be delegated to the JAO needs further reflection**, we would stress that democratic oversight and decision making is fundamental to good governance and needs to be embedded in partnership arrangements. We would stress that the consultation proposals could be interpreted as if the JAO was not subject to these checks and balances. This needs to be corrected when the legislation is written.
164. We also think that **there should be more flexibility for partnerships to determine how best to design and appoint to the senior post, or posts, accountable to the committee**. We pick this point up in more detail at paragraphs 89-92 below.
165. In terms of the deployment of a Jointly Accountable Officer, in some larger partnerships, the size of the job might lead partners to decide that several JAOs would be beneficial: for example, one JAO could manage an integrated programme budget for older people, another for adult care (drawing on the relevant contribution from social care, primary care and acute – and perhaps even from other funding streams). As long as the accountability to the Partnership Committee and reporting to the Chief Executives remains in place, we believe that Partnerships should be able to explore this possibility.
166. Equally, the notion of a JAO should not be confined to health and social care. For instance, we already have good examples in Scotland of JAOs being appointed to manage public health. Indeed, building on the example above, if a partnership wanted to create an integrated resource to improve public health – and appoint a JAO to manage that budget – then we believe the legislation should allow for that development.
- 167.
168. Locally-generated Delivery Models
169. Notwithstanding the amendments suggested above, there may be some cases where councils and NHS boards wish to put in place alternative delivery arrangements to achieve the same outcomes.
- 170.
171. In practice, and in view of the flexibilities suggested in this response, it is likely that most partnerships will form in line with option 2. For the minority of those who wish to pursue a slightly different route, the precise nature of delivery arrangements will vary according to the scope of the integration project and the existing service infrastructure.
172. So while **COSLA is unambiguous in our support for an integration agenda based on the principles of joint accountability, integrated resources, joint outcomes, and appropriate linkages to community planning, and while the two models of integration proposed by the Scottish Government are good examples of delivery arrangements which COSLA supports, there may be other arrangements which could satisfy the core principles of integration. We believe that the Scottish Government should therefore be open to locally-generated delivery models that satisfy these criteria.**
173. Given that this approach would represent an exception to the options set out in the Scottish Government's proposals, we believe it would reasonable for any locally-generated delivery arrangements to be subject to agreement with the Scottish Government.

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177. Dealing with Failure

178. Across all delivery models, the test of the proposed arrangements will not simply be in their capacity to deliver success but also in their capacity to deal with failure. Indeed, despite an improving relationship between NHS Scotland and local government, it is clear that there is still a possibility of dispute emerging.

179.

180. Under the new arrangements, we would hold that there should be a philosophy of early intervention to reduce the likelihood of significant failure. A clear process of dispute resolution and escalation needs to be defined by partners in the Partnership Agreement. **The ultimate arbiters in an escalation process should be the Cabinet Secretary and Council Leader.**

181. A partnership improvement ethos should be developed between the statutory partners, improvement support organisations like the JIT/Improvement Service and formal scrutiny bodies such as Care Inspectorate/Health Improvement Scotland/Audit Scotland. We would suggest that this will require further thought and reflection and that the formal scrutiny bodies in particular need to think about how to integrate to ensure that the regulatory burden is appropriate and a common approach adopted.

182. Integrated Resource

183. In our view, the possibility of a truly integrated resource should help deliver against the policy ambition of shifting the balance of care to keep people living independently in their own homes. However, the advantages of formally pooled budgets over aligned budgets needs careful consideration. Based on our assessment of practice in local authorities and on a review of the literature, we would suggest the following advantages and disadvantages flow from aligned and pooled budget arrangements respectively:-

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| 187. Aligned Budget | 188. Pooled Budget |
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| Beneficial where there is a need to engage many different service interfaces across organisations and where the drivers of cost across organisational boundaries are relatively weak (i.e. a low risk of cost-shunting) | 189. Pooled budgets are beneficial where there are a smaller number of strong interface connections which are capable of driving significant costs across organisational boundaries (i.e. a high risk of cost-shunting). |
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| Sufficient where there is no overarching agenda to shift patterns of investment across organisational boundaries but creates pressure on resource transfer mechanisms if there is a need to effect lateral shift in resources | 190. Beneficial where there is a need to effect a lateral shift in resources across organisational boundaries. Removes organisational barriers and makes it easier for resource to support commissioning decisions |
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| Greater flexibilities for parent organisations to manage competing budget pressures under significant financial constraint | 191. Requires strong financial discipline to manage budget pressures where there are significant strains on resources of parent bodies |
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| More suitable for partnerships where there is a concern that partners will be over cautious or under-fund pooled budgets. | More effective where partners have a strong track record of partnership working and trust and relationships between partners are good. |
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|---|--|
| More flexible in bringing the 'total resource' of non-statutory providers into a partnership | More useful where better use of statutory sector resource is the primary goal. |
| Less bureaucratic and resource intensive in the short term but could be more bureaucratic than a well-run pooled budget over the medium to long term (as it requires separate decision-making processes). | Pooling is cost-effective in decision-making and planning in the medium and longer term whilst being resource intensive in the short term. Can help eliminate the need for repeated renegotiation of joint agreements. |
| More appropriate where there is competing performance management, governance and professional arrangements in place between partner organisations | More appropriate where there is an agreed vision and outcomes, with well-defined management and governance arrangements for the pooled resource |

192.

193. Applying the analysis above to the matter of health and social care integration, the pooling of resources has a number of clear arguments in its favour. The first and most important of these is that *we are explicitly looking to shift resources from secondary care to primary and social care*. In other words, the lateral shift of resources is at the heart of the agenda to improve outcomes. Secondly, in the case of older people in particular, the interfaces are relatively narrow but significant in being able to drive costs across budgets. So for example, GPs can create huge costs for secondary care in respect of admission to hospital; equally, the absence of responsive social care services can create delays at the point of discharge from hospital and therefore build costs into the system. There is a strong case, by this analysis, to move to pooled budgets for older people's care.

194.

195. By contrast, the argument for pooled arrangements applying to, say, services in support of parents with drug or alcohol problems is more complex. In this circumstance, the interfaces are greater in number (not just social/primary/secondary care but children's services and – importantly – the criminal justice system) and, for this population group, cost drivers extend in different directions: indeed, the cost to the criminal justice system is arguably greater than to the health and care system in respect of this population group.

196.

197. What is more, there is rarely a circumstance in which there is no opportunity cost associated with the creation of pooled or aligned budgets. For instance, while older people's services may benefit from a pooled arrangement (allowing for the lateral shift of resources), this will remove some levers currently used within health and social care to manage other budget pressures through cross-subsidisation processes (e.g. transferring monies from the budget for older people's care to children's care).

198. Finally, while pooled arrangements might remove organisational barriers and make it easier for resource to support commissioning decisions, greater onus is then placed on the quality of commissioning. A circumstance could easily arise in which resource is used expediently in a way that is detrimental to personal outcomes. For example, inappropriate care home placements to reduce delayed discharges might be easier to facilitate under pooled arrangements.

199. Given the complexity of the issues associated with these arrangements, COSLA believes that partnerships should give careful consideration to the mechanism and extent to which resources should be integrated. **While recognising the advantages of pooling resources, COSLA believes that the Scottish Government should define in legislation a spectrum of mechanisms to integrate resources, ranging from formally aligned budgets with resource transfer mechanisms in place, through to fully pooled budgets within a body corporate. The mechanism used to integrate resources should be at the discretion of local partnerships.**

Integrating Acute Sector Budgets

200. The integration of acute sector budgets into the Health and Social Care Partnership is perhaps the most technically demanding element of the integration agenda. Nonetheless, COSLA wholly welcomes this proposal. If we are to succeed in unlocking acute sector resource, we need to be ambitious.
- 201.
202. There is considerable debate about what 'some acute' should mean. For COSLA, the answer to this is determined by the relevance of the acute specialty to the care and support of the population. For example, in developing an integrated budget for older people's care we should not limit the acute sector contribution to the geriatric specialisms – we need to be able to draw down on the full resource of general medicine and other acute specialisms – but equally it is unlikely to include tertiary healthcare services. We are interested in the relevant patient pathway and all of the resources used along the way. If we are to alter existing patterns of spend, it is important that all relevant costs are considered.
203. COSLA recognises that there are two primary ways to assimilate the acute budget within the overall pooled arrangement: to import the relevant acute services into the budget and ask the JAO to directly manage these services; or to create a 'commissioning' budget, which can be accessed by the Health and Social Care Partnership but which is not directly managed by it. We do not think that one of these models is inherently superior and partnerships will need to come to a view about what works best for them. Whatever model partnerships develop, we would suggest that transactional relationships and incentives need to be built into the new system in respect of accessing secondary care. Otherwise, we might continue to struggle with the 'free good' problem, which will make it more difficult to reduce admissions, and free up resource to disinvest in secondary care in favour of community based care.
204. At the same time, we do recognise that for a Health Board that has a number of local authorities within its territory, it may be difficult to opt for a direct management approach in all cases. So for example, while the West Lothian Health and Social Care Partnership could in principle seek to manage St John's Hospital directly, it becomes more complicated in respect of the Royal Infirmary in Edinburgh, which draws its resident population from three partnership areas. The reality is that many acute hospitals are used by people from more than one partnership area, which would make a direct management approach difficult, unless a 'lead' partnership approach were to be developed, whereby a single partnership managed the acute hospital on behalf of all of the partnerships whose residents accessed that particular hospital.
205. The scenario referred to above, which involves a single Health Board with an irregular spread of District General Hospitals spread across a number of Local Authorities (the most common position in Scotland) is a particular challenging environment in which to progress the integration agenda and does not come without operational risk to the acute sector. However, it would be wrong to insulate the NHS acute budget from partnerships' commissioning objectives and therefore we need to develop solutions that are capable of managing that risk.
206. The challenge is made greater if we attribute acute sector resource by weighted capitation rather than historical spend. The problem in identifying a budget based on historical spending patterns is that usage patterns are themselves the product of variable commissioning relationships. As such, if we simply provide partnerships with their historical share of the acute pot, we risk perpetuating and accentuating current levels of variation. By contrast, however, we will find that if we move to a weighted capitation system that the resources allocated to partnerships – being different to historical share – may not be

able to support existing acute sector capacity in an area. There is therefore a clear tension between fair allocation to partnerships based on weighted capitation against financial stability for those acute hospitals which are operating at sub-optimal efficiency. It may be that Partnerships should start with budgets based on historical spend but that we should migrate to weighted capitation over, say, a five year period. **Whatever route we agree on, it is vital that the attribution of acute sector spend to Partnerships' budgets is completely transparent at both Partnership and Health Board level.**

207. Thinking this problem through will allow us to determine the true nature of the partnerships we want to create. If we want to overcome variation and deliver budgets based on a fair share, it will leave some partnerships with very difficult decisions to make about the nature of acute provision in their area. If the result of that consideration is that the partnership wishes to down-size the acute provision to stay within budget and focus on community support services, then that would be the logical conclusion attaching to this model. However, this will require significant levels of decision making to be delegated from the Scottish Government, health board and council to the Health and Social Care Partnership. **This speaks to a partnership commissioning agenda that COSLA is comfortable with and we would seek clarification that the other partners are similarly committed to this approach.**
- 208.
209. At the same time, it is clear that with the delegation of powers to the Partnership, there will be a responsibility on Partnerships to collaborate with each other, especially in respect of service redesign initiatives which impact on acute services that operate across partnerships. Acute hospitals are seldom used solely by the population of the local authority territory in which the hospital is situated and therefore significant thought needs to be given to how partnerships can contribute to strategic planning initiatives at Health Board level. In recognition of this, **there will be a need to develop a supra-partnership agenda around the strategic development of the acute sector within a Health Board.** We would suggest that this supra-partnership agenda is linked to individual Partnership Agreements.
- 210.
211. We also need to develop analytical capacities to map cost and activity data across health and social care partnerships. The Integrated Resource Framework pilots are instructive in this regard but now need to be rolled out to ensure that all partnerships have the requisite ability to examine and overcome unwanted variation within the system.
212. In light of all of the technical challenges set out above, **COSLA believes that National Guidance will be required to assist in the integration and attribution of acute budgets at partnership level.**
213. Capital Planning and Spend
214. There is a risk that unless we bring capital planning decisions into the supra-partnership arena described above, models of care could be 'locked-in' as a result of long-term capital investment decisions that do not take cognisance of partnership commissioning plans. The decision to build a new hospital, for example, should be subject to the business case being agreed at a supra-partnership level.
- 215.
216. Detailed work will also need to be undertaken at partnership level to ensure effective asset management plans are produced.

Management of Budget Pressures

217. Beyond this general assessment, there are a number of important points of detail to work through in respect of managing budget pressures

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219. Managing Overspend. The potential for cross-subsidising activity would be heavily proscribed for both councils and NHS Boards (both councils and NHS Boards currently use cross-subsidisation as a tool to manage pressures) and this would require greater levels of discipline in spending – and, importantly, solutions to be developed for the management of over-spend. While this is clearly a job for partnerships locally, it is arguably too simplistic to suggest that overspend in social care budget lines becomes a council problem or overspend on prescribing an NHS problem.
220. Managing efficiencies/uplifts. It will be important that the management of efficiencies/uplifts is agreed by both parent bodies. It is in both parties' interests to take account of the broader Scottish Government settlement and inflationary/demand pressures before coming to an agreement. Consideration of national protocols should be explored as we have done in respect of the Resource Transfer relationship.
221. **The management of budget pressures should be attended to within the context of a Partnership Agreement.**
- Implications of Integrated Resource for the Scottish Government
222. It will be important that all partners make a full contribution to the new arrangements. In respect of integrating finance and delivering more fluid resource that loses its organisational identity, we would argue that the Scottish Government has three primary responsibilities:
- 223.
224. Legislate to ensure that formally integrated budgets are legal and that existing legal responsibilities to account for the use of resources are addressed as part of this (for example, clarification is needed on the role of the Section 95 Officer - this point is expanded under technical issues below).
225. Ensure that the budget planning cycles of NHS Boards and councils are brought into alignment. There continues to be a view that Boards do not get all relevant financial information early enough in the financial year.
226. Take steps to remove any ring-fencing from the relevant NHS budgets. The use of ring-fencing is in complete contradiction with the proposition to create fluid resource.
- 227.
228. **We would want to pick up on all of these issues with the Scottish Government as part of our commitment to this agenda.**
- 229.
230. Locality Planning
231. Further work needs to be undertaken to determine what is meant by locality planning. There are a number of different activities which are all relevant: community engagement and involvement; service coordination; and 'meso' or 'intermediate' level commissioning.
- 232.
233. On the first issue, it is crucial that we do not duplicate effort across different organisations and public service reform platforms. Creating the right community engagement structures for health and social care partnerships is important but we need to be aware that there will be similar needs expressed in respect of the community planning and community empowerment agendas. As such, the development of this line of work needs to be holistic and the philosophies that tie into community engagement – such as co-production and assets based approaches – need to tie back to the overarching community planning agenda. The needs of communities are often complex and layered and cannot find expression in health and social care alone.
- 234.
235. The principle of community engagement does not easily align with administrative territories (such as GP practices or a particular population size). As such, given that partnerships vary in size, population, rurality, and so on, **the starting point for locality planning needs to be natural communities, as defined by partnerships in consultation with those**

communities. Area team coordination and 'meso' level commissioning should be built on this foundation.

236. On the second issue, it is clear that many partnerships will already have area team coordination, and where this works well we should not insist on a national prescriptive blue-print. To that extent, we do not believe that this is legitimate territory for the Scottish Government to take a view on: the development of sub-locality service coordination needs to be decided by partnerships alone.
237. The third issue is more complicated and there may be a need for national guidance. If partnerships have a clear sense of what will be required by way of a joint commissioning plan at partnership level (i.e. macro-level commissioning based on designing services whole populations), and if there is similarly a growing sense of what micro-level commissioning might involve through the introduction of Self-Directed Support, then it is probably fair to say that less thought – at both national and partnership levels – has gone into the development of locality or 'meso' level commissioning. We would agree, therefore, that there is a need to consider how the aggregation of commissioning decisions at middle management or practitioner level contribute to wider challenges and opportunities at partnership level. For instance, the need to tackle challenging issues like variation in admission rates to hospital from different GP practices needs to be tackled by way of effective meso-level commissioning. **A system of incentives and disincentives needs to be developed in order to better control these commissioning relationships and the co-production of national guidance around this would be helpful.**
- 238.
239. Organisational & Staff Development
240. A good understanding of the importance of an integrated workforce has been built up over the past decade, particularly – but not exclusively - from the experience of CHCPs. The development of a properly integrated and skilled workforce will continue to be a key factor in ensuring high quality outcomes for service users and carers.
- 241.
242. Successfully integrated partnerships will need to span different organisational cultures to embed effectively-coordinated teams of professionals working within health and social care settings. Many partnerships have a pre-existing or developing culture of multi-disciplinary working which is based on effective communication, trusted referral processes and a shared professional ethos. However, more work needs to be done to ensure that we fully harness the potential of integrated teams, and to identify and overcome any technical obstacles. For example, despite the successes of the last decade, single assessment processes and the advantages of co-location have not yet been fully realised.
243. Recognising and handling the distinctive models for industrial relations across local government and NHS Scotland will also be an important factor in developing harmonious delivery models. Following the introduction of *Agenda For Change*, organisational development in NHS Scotland is progressed through local partnership agreements which include the trades unions. This approach was introduced in 1999 and is informed by the national partnership model for the NHS in Scotland. This model explicitly promotes transparency, partnership and early involvement of all stakeholders - including staff representatives - in the formulation, consultation, implementation and evaluation of staff policies. A key characteristic of the NHS model has been the separation of staff policy development from the arrangements for the negotiation of terms and conditions.
- 244.
245. Within local government, each council is an individual employer and the bulk of terms and conditions of employment and staff policies are developed locally in conjunction with relevant trade unions. Pay, conditions, and costs for comparable posts, along with associated workforce policy are therefore often highly localised in order to reflect the specific service delivery models that individual councils have put in place. Although each

approach has merits, the reality is that pay and conditions for comparable posts are likely to vary between local authorities and the NHS. It may also mean that the approach to workforce management within local government offers greater flexibility to reshape its workforce than the NHS.

246. These differences have the potential to lead to tensions in how health and social care partnerships manage and deploy their resources, particularly in relation to how councils and health boards work to prioritise front-line delivery. We would suggest that while councils may have greater local flexibility to re-shape or re-size their workforce, both organisations must develop and commit to an organisational development strategy for Health and Social Care Partnerships. The objective must be to avoid any imbalance or asymmetry across the workforce and to ensure that all the necessary skills, capacity and cultures required to ensure effective transition to the new partnership arrangements are in considered and developed. **COSLA recommends that this matter is given significant attention in the development of partnerships' organisational development plans, both in the transition to the new partnership arrangements, and in the on-going work to develop capacity and improve service delivery over the next few years.**
247. Moreover, if the fulfilment of our policy ambition can only be realised through the creation of more fluid and integrated resources, it follows that we need to cultivate more fluid and integrated *human* resources (the absence of the latter would defeat the purpose of the former given that the resources are mostly invested in the workforce). Just as the financial resource needs to lose its organisational identity, so too do partnerships need the tools to deploy different professional groupings, as required by joint commissioning strategies. To put this another way, if models of delivery are highly inflexible, the necessary change to services will be extremely difficult to realise. **COSLA and the Scottish Government should arrange high-level discussions on the capacity of the new partnerships to redeploy human resources in order to meet commissioning needs.** These discussions should include both relevant professional associations and trades unions.

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258. **Section 5: Wider Policy Context**

259. Demographic Change

260. Planning for the impact of Demographic change has been the focus of considerable modelling, analysis and policy development work over the last decade. It is widely accepted that the impact of demographic change will be significant, with the number of people aged over 65 expected to grow by around 1.6% every year.² This growth is particularly concentrated among the 'older' old - those most likely to require long-term care.

261.

262. The impact of demographic change has been the subject of political debate nationally and locally for some time. The Sutherland Review of Free Personal and Nursing Care provided a well-considered analysis of the likely challenges associated with the delivery of health

² Lord Sutherland's Review of Free Personal Care, 2008. Paragraph 216 <http://www.scotland.gov.uk/Publications/2008/04/25105036/0>

and social care services within the context of an ageing population. The last chapter of the Sutherland Review, authored by Professor David Bell of Stirling University, concludes that “costs mainly payable by the Scottish Government... [will] increase from 1.4% of Scottish GDP in 2006 to 2.7% in 2031. Unless there is a marked increase in the share of taxation in the Scottish economy, quite significant cuts will have to be found in other programmes to continue to fund the present structure of care.”³ To provide some context for this, the same report estimated that a 1p increase in the basic rate of income tax in Scotland would raise £370 million or 0.4 % of GDP.

263. This conclusion highlights quite straightforwardly the choices we face as a result of demographic pressures: to deliver services differently; to provide less service in some areas of delivery; to ask the Scottish population to pay more for care services; or a combination of all of the above.
264. Understandably, the focus of our efforts in Scotland has been on the first of these interventions: doing things differently. We started to focus on this change agenda with Reshaping Care for Older People⁴, which concluded that if we fail to change our service models “we will require an estimated annual increase in investment in health and social care services for older people of £1.1 billion by 2016 and £3.5 billion by 2031.” The prospectus that Reshaping Care set out was based on stripping back demand by preventing high cost care which very often delivered poor outcomes. We needed to assist more people to live independently in their own home, supported by a network of professional and unpaid carers. This policy formulation was not necessarily new but it served to highlight the necessity of reform.
265. The most recent iteration of our work to deliver maximum effectiveness is expressed in the health and social care integration proposals considered above, which will deliver integrated budgets and - for the first time - the levers to shift the balance of care from secondary care to primary and community care. However, while we are confident that the work on integrating health and social care has the potential to take the edge off of the cost of rising demand, it will not eliminate it. Irrespective of the success of health and social care integration, it will not close a funding gap which will amount to billions of pounds within the next decade. **COSLA and the Scottish Government should continue to work together on this agenda, to consider how best to mitigate the cost of rising demand and to plan for a more sustainable funding platform for health and social care services.** In our view, a failure to undertake this work may actually undermine the potential gains made through integration as partnerships will need to prioritise cost saving measures over ambitious service reform.
266. Charging for Services
267. While there are a small number of examples of the NHS charging for services (e.g. dentistry, optometry) it is not as extensive or politically sensitive as councils’ ability to charge for some social care services. For Adults and Older people, charging income for non-residential services amounted to £42.6 million in 2010, which represents 3.0% of gross expenditure.
268. We know that local populations can be sensitive to changes in charging arrangements and it is important that political accountability for charging rests with the full council. If left to Health and Social Care Partnerships to decide on the charging regime, it would be theoretically possible for elected members to be over-ruled by a combination of the NHS Non-Executive Directors and the casting vote of the Chair, which would break the decision making process from the democratic representatives of the local population. At best this

³ Ibid., paragraph. 231

⁴ Reshaping Care for Older People: A Programme for Change 2011-2021
<http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/>

could create political challenges for elected members, at worst it leads to a democratic deficit.

269.

270. **While the Health and Social Care Partnership has a legitimate role in assisting in the preparation of a charging regime for non-residential social care services, it cannot itself decide on charging levels but rather should put recommendations to the full council.**

Self-Directed Support

271. If the Scottish Parliament decides to pass legislation on SDS, it needs to ensure this provides a statutory underpinning that supports the policy intentions of both SDS and the wider integration of health and social care. Our joint ambition for health and social care is to ensure that services are organised around citizens' needs, and not institutional boundaries. If we are to realise this ambition, the principles of choice and control need to extend across all health and social care services, and the bill must act as an enabling force in this respect. While the bill does make some provision for NHS duties to deliver SDS options, this relates only to their delivery of social care services when acting on behalf of a local authority, and not to wider NHS services.

272.

273. Extending SDS duties to these wider services, for example in relation to palliative care, or managing long-term conditions, could bring significant benefits for groups of people who currently do not have a right to SDS options. For example, people with long-term conditions could enter into a transparent discussion about the broad resource envelope services are operating within, what outcomes are most important to them, and how that translates into different intervention options. That individual could then exercise greater control in choosing interventions, for example, through choosing to whether to access a pain clinic, receive medication, or even a direct payment to allow them to access their local gym and keep mobile.

274. Despite these advantages, COSLA recognises that there are particular issues in relation to extending the principles of choice and control to NHS services more widely, especially around clinical decisions about the range of interventions that would be appropriate. Lessons learned from the two NHS SDS pilot sites will be helpful in exploring some of these issues in more depth. Clearly there will always be some NHS services where the provision of one or more of the SDS options may not be appropriate, for example in relation to surgery or emergency provision.

275. Another issue is the desire to ensure that health services remain free at the point of delivery; however, exercising greater choice and control over how services are provided, or even receiving a direct payment, is not the same as being charged for services. There are numerous other cultural and system challenges in applying the principles of self-directed support to the NHS; however, these are not insurmountable and do not in and of themselves constitute sufficient reason to limit the scope of the bill. **COSLA will therefore continue to argue that we are being insufficiently bold in connecting SDS to social care services alone.**

276. **Section 6: Conclusion**

277.

278. COSLA has expressed general support for a public service reform agenda that develops an outcomes based approach to service delivery; allows resources to be used flexibly in support of those outcomes; promotes the principles of co-production, early intervention and prevention; facilitates greater integration of local services; and enhances local democratic scrutiny.

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280. The general thrust of the Scottish Government proposals on health and social care integration would seem to align with these general principles. COSLA would argue,

however, that the proposals are at times too prescriptive and too detailed, and as a general rule there should be more flexibility at a local level to determine the shape and governance of the proposed partnerships.

281. In the preceding narrative, we have highlighted in bold those elements of the Scottish Government's proposals that we would like to see altered, amended, expanded or explored. We will want to take forward discussion on all of these themes at both officer level and in discussion with Scottish Ministers.

282.

Annex 1: Technical Issues

Integrated Resources

283. There are a number of technical finance issues, which need to be considered both in terms of legislative change, and in terms of developments required outwith the scope of legislation. COSLA is satisfied that the following issues, identified as part of the on-going work with Scottish Government, cover the relevant issues:

- Accounting treatment and VAT
- Financial recording and reporting
- Financial controls, assurance and risk
- Financial planning, financial performance management and finance function
- Capital and assets

284. Within this context, there are a number of matters that the local government community is particularly keen to clarify, including the role of Section 95 Officer and the alignment of budget planning cycles across local government and the NHS.

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286. Integrated Human Resources

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288. As above, there are a number of technical HR issues that require to be thought through as part of the on-going work to develop integrated arrangements. These include:

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- Any equal pay risk to councils and Health Boards with comparable posts on different terms and conditions within Partnerships (e.g. Occupational Therapists; clerical staff)
- The operation and impact of the NHS Staff Redeployment Register on the Health and Social Care Partnership
- The operation of a policy of no compulsory redundancies across Health Boards
- The impact of corporate HR policies within councils or Health Boards on the Health and Social Care Partnership
- The relationship between the Jointly Accountable Officer and the Chief Social Work Officer
- The managerial authority of the Jointly Accountable Officer for Health Board and Local Authority staff

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291. We would maintain that the issues listed above require the same amount of thought and attention as the issues around integrated finance.

292.

Outcomes and performance management

293. In paragraph 31 we set out our general support for the principle of shared and multiple accountabilities as a necessary condition for delivering outcomes that cannot be achieved by one partner acting alone, along with the amendments we consider necessary for that process to take effect. In particular we outlined the need to consider how outcomes are appropriately featured within SOAs or in the planning arrangements for health and social care partnerships.

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295. We recognise that this is a complex area and that further discussion will be needed to consider the issues and converge on a solution. We also recognise that our joint review of community planning and SOAs is currently developing revised SOA guidance and that it is therefore not yet possible to fully specify how health and social care outcomes might feature in these arrangements. The integration proposals acknowledge that national outcomes for health and social care will be developed over time as part of a joint and iterative process and this approach is welcomed. However, we believe that the nationally agreed outcomes should be reported at different levels and classified in different ways, and

suggest the following arrangement be considered:-

Health and Care Integration Outcomes and Performance Management

Health and Social 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. This is a population outcome that should be contained within the SOA

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. This is a population outcome that should be contained within the SOA

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. This is an intermediate outcome that should be contained within the SOA at that level

4. Carers are supported

People who provide unpaid care to others are supported and able to maintain their own health and wellbeing. This is a population outcome that should be contained within the SOA

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. This is an intermediate outcome that should be contained within the SOA at that level

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. This is a HSCP outcome that should be reported at Partnership level and should not feature in the SOA

7. Effective resource use

The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation. This is a HSCP outcome that should be reported at Partnership level and should not feature in the SOA

296. We face a significant data gathering challenge if we are to ensure these SOA arrangements, and the more detailed local performance monitoring and management systems that sit underneath them, operate as efficiently and effectively as possible. It will be important that information management systems evolve at the same pace as the more general reforms and consideration of how we can further harmonise NHS and local government systems will be required.
- 297.
298. It will also be important to ensure data supports self-assessment, benchmarking activity and community-facing performance reporting. Councils currently have a statutory duty to publically report how their services are performing in delivering best value. This has traditionally focused on a number of statutory performance indicators specified by the Accounts Commission, however, in recent years the Commission have gradually reduced the number of prescribed indicators, leaving councils free to publish performance information that best-suits their local circumstances. Many councils have used this as an opportunity to re-design their information systems and align SOA reporting with other public performance reporting to produce integrated, accessible information intended for public consumption.
299. COSLA would suggest that the reporting requirements for health and social care outcomes should be firmly located within these public-facing arrangements, grounded in the SOA processes, and not subject to any additional layers of performance management architecture. These arrangements, and the proposed governance and accountability arrangements, will be sufficient to ensure appropriate political oversight at both national and local levels.
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