INTEGRATION OF ADULT HEALTH AND SOCIAL CARE IN SCOTLAND

RESPONSE BY SOLAR (SOCIETY OF LOCAL AUTHORITY LAWYERS AND ADMINISTRATORS) TO SCOTTISH GOVERNMENT'S MAY 2012 CONSULTATION ON PROPOSALS

Introduction

SOLAR is a body comprised of and representative of Local Authority Lawyers and Democratic Services Staff in Scotland. While the Government's proposals are of general interest, SOLAR has particular expertise in the governance arrangements relating to Local Authorities and this response focuses on these matters in particular. In order to provide a structured overview of the potential governance implications of the proposals we have detailed some key points in a general introductory section, before responding to the questions posed in the Consultation document. At the end we detail some of the amendments to legislation which we have identified as required in order to give effect to the changes.

Executive Summary

SOLAR is supportive of the principles behind the Consultation. In particular, we are supportive of the use of the Health and Social Care Partnership Model, being a Joint Committee of the Health Board and Local Authority with equal representation. Our submission highlights certain governance pitfalls in the proposals which have the potential to undermine the Government's aims and impede integration. Two particular areas are the subject of our focus being:-

- The models for the Health and Social Care Partnership and for integrated funding; and

- Accountability arrangements.

SOLAR's view is that a more straightforward governance structure will be more effective and this response proposes an amended solution which we believe is better equipped to deliver integration.

General Comments

It is SOLAR's view that the proposed governance arrangements are in places unnecessarily complex and contradictory, and at times impose a governance structure alien to Local Authorities.

The Consultation Paper proposes a governance structure comprising various elements. Certain of these we agree with, others are more problematic:-

- National outcomes set by Ministers – SOLAR agree with this;

- Existing statutory duties will remain with Health Boards and Local Authorities – SOLAR agree with this ;

- A Partnership Agreement between the Health Board and Council detailing the services to be delivered, the outcomes and the financial input of each partner to an integrated budget – SOLAR agree with the principle of this;

- A Governance Committee will oversee the running of the Health and Social Care Partnership (4.8) – SOLAR think this unnecessary;

- The Health Board and Council will be required to delegate certain functions to a Health and Social Care Partnership which will be a Committee of the Health Board and the Council (4.26). It will be made up of an equal number of Health Board non-executive directors and Councillors with the Chair rotating on an annual basis. It will be supported by non-voting members representing professional service user perspectives – SOLAR agree with this subject to the comments later in this response;

- The Health and Social Care Partnership will have delegated authority to take decisions on the functions delegated to them – SOLAR agree with this;

- The Health Board and Council will jointly appoint a Jointly Accountable Officer (JAO). He will report to the Chief Executives of the Health Board and Local Authority and manage the integrated budget for Adult Health and Social Care Service Provision – SOLAR agrees with the principle that a senior officer with power to manage the integrated service needs to be appointed but disagrees if this is to be an Accountable Officer in a formal, central government sense of the role;

- The Cabinet Secretary, Local Authority Leader and the Health Board Chair will together hold the Chair and Vice Chair of the Health and Social Care Partnership, the Health Board Chief Executive and Council Chief Executive to account for delivery of the National Agreed Outcomes. The NHS Chair and Local Authority Leader will form a community of governance overseeing the effectiveness of the Health and Social Care Partnership – SOLAR disagree with this;

- Each Health and Social Care Partnership will produce joint commissioning strategies and delivery plans over the medium and long term – SOLAR agree with this;

- Locality Service Planning will be led by clinicians and care professionals – no comment;

- Two options are described for integration of budgets which differ from the joint committee model detailed above. One option is delegation to the Health and Social Care Partnership as a body corporate. The other is the delegation of functions from one partner to the other, with the budget following. It is unclear if these are merely examples of the governance arrangements which could apply to an integrated budget or whether it is proposed that legislation will require one of

these two options to be adopted – SOLAR disagree with this and further clarity is required on the options being proposed in the consultation.

Prior to commenting on the specific issues which arise from these proposals it is necessary to detail the broad governance principles on which Local Authorities are based. The way that Local Authorities work is that the Government delegates statutory functions to a Council. The Council can then agree to delegate certain of these functions to a Committee, Joint Committee or Officers. Accountability for delivery of these services is that of Council as a corporate body. Functions or powers cannot be delegated to an individual Councillor, even the Leader, and such individual Councillors have no direct power or accountability. The Leader may or may not be able to exert authority over Council, let alone his own party. This is particularly the case in a minority administration. The Chief Executive reports to Council, implements their decisions, is Head of Paid Service, deals with operational matters and is accountable to Council. However, the Chief Executive is not accountable for decisions of Council. Similarly, Committee Chairs only act as the Chair of the Committee. They do not control the business which comes to their Committee nor its outcome. In short, it is the Council as a corporate body, not individual officers or individual members who hold accountability. While the statutory officer posts of Monitoring Officer, Section 95 Finance Officer and Chief Social Work Officer have the power to report issues to Council, the ultimate responsibility for statutory duties falls on the Council as a corporate body. The democratic model is that individual Councillors are in turn accountable through the ballot box to their constituents. The role of Accountable Officer (or its equivalent Accounting Officer in England) with personal responsibility, which is common in the NHS and Scottish Government, conflicts with the principle that Council as a corporate body is accountable and this role does not appear in the legislation relating to the governance of local authorities

It will be apparent from the previous paragraph that the proposals in the consultation paper in so far as they relate to governance and accountability, mark a significant departure from existing models of local government governance and accountability and would require primary legislation to implement them. Against this background it is SOLAR's view that the accountability arrangements are overly complex and run contrary to fundamental principles of Local Authority governance. In particular, we identify the following issues:-

- Local Authority Leaders have no formal power and cannot be held accountable for the actions of the Council. Similarly, the Leader could not oversee the work of the Health and Social Care Partnership or the Council Chief Executive. It is the Council as a corporate body which would hold its Chief Officer or Committee accountable. Similarly, the Convenor and Vice Convenor of the Health and Social Care Partnership cannot be held responsible for the performance of the Partnership. They hold no individual power and merely act as the person chairing the Committee meeting.

- If the Council and Health Board retain the statutory duties but are statutorily obliged to delegate certain functions to the Health and Social Care Partnership and are also statutorily obliged to delegate certain functions to the Joint Accountable Officer, how can the Council, as a corporate body, be held accountable for functions over which it can have little control?

- Paragraph 2.6 states that Health and Social Care Partnerships will be accountable via Chief Executives to Ministers, Local Authority Leaders and Health Board Chairs. However, as a Committee of the Local Authority and the NHS the Partnership would be accountable to the Council, not an Officer, or individual Councillor.

- The role of the Joint Accountable Officer needs clarity. It is agreed that the Lead Officer supporting the Health and Social Care Partnership must have an appropriate level of seniority and delegation to enable the post to run the joint service and be responsible for it. However the term 'Accountable Officer' has a specific meaning which goes beyond this and is alien to the governance of local authorities. As detailed in the Scottish Government Finance Manual "the essence of the accountable officer's role is a personal responsibility for the propriety and regularity of the finances under their stewardship and for the economic, efficient and effective use of all resources. Accountable Officers are personally answerable to the Parliament for the exercise of their functions". However, if the statutory duties are to remain with the NHS and the Council then they would hold the primary accountability. In turn, they would hold the Joint Committee responsible for functions delegated to it and through the Chief Executive as Head of Paid Service hold the Joint Accountable Officer responsible for functions delegated to him or her. While we can understand the aspiration to have one single individual who can be summoned before ministers and Parliament and be held to account, it would be difficult in practice for the JAO to hold the entire responsibility if local outcomes and budgets are being set by the NHS/Council and strategy and direction are being set by the Partnership. This is further complicated by lack of clarity over who reports to the Partnership. While in terms of local government governance and employment the JAO should report to the Chief Exec as Head of Paid Service, and the Chief Exec reports through the JAO to the Partnership the present proposal means that there is no direct reporting line from the Joint Accountable Officer to the Partnership. Given the extent of the Joint Accountable Officer's delegated powers which enables him or her to make decisions about use of the integrated budget without needing to refer back up the line within either partnership organisation, this post needs to have clear accountability which fits within existing governance structures.

- How does the role of the Joint Accountable Officer sit with the existing Council roles of Monitoring Officer, Section 95 Finance Officer, Head of Paid Service and Chief Social Work Officer, even if it is not an Accountable Officer in the strict sense of the word? In particular, further consideration requires to be given to what if any continuing role the Chief Social Work Officer would have following implementation of the proposals.

The second fundamental issue relates to the integration of budgets. In Chapter 4 of the Consultation paper, paragraph 4.26, it is stated that the Health and Social Care Partnership Committees will be Committees of Health Boards and Local Authorities. However, under the "Options for Integrating Budgets" in paragraph 5.13 the Consultation paper proposes two different governance options of either (a) the Health and Social Care Partnership is established as a body corporate; or (b) functions and budgets are delegated either to the Health Board or the Council. This is inconsistent. While SOLAR would agree with the principle of compulsory

integration or alignment of budgets and also agree with the joint committee model, we think that these two further options are not necessarily the best means of ensuring integration. The particular issues are:-

1. The establishment of the Health and Social Care Partnership as a body corporate:-

   As the Deputy First Minister indicated in the debate on integration of Health and Social Care in the Scottish Parliament on 20 March 2012, it is important that everyone's energies are not consumed by structural change instead of being spent on an outcomes driven approach. The body corporate route has the potential to become bogged down in structural change without delivering true integration or partnership working. Key points are:-

   - Transfer of staff under TUPE is a major exercise in itself.

   - Health Board and Council staff have different terms and conditions and pay scales. Both are still wresting with the repercussions of equal pay and harmonisation of terms and conditions would undoubtedly raise further equal pay and other difficult issues.

   - The splitting of the NHS and Council physical assets, property, ICT systems, support functions etc would be time consuming and difficult. For example, shares of buildings such as hospitals would presumably have to be disaggregated between the remaining Health Board/Council functions and a new Board. Support services such as administration, legal, ICT, Buildings Maintenance etc would either needed to be disaggregated or purchased. The involvement of acute services makes this even more difficult to achieve.

   - Would it be intended that the NHS Board and Council will still have the statutory functions and enter into a contractual and funding agreement with the Board?

   - Creating a third body out of two, while creating some linkages will also lose others. For example, the new body corporate will need to develop partnership arrangements with the remaining acute services and children's services. Instead of trying to get two bodies to share services we would now be looking at three bodies.

   - It makes it more difficult in the long term to integrate further services, such as children's services into the same model.

2. Delegation between partners. The issues are:-

   - This power has existed since the Community Care and Health (Scotland) Act 2002 but has only recently been used in the case of Highland. The unwillingness of all bar one area to use this model probably indicates its underlying complexity.

- If it is assumed that staff and other resources would follow the delegation, then many of the same issues as identified above would also arise.

- It is far from clear what the role of the Health and Social Care Partnership would be where functions were delegated by the Council to the NHS or vice versa. As regards Council governance, the same functions cannot be delegated by Council to the Partnership and to the NHS.

- Similarly, what would be the role of the Joint Accountable Officer if functions were being delivered by the NHS or the Council and not the Health and Social Care Partnership?

- One of the key aims of the reform is to ensure that the customer moves seamlessly from one area of care to another. Unless very large areas are being transferred (e.g. the Highland model which appears to involve Adult Health being the responsibility of the NHS and Children's Health being the responsibility of the Council) then it may be hard to devise distinct business units where the patient does not at some time move from the control of one authority to another.

It may be that these two models are only intended to be examples of options which could be developed. Certainly it is noted that the Deputy First Minister in the debate on 20 March 2012 stated that integration could be done in many ways. Our view is that the potential difficulties inherent in these two models have the potential to de-rail the integration process. As a result it is SOLAR's view that the new Partnership should have the option to remain as a Joint Committee, with aligned budgets. There may of course be areas where either of these options is still the best one, such as areas where a number of local authorities intent to integrate with one health board. As such these options need to remain but as alterntives.

An Amended Governance Solution

A key aim of this response is to provide the solutions, not just problems. It appears to us that none of the problems detailed in this response are insurmountable through legislative change and that there is an alternative simplified governance structure which would deliver the aims of the Consultation, without restricting the ability of those Health Boards and Councils who have made considerable progress from continuing to do so. We also think that there is a governance solution which follows tried and tested approaches and is not in fundamental conflict with basic Local Government principles. What we would suggest is:-

- Primary legislation would allow the creation of the Health and Social Care Partnership as a Joint Committee between the Health Board and the Local Authority retaining flexibility to enable local variances to be taken into account.

- Subordinate legislation would set out a list of functions (with relevant budget) which Health Boards and Councils are required to delegate to a Health and Social Care Partnership.

- The Minister, in consultation with COSLA would determine national outcomes.

- Each Local Authority and Health Board would agree local priorities or outcomes required to meet the national outcomes in its area and agree the level of funding necessary to be transferred from each to deliver this. This Agreement would be signed off by the Minister. In this regard the Agreement would be not dissimilar to the Single Outcome Agreement. The Agreement would form part of the Single Outcome Agreement, albeit signed off separately. In due course it could come together as a single process. The performance reporting regime is aligned to enable the new partnership to report on integrated, outcome-focussed performance standards.

- The Health Board and Council would retain statutory responsibility for their existing services.

- The Health and Social Care Partnership is set up as a Joint Committee of the Health Board and the Council. As previously mentioned the functions to be delegated to the Partnership by the Health Board and Council would be set out in subordinate legislation and the funding to be delegated would be set out in the Agreement mentioned in the third bullet point. The role of the Health & Social Care Partnership is strategic, to produce joint commissioning strategies and delivery plans over the medium and long term, to put in place locality service planning structures and to monitor performance.

- There would be a requirement for the Partnership to appoint a Chief Officer. He would hold two Contracts of Employment with the NHS Board and Council, similar to Consultants at Teaching Hospitals. There would be a duty on the Partnership to prepare a scheme of delegation to the Chief Officer which would be approved by Ministers. Ministers by statutory instrument would set out the minimum levels of delegation to be included in this scheme. This approach is similar to that adopted in the recent planning legislation which required Councils to put in place a scheme of delegation to officers containing certain prescribed levels of delegation which had to be signed off by Ministers. Guidance could be provided, including a model scheme of delegation. The Chief Officer could be designated a formal Accountable Officer in relation to the NHS functions, meaning that if required the single person responsible for managing the service could be summoned before Parliament.

- As regards budgets, the budgets have been delegated to the Partnership Committee and the approved Scheme of Delegation to the Chief Officer/JAO ensures that he or she has full authority to manage the budget. It would still at this stage be an aligned budget rather than an integrated or pooled one. However as regards outcomes and the patient perspective this should make little difference in practice.

- As regards accountability, this follows normal Local Authority and NHS governance principles. The Chief Officer of the Partnership would be responsible to the Chief Executive of the Council as Head of Paid Service. In turn the Chief Exec would report through the Partnership's Chief Officer to the Health & Social Care Partnership and be responsible for the exercise of delegated functions. In employment terms the Partnership's Chief Officer would also be responsible to

the Chief Execs. The Partnership, as a Committee of the NHS and Council would be responsible to the Council as a corporate body and the NHS Board. As the statutory responsibility for the services remains with the NHS Board and the Council, they would be responsible to the Minister and the Scottish Government. The NHS Board would be directly responsible and the Council responsible via the signed SOA. While we have reservations about the Chief Officer post being designated an Accountable Officer in the formal sense of the word, he or she could if necessary be designated as such in relation to the NHS functions delegated. As functions would be integrated, the post would effectively speak on behalf of its full role. However this would avoid introducing a role which conflicts with the basic principles of local government governance.

- The powers contained in the 2002 Act to delegate functions from the NHS Board to the Council and vice versa are retained as an option. Similarly, new powers are granted, not just to pool or integrate budgets by delegating from one partner to another but to a joint board. At present Section 62A of the Local Government (Scotland) Act 1973 allows Joint Committees established by Local Authorities to be made into a Joint Board with the Scottish Minister's consent. This provision could be extended to provide that the Health & Social Care Partnership could also develop into a Joint Board. However, this would remain an option for the NHS Board and Council to agree. Thus the Partnership could develop these alternative models, with fully integrated budgets.

- Locality Planning - the Health & Social Care Partnership to produce a Scheme of Locality Planning. No doubt there could be guidance and subordinate legislation, if required, to assist in the preparation of this.

Consultation Responses

Question 1 - Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all area of adult health and social care practical and helpful?

Question 2 - Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

If the proposals are solely implemented in relation to adult health and social care, then the governance arrangements need to be sufficiently flexible that they would not impede further integration. For example, it is noted that in some areas criminal justice services are delivered by a Joint Committee of neighbouring Local Authorities. If the Health & Social Care Partnership was restricted to a single area, would this involve the sub-division of criminal justice into smaller and non viable business units for each authority, or would the option of joint arrangements across authorities still apply? It is also noted that the geographical extent of a Health Board's remit includes a number of Local Authorities. As the proposals stand at present this will result in a Health Board having to accommodate different working arrangements with different local authorities. Obviously this undermines the aim of consistency of outcomes across Scotland and will complicate the governance situation for NHS Boards. Arguably, comprehensive integrated partnerships would

be better placed to focus on prevention and early intervention, working with the whole family and the whole community.

The counter argument is that not all NHS Boards and Councils will be either ready or willing to engage in comprehensive integrated partnerships involving both child and adult care.

The position of Community Justice Authorities in the potential governance arrangements also needs to be considered and the impact of these proposals should to be taken into account in the present review of criminal justice.

There is also a need for clarity on the exact acute services which would transfer.

Question 3 - This proposal will establish in law a requirement for statutory partners - Health Boards and Local Authorities - to deliver, and to be held jointly and equally accountable for nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms which that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

Question 4 - Do you agree that nationally agreed outcomes for adult and social care should be included within all local single outcome agreements?

As explained earlier in this response, we think the proposals unnecessarily complicate the governance arrangements. However, the model of the single outcome agreement could provide part of the solution. It is important that there is local discretion as to how to meet the national outcomes. It is also important that budgetary resources are allocated to best meet local agreed priorities and the money to be transferred to the Health & Social Care Partnership is clearly agreed by the NHS Board and Council. As previously detailed, an obvious solution is an agreement between the NHS Board and the Council, which agrees local outcomes and indicators as to how the NHS/Council will meet the national outcomes and agrees the funding from each partner to do so. This agreement would be signed off by Scottish Ministers, thus ensuring transfer of the required budgets, and consistency across Scotland as to what services and budgets transfer.

What is imperative is that the performance management regime does not follow the target driven model which is hopefully now discredited. Resources need to be directed to meeting local priorities which feed into national outcomes, rather than aimed at meeting national performance indicators. In addition, it is important that new nationally agreed outcomes and accountability arrangements replace existing regimes rather than are introduced in addition to what is currently in place. The opportunity could also be taken to streamline reporting regimes to avoid confusion and reduce unnecessary bureaucratic processes.

There is need for clarity of the precise role of CPP Boards in relation to the partnership outcomes that are included within the local single outcome agreement to ensure that these do not either duplicate or dilute the arrangements relating to the new partnerships.

Question 5 - Will joint accountability to Ministers and Local Authority Leaders provide the right balance to local democratic accountability and accountability to central government for health and social care?

No. As detailed in the general section the arrangements for governance, accountability and budgets set out in chapters 4 & 5 of the Consultation Paper are inconsistent and at times appear to misunderstand the governance arrangements which underlay the workings of local authorities. We do however agree that it is important that the Chief Officer supporting the Health & Social Care Partnership has a sufficient level of seniority to enable him or her to deliver the managed service. We also agree that it is important that there is extensive delegation to that Officer to enable him to deliver and manage the service without the need for decisions further up the line. The role of the Partnership Committee should be largely strategic and to scrutinise.

As detailed in the general section, if statutory functions are to remain with a Council then it is the Council as a corporate body which is responsible for them. The Council Leader and Chief Executive do not have direct accountability. We also believe that the "community of governance proposal" in paragraph 4.11 of the consultation is unnecessary and should not be taken forward.

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

It is will be complex to have a partnership which covers more than one Local Authority. However for some areas it may make more sense to integrate the services of a number of different Council's across a single health area. Care should therefore be taken when drafting the legislation to ensure that partnerships are not excluded from sharing or delivering functions across Local Authority boundaries.

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

We would support the proposal that the Health & Social Care Partnership is a Joint Committee of the NHS and Council and we would support legislation to enable that to happen. We agree that the partnership should replace Community Health Partnership Committees, albeit that care will be needed to ensure that either all functions previously delegated to CHPs go to the new partnership or suitable arrangements are otherwise developed. We also agree that the Health Board and Local Authorities should be obliged to devolve budgets to the Health & Social Care Partnership and that there should be an obligation to devolve extensive powers to the Partnership's Chief Officer, sufficient to allow him or her to manage the integrated service.

As regards the composition of the Committee we agree with proposals for a Chair and a Vice-Chair who would rotate on an annual basis and would have a casting vote. Given our previous comments that the Leader of a Council has no accountability, we do not see any reason why the Leader of the Council nor the NHS Chair should not also be Chair of the Partnership. This would help ensure 'buy-in' from the parent organisations. We would agree that there should be an equal number of Health Board and Local Authority members on the Partnership. However

we are concerned at the limited numbers of councillors who would sit on the Partnership, presumably a result of the difficulties of a limited number of NHS Board members serving a number of partnerships. This will create difficulties in terms of democratic accountability to communities and ensuring political balance. This could perhaps be redressed by NHS Boards recruiting additional Non-Exec Directors or a weighted voting system which allows more Council members but an overall equality of vote between NHS and Council.

As regards non-voting members, the local government legislation makes no provision for this and amending legislation will be needed. While, in principle, the Partnership could have such non voting members, care needs to be taken in the drafting of the Standing Orders. For example, would such non-voting members be entitled to propose motions and amendments or raise points of order? The one advantage of having non-voting members is that they would presumably have a right to speak on items of business, which might otherwise not be available to them.

As previously detailed it is important the Partnership's Chief Officer reports to the Council's Chief Executive as Head of Paid Service. He or she would report through the Partnership's Chief Officer to the Partnership. As the Partnership have the a key scrutiny role the JAO should not be a member of the Committee

Question 8 - Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

As previously detailed it is important that existing performance and accountability regimes are revised so that new nationally agreed outcomes and accountability arrangements replace existing regimes rather than are introduced in addition to what is currently in place. The opportunity should therefore be taken to streamline reporting regimes to avoid confusion and reduce unnecessary bureaucratic processes. Ideally, the performance management arrangements would be closely linked with the reporting of SOA and Community Plan outcomes

Question 9 - Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions - apart from adult health and social care - within the scope of the Health & Social Care Partnership?

For the reasons set out in our answers to Questions 1 and 2 we are of the view that Health Boards and Local Authorities should be free to include the budgets for other CHP and Social Work functions within the scope of the Health & Social Care Partnership.

Question 10 - Do you think the models described about can successfully deliver our objective to use money to best effect for the patient or service user, whether they need "health" or "social care" support?

The two options of Joint Boards or delegation from one partner to the other appear to contradict the model of the Partnership as a Joint Committee of the Health Board and Council. As detailed in the general section there are a number of reasons why both the Board and delegation option are problematic. They have the potential to exhaust the energies of organisations in structural change, at the expense of true

integration. Arguably the delegation of functions represents a case of 'rearranging the deckchairs' rather than true partnership and integration. There is nothing to stop the two budgets being transferred to the Partnership, theoretically operated as aligned budgets but increasingly being integrated in operation. While we leave it to others to comment on the accounting implications of operating aligned budgets as one, these budgets would effectively operate as one when under the control of the partnership and its Chief Officer. In due course if the Partnership wished to form itself into a Joint Board, or delegate functions from one organisation to the other with integration of budgets, it would have the power to do so.

It is also essential that the opening financial allocations fully reflect currently spending on health and social care and this will require consistent national guidance. Further clarification is also needed on what responsibility the Partnerships will have for defined areas of NHS acute activity.

The roles of the Council's Section 95 Finance Officer and NHS Health Board Director of Finance also need to be clarified. In the governance of local authorities it is the s95 officer who fulfils a similar, but not identical position to the 'Accountable Officer' role in the NHS and central government. What happens, for example, if the Council's Section 95 Officer does not agree with a decision made by the JAO? The same holds true for the Council's Monitoring Officer, Head of Paid Service and the Chief Social Work Officer. If the Partnership is a Joint Committee of a Council, then any report by a Monitoring Officer or Section 95 Finance Officer under the Local Government and Housing Act 1989 would go to the Council, rather than the Partnership. If the Partnership was set up as a separate board the Monitoring Officer or Section 95 Officer would have no duty or power to intervene.

In relation to Finance there is need for clarification on the rules for capital planning funding, the rules for ongoing resource allocation (e.g., a scenario where one partner decides to prioritise revenue allocation within a given year to another part of its system or organisation) and how year end exigencies would be managed (e.g., if a Partnership either substantially underspends or overspends its pooled budget - could this be spent in another part of the Health Board area?).

Question 13 - Do you think that the proposals described here for the Financial Authority of the Joint Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

We think that it is important that there is a Senior Officer responsible to the new Partnership who has substantial delegated authority. We also agree that it is essential that this Senior Officer has extensive delegated powers to enable him or her to manage the integrated budget. However, we feel that the governance and accountability proposals are overly complex. The JAO's primary accountability is in relation to their delegated powers. This is limited by the facts that the Partnership also has accountability as it sets direction and strategy, while the NHS and Councils will retain their statutory duties and remain responsible for setting local outcomes.

Running through this Consultation Paper, plus the Consultation Paper on Community Empowerment there appears to be a concern that accountability should primarily rest with one person, who is designated as an Accountable Officer. To enable this, a complex governance structure has been put in place, which is largely alien to

fundamental Local Authority principles of the Council as a corporate body holding powers and duties. Without wishing to repeat the explanation detailed in the general section of this response, it is our belief that it would be far more straight forward to retain traditional accountability rules, that a Chief Officer holding very extensive delegated powers should report through the Chief Executive as Head of Paid Service to the Partnership; the Partnership to Council and the NHS; and the NHS Board and Council to the Minister via the SOA, or its equivalent. As previously detailed, the post could be made a formal Accountable Officer in relation to NHS functions. As the post would be managing an integrated service, he or she would in practice be able to advise parliament in relation to the whole service, even if, strictly speaking it only has personal responsibility for NHS services.

As previously detailed there is also a need to clarify the roles of the Council's Section 95 Officer, the NHS Health Board Director of Finance, the Head of Paid Service, the Council's Monitoring Officer and the Chief Social Work Officer. The proposals also involve a new role for the Chief Executive of a Council which is outwith the normal role of a Chief Executive. At present the Chief Executive is accountable to the Council as a body. That post is not accountable to any individual Elected Member, including the Leader of the Council, nor is it directly accountable on a personal basis to the NHS Chair or any Members of the Scottish Government.

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

Yes, subject to the comments made in the preceding answer.

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

It is important that this be matter for local determination, particularly if the governance arrangements will vary from area to area depending on whether other services are included within the Partnership. No doubt there could be government guidance on this issue.

Questions 16-18 - No comment.

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

It is our view that delegation of specific responsibility and decision making would further complicate and undermine the overall governance arrangements for the new Partnerships. For example, would the JAO be held to account for decisions made by locality planning groups who themselves were not formally accountable to anybody, let alone the Partnership Committee for those decisions? It would be more constructive to specify that the Partnership had to produce a strategy for locality planning and to frame the purpose of locality planning as being primarily one of engagement in dialogue to ensure local intelligence underpins the planning and development of services.

Question 20 - Should localities be organised around a given size of local population, e.g., of between 15-25,000 people or some other range? If so, what size would you suggest?

It is our view that localities within different Partnership areas should be locally determined on the basis of recognises natural communities of residents rather than an arbitrary population number.

Legislative Changes Required

A number of key legislative changes will be needed to make this work. In particular we would recommend the following:

Local Government (Scotland) Act 1973 - section 56 does not presently allow delegation to a joint committee with a Health Board and this will need to be amended. Section 57(3) - provides that a Local Authority Committee cannot contain any less than two thirds Councillor membership. This is not applicable to sub-committees (although note that if Section 14 of the Local Government and Housing Act 1989 is ever brought into force it would also apply this to sub-committees). Thus Section 56/57 will need to be amended to provide that a Local Authority is required to set up a Joint Committee with the Health Board to carry out certain functions, deleting the restriction on the number of Councillors who can serve. The opportunity could also be taken to disapply Section 14 to Scotland.

The Community Care & Health (Scotland) Act 2004 provides in Section 13 for payments from a Local Authority to the NHS and vice-versa. Section 15 provides for delegation of defined functions from a Council to the NHS and vice-versa. Section 15 provides for pooled budgets with either the Local Authority or the NHS running the pooled budget. The Community Care (Joint Working) Regulations 2002 detail the functions that can be delegated. This legislation will need to be substantially amended to provide for the Joint Committee to exercise the relevant functions and operate the integrated budget. The power under Section 15 to delegate functions from one body to the other should remain. A new power to integrate or pool budgets under the joint committee, or board should also be included.

The NHS Reform (Scotland) Act 2004 provides in Section 2 that Boards must establish a Community Health Partnership as a Committee to deliver prescribed Health Board functions. The Consultation Paper states that CHPs are to be abolished and the 2004 Act will need to be amended accordingly.

The relationship of the JAO with the Council's Monitoring Officer, Section 95 Officer and Chief Social Work Officer will need to be closely looked at and relevant changes made. If it is proposed that the JAO holds any personal accountability then this will need to be provided for in legislation.

Section 62A of the Local Government (Scotland) Act 1973 allows a Joint Committee of Local Authorities to become a Board in certain circumstances. This will need to be amended to provide that this also applies to the Partnership.

Provision will need to be made in Section 57 of the Local Government (Scotland) Act 1973 for non voting members of the Partnership.