Annex G Consultation Questionnaire

The case for change

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

In general terms offering a yes or no answer to the consultation questions is not helpful. This response has not utilised the facility for a clear yes or no, rather we have provided text to address the issues within the consultation questions.

We agree that a focus on older people's services is the initial priority given the radical demographic change (although this is not uniform across Scotland) and the clear strategy position of creating a shift in the balance of care from institutional towards home based services.

Health and social care provision for older people is complex, involving the NHS and local authority provision, and also a web of associated services, for example, housing support (RSLs) and third and private sector

care services. There is therefore a need for much wider engagement than solely the NHS and local authorities in pursuit of seamless services. Current approaches including the Change Plan are addressing the need for wider engagement and we would therefore be concerned about any potential disruption to current approaches which are proving to be effective through the involvement of other partners and service providers.

The proposals are overly prescriptive on organisational arrangements. These should be for local determination. The proposal should focus on the joint outcomes we want to achieve.

There are already ministerial powers of intervention contained within the Community Care & Health (Scotland) Act which are not used. We do not agree that there is a need for a legislative approach to organisational arrangements. A more helpful approach would be to focus the legislation on joint outcomes, with local partnerships agreeing the scope and operational arrangements relevant to their local circumstances.

Outline of proposed reforms

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

We would not describe the proposals as comprehensive. On the one hand they are very prescriptive, and on the other they lack detail on how particular aspects of their ambition would be achieved within the stated aim of minimal disruption. In general the proposals do not provide any evidence around how the objectives will be achieved. There is a wealth of evidence (Petch, 2011) highlighting that imposed partnership arrangements do not work. This appears to have been disregarded in the current set of proposals.

The proposals do not adequately address issues around governance and accountability. Whilst arrangements are set out, they fall significantly short of the standards of transparent governance, accountability and financial safeguarding that is currently in place within local authorities. We would argue that the proposed arrangements are not sufficiently robust even for a partnership of minimal scope. The proposals suggest flexibility to include other aspects of social care services. However, the level of risk would increase as the scope of the partnership increased.

Whilst we consider the proposals as going too far in prescribing arrangements for partnerships, there is a significant lack of information on how the proposed arrangements will address fundamental issues such as the disconnect between primary and acute health services. This is surprising given that these issues are highlighted as pivotal to the success of the partnership. There is no evidence that the proposed arrangements will assist the partners to achieve joint outcomes.

The proposed organisational arrangements actually detract from the core issues the proposals aim to address.

National outcomes for adult health and social care

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

We agree that there should be nationally agreed outcomes; however we would assert that the mechanisms for how these outcomes are met should be agreed locally. To do otherwise would ignore the evidence that exists which cautions against prescribed arrangements. (Petch, 2011) It will be necessary for each area to have locally agreed short, medium and long term plans to reach the outcomes required. These will differ across local authorities depending on local factors.

The proposed mechanism for monitoring of performance is the SOA, a high level performance monitoring process. Day to day performance in health

and social work is subject to separate target setting and performance management systems which to differing degrees shape how services are delivered. If the proposal for joint performance measurement is to achieve any real difference in how performance is achieved it would have to affect change at the operational level and not only at the higher level SOA, i.e. work towards a singular performance monitoring system.

It was noted at a consultation event held recently in Glasgow that distortions in service provision are created by the application of unhelpful targets to Health Boards. An example cited by a senior manager was that hospital admissions increase when people have to wait more that four hours to be attended to at A&E departments. That is - the HEAT target of keeping waiting times below four hours encourages more admissions when waiting times get close to four hours waiting to be seen.

The proposal is not clear on how the current separate performance management systems within Health and Local Authorities would change other than the addition of high level indicators within the SOA.

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

Yes, the SOA is the relevant vehicle, although the inclusion of high level indicators won't affect change on its own.

As above, we need to look at changing the current approaches to performance targets in each organisation towards a joint approach. For example, if the NHS is still characterised by an approach focussed on HEAT targets, this will undermine a joint approach.

The general policy direction in Social Work Services has been to adopt a personalised approach to services. Within Glasgow City Council we have made significant inroads to implementing that approach. This approach cannot be fundamentally separated for various aspects of service. Therefore in terms of achieving cogency of reporting we would welcome further clarity on the Scottish Government's thinking on policy alignment across the various reporting requirements for both the NHS and local authorities in terms of performance management.

Governance and joint accountability

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

No, councils are accountable to the electorate. The proposals in their current form blur the issue of democratic accountability and scrutiny and fail to give sufficient recognition to the role of councils.

Local democratic accountability is key within local authorities. The proposals as currently set out shift decision making from the council to a joint committee of the Health Board and the Council.

4.9 of the proposal suggests that the chair and vice chair of the partnerships and the chief executives of the Health Board and Local Authority would be accountable to the Cabinet Secretary, the Local Authority Leader and the Health Board Chair. The current proposal sets out an arrangement where accountability is heavily anchored towards health related governance.

Whilst we acknowledge the role of the Minister in overseeing the services within that ministerial remit, it is difficult to envisage circumstances when ministerial oversight forms part of a local governance arrangement for the operational delivery of the partnership.

Current accountability arrangements cannot be overwritten. The Leader is accountable to his/her own local authority. The Chief Executive is accountable to the full council, not the Council Leader. As the proposal currently stands it blurs the boundaries of accountability and diminishes the role of local government by shifting accountability for statutory local government functions to the Scottish Government.

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

This should be a matter for local determination.

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

No. As currently described the proposed Committee arrangements are not appropriate to ensure governance of the Health and Social Care Partnership. The proposed committee arrangements are in some ways similar (in composition) to joint working arrangements that we have in Glasgow and which have been beneficial in maintaining positive joint working. Our Joint Partnership Board with NHS involves similar numbers in terms of membership. However, it is not a decision making body. This Board is not legislated for, but has grown organically within the local area and it does not aim to shift accountability between the partners or to the Board itself, rather it aims to progress work jointly. Glasgow City Council has serious concerns about the formal committee arrangements as proposed and these are set out below, along with a number

of associated questions;

- The proposal lacks any formal approach around good governance and financial probity.

- The ethos of partnership is about consensus; therefore the idea of the chair having a casting vote does not sit comfortably within a partnership environment.

- The proposal refers to integrated governance, and the two roles (Chair and Vice Chair) forming a team and not representing the individual interests of the partner organisation. Within this context the idea of a casting vote is contradictory. This implies voting on an organisational basis rather than voting for the good of the service user / patient.

- Democratic accountability of the council is undermined in this model. Where currently decisions around services and budgets are subject to scrutiny within the council structures and by the full council, this would be replaced by joint scrutiny from a committee comprising of a relatively small number of people overall, and a very small number of elected members relative to the council membership. At the same time the legislative responsibility for associated functions would remain with the council and the health board.

- The proposed arrangements allow for a minimum 3 voting members from each partner. Having only 3 elected members from their number is insufficient to reflect the range of views from 79 elected members in Glasgow. Current decision making, governance, policy and scrutiny arrangements in the council are overseen by the relevant committees and therefore involve significant numbers of elected members from all political parties. The number of elected members should not be constricted by the small number of non-Executive Directors that serve on NHS Boards.

- At 4.18 the proposal details non-voting members to support the committee. Surprisingly, this does not include finance and governance experts, elements of management which are absolutely essential to the workings of a body responsible for public funds.

- The role of opposition members in decision making is unclear; in order to affect relevant council views a significantly larger number of members on the Committee would be essential.

- The suggestion that decisions should be made without going through governance structures of the respective organisations is unworkable and dangerous. We need to have relevant checks and balances on the utilisation of public resources and on the governance of public services.

- The proposals as they currently stand would effectively lift the council's adult social care services out of the current decision making and scrutiny processes. Where currently decisions are made by the council's Executive Committee this would no longer be the case. Health and Social Care Services would no longer be subject to the Operational Delivery Scrutiny Committee or the Finance and Audit Scrutiny Committee. The current checks and balances around financial decision making are eroded within this set of proposals.

- The development of policy for health and social care services currently sits within the council's Policy and Development Committees. This includes, for example, the review of charging policies on an annual basis. The responsibility for this within the current set of proposals would shift to the new Committee of the Health and Social Care Partnership.

- The proposals would effectively shift governance of health and social care from a situation whereby decisions are made, by a council of 79 members, involving a number of committees around operational delivery, policy development and financial scrutiny. Each committee typically has a membership of between 15 and 17 members representing a range of political parties. Appendix 1 outlines current accountability arrangements for social care services within the council alongside proposed arrangements as detailed in the proposal.

- The Jointly Accountable Officer appears to have significant authority over public funds. This is outwith the general scope that officers within a local authority would have and conflicts with the council's financial accountability arrangements.

- There is a need for consideration of the role of the Chief Social Work Officer, a statutory function contained within Section 3 of the Social Work (Scotland) Act 1968.

- In addition, the council's Chief Financial Officer is a statutory appointment under Section 95 of the Local Government (Scotland) Act 1973. The proposals in the consultation document do not take account of the responsibilities of that role, i.e. the proposals require the council to on the one hand, let go of responsibility for resources for which it has a legislative responsibility, and on the other maintain the legislative responsibility for the same. This potentially compromises the role of

the Chief Financial Officer and of the council itself.

Questions

- What arrangements will be put in place to ensure that the rotation of the chair on an annual basis does not create a start /stop situation regarding the implementation of policy?

- How long will partnership agreements last for?

- What is the mechanism for dispute resolution?

We agree to the concept of working jointly with the NHS in relation to integrating adult services, and in fact are already doing so extensively. The Change Plan approach we have adopted exemplifies significant progress in this regard. New approaches are being developed in partnership with health which aim to address the tensions in the system of health and social care services for older people. These include, for example, assessment at home – an approach to ensure that people are effectively assessed in their homes rather than in hospital settings. Reablement is a process which aims to provide enabling support to people in their homes, working towards achieving independent living for as long as possible.

Over the last year and a half we have worked with health colleagues (and other partners) to develop an adult services plan. This is supported by an appropriate joint planning structure (Appendix 2) which reports to our Joint Partnership Board. We are satisfied that this approach can address the need to work jointly across the broad range of adult services.

We do have a concern that the clearly articulated wish of the Scottish Government for integration to cause minimal disruption could be undermined through the proposals as they currently stand. The proposals significantly under-estimate the scale of change in relation to governance which these proposals contain and the likely impact of their implementation.

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?

Performance management arrangements for health and social care partnerships do not sit outside the current infrastructure of pre-existing inspection and regulation arrangements. Therefore, the role and relationship between external scrutiny bodies also needs scoped out much more fully. These include the Care Inspectorate, The Mental Welfare Commission, The Scottish Social Services Council, QUEST and the Older Peoples Inspection Programme managed by Health Improvement Scotland.

In terms of providing public confidence that effective action will be taken where services are failing we believe the proposals fall short of this. Democratic accountability would be significantly eroded if the model as currently described was adopted.

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

Yes – we would go further to suggest that what is in scope should be decided locally with a minimum requirement being older people's services. This will enable partnerships to focus on particular areas of pressure, rather than being distracted by an overly complex and unwieldy agenda.

Whilst we agree that the scope for inclusion of services within the partnership should be for local determination, the governance and accountability arrangements as described within the proposal are not adequate. Appendix 1 demonstrates the current decision making structures that apply to social care services within the council, as compared to the arrangements within the proposal. The council's current decision making, policy and scrutiny arrangements are embedded and work well in a transparent manner. The proposals clearly fall short of a transparent and accountable system of governance for whichever services are agreed as being in scope for the partnership.

It is clear that a one size fits all approach will not be relevant for Health and Social Care Partnerships. There are currently a significant number of models across Scotland exemplifying the differing scale, geography and demography of the populations they serve.

It is also important to remember that whilst health is a crucial partner, it is not the only partner. Education, housing, the private and voluntary sector and the Scottish Prison Service are among a number of key partners in social work. It is therefore extremely difficult to envisage how all elements of social care could fall within the remit of the partnership as described within the proposal. The council do not believe that the social work service could be sufficiently governed within such a structure.

As mentioned at Q7 above, we believe that cognisance should be taken of arrangements for joint work which have evolved locally rather than having

imposed arrangements. Therefore we would suggest that a minimal approach to prescription is adopted enabling local areas to develop relevant arrangements.

Integrated budgets and resourcing

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

No. A key pre-requisite for ensuring that money is spent to best effect is to have absolute clarity on the aims of the partnership and to ensure that everyone involved in the partnership has a shared understanding of this. Whilst some areas of the proposals are clear there are others which need further attention. These can be set out in three sections around 1)

the core aims of integration and 2) a prescriptive or enabling approach 3) financial management / technical issues.

1 – The Core Aims of Integration

The case for change in relation to older people's services is well made in the paper. It does not, however, take account of on-going work through the Change Plan and other local service reforms. The council has welcomed the approach initiated through the Change Plan which is gaining momentum and affecting change.

The case for change section of the proposal focuses by and large on older people. However the remainder of the document then refers to adult services, with potential scope for the inclusion of other services. A very clear message needs to be given about the core aims of the partnership, what it is for, and how it can work. This should be evidence based. The proposal as it is currently presented leads to confusion rather than clarity.

On the whole the proposals focus largely on partnership arrangements and we would suggest there is need for a stronger focus on the vision of what the proposed integration aims to achieve. Our experience of the CHCPs in Glasgow has demonstrated that the core vision and aims of the partnership need to be very clearly articulated and agreed before the partnership comes into being. If this is not the case significant time and energy will be spent thereafter aiming for agreement on areas where clarity is required. This

can mean that the partnership focus becomes about aiming for clarity and agreement which is a distraction from focussing on using money to best effect for the patient or service user.

Some of the messages within the proposals are not as clear as they could be, or are potentially contradictory, and could therefore lead to differing interpretations of their meaning.

If the key aim of the partnership is around shifting the balance of care from institutional to community based care we need to have clarity on how resources will shift to enable this across the whole system, including acute services. It will not be sufficient to include only specialist acute care of elderly services given that older people are majority users of a number of specialities, e.g. coronary care, general surgery etc.

In addition, there needs to be clarity around charging policies for community based services (other than personal care) which aim to keep older people at home rather than in hospital. Some elements of social care services which are delivered by or on behalf of the council are subject to charging regulations and policies. This is not so for health services which are free at the point of delivery. Our experience of CHCPs demonstrated that this may lead to friction around the implementation of charging.

In addition, if the proposal to integrate all adult services is agreed it is difficult to see how personalisation and the implementation of Self Directed Support (SDS) could apply to only one of the organisations that comprise the partnership.

In general terms it is evident that policy alignment will be crucial to make joint arrangements work.

2) A Prescriptive or Enabling Approach

The proposals aim to be enabling and to create change with minimal disruption. We welcome the Scottish Government's commitment to this approach. However there are a number of points in the proposal which on the face of it appear contradictory to the government's stated approach.

At 2.4 and 2.5 the proposal confirms that there will not be centrally directed structural reorganisation. However a number of elements of the proposal are then articulated which do appear to be / or which will lead to, centrally directed structural reorganisation.

For example, at 2.6 the proposal goes on to describe what the framework is. The proposed framework contains within it major changes around governance, accountability, decision making, budgetary arrangements and workforce issues. As it currently stands the framework is prescriptive around governance and proposes some very fundamental changes to how councils make decisions around health and social care in a democratic environment.

If implemented in its current form the proposal will inevitably lead to structural reorganisation. The appointment of a JAO appears to be an operational delivery arrangement which will have consequences on staffing structures and on financial accountability arrangements. There is no evidence to support the assertion that the appointment of such a post will lead to better outcomes. We strongly assert that the appointment of staff to support the partnership should be for the partnership's determination, not the subject of legislation.

A number of core organisational issues around the changes required for the integration of health and social care for older

people will need to be addressed. For example, where there is need for significant workforce changes, either to staff roles or compulsory redundancy, how will this be managed in a context where government protection is in place for staff in the NHS?

3) Financial Management / Technical Issues

As mentioned briefly above the proposals do not adequately address financial management issues. It appears that there would be an agreement to include budgets within an integrated envelope of resources for which the then management of the same has been in many ways overlooked. A number of questions in this regard are posed below;

Financial Management Issues

- Who will "audit" the value of budget from each service area (primary and community health, adult social care and some acute hospital spend) to be devolved?

- Whose, if any, procurement arrangements will be adopted?

- Who will provide the internal audit function?

- What will be the reporting lines to Committee?

- The paper does not mention how overspends would be dealt with. In addition, it reads as a one time budget transfer and doesn't address where there is a requirement for budget increases. What is the government's thinking on addressing such issues for what is a demand led service?

We acknowledge that we have suggested the proposals are overly prescriptive and are then asking detailed questions. The purpose of highlighting these kinds of questions is to demonstrate that organisational arrangements cannot in fact be

legislated for without attention given to operational management issues. These matters must be dealt with at a local level.

VAT Implications of the models proposed

In summary we believe that the VAT implications are as follows;

The option for devolving budgets to a body corporate would be VAT inefficient resulting in a loss of funds to the public purse in Scotland.

Delegation between the partners will have no VAT impact for either partner if it is carried out under an agency agreement (other than a potential administration cost to identify each party's VAT costs because these will need to be recharged to the other partner). Under this arrangement either party can be the lead agent.

If NHS resources are delegated under a partnership arrangement to LAs this will increase the amount of VAT recovered from HMRC because LAs have the ability to full tax recovery (subject to meeting certain criteria). Therefore delegating resources to LAs would have a positive impact on the public purse. Delegating LA resources to the NHS would represent a loss to the public purse because the NHS is not able to achieve full VAT recovery, nor would it be able to recharge the LA with the VAT it incurred on its behalf.

However, any saving of VAT must be incidental to the scheme proposed and it is likely that HMRC will have to approve any scheme adopted if it appears to significantly change the recovery of VAT. Specialist advice will be required in this area.

Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

We have significant experience gained through the CHCPs in Glasgow. As outlined above at question 10, our experience would indicate that clarity of vision and scope of the partnership is a major pre-requisite for effective partnership working and focus.

In terms of the flexible use of resources across health and social care our experience in the CHCPs is very relevant, in particular to older people's services. Whilst it is easy in principle to move money across budgets, in reality it takes time. It is important to highlight that resources for older people's services (e.g. care homes) tend to be tied up for significant time periods in line with the duration that elderly people occupy the care home. It is therefore difficult to shift significant levels of care home budgets in a short time period. By necessity an incremental approach needs to be adopted.

Our experience in the CHCPs around the pursuit of zero delayed discharges was that social work home care and purchased care home budgets (£140m in total) were very significantly overspent and our aim of achieving zero delayed discharges was not met

The council is currently working closely with the NHS in reshaping care for older people. Our approach through the change

plan to delayed discharge is proving to be more effective. The lever provided by the change fund has enabled us to take a more planned approach to this issue and to deal with practice issues across the services more effectively. In terms of results, we currently have no delayed discharges over 6 weeks and only 7 over four weeks. Both the home care and purchased care home budgets are in balance.

It is clear that meeting the challenges we face as a result of changing demography will require a serious effort to address the disconnect between primary and acute health care services. The proposals do not appear to provide a solution to this fundamental issue.

Our most important resources in affecting change are our staff. Flexibility in the utilisation of staff resources is crucial in affecting change. A number of very practical issues did arise within the CHCPs in relation to staff resources. Not least where two separate employing organisations have staffing at different grades and terms and conditions. This can prove a major barrier to effective integration.

It is important to note that a significant proportion of our social care resources are used for purchased, rather than directly provided services. Whilst on the face of it this resource could appear to offer greater flexibility, this is not the case. The personalisation approach means we need to respect user choice of service and provider. Therefore as we continue to implement this approach the market will be determined more and more by the service user.

The proposals highlight that integration will include ‘some’ acute services. The aim of achieving a shift in the balance of care between institutional and community based care will not be met without flexibility across the entire system of care. Greater Glasgow and Clyde Health Board acknowledge in their recently produced discussion paper that the resource movement that can be achieved from acute will not in itself address the pressures on health and social care. It seems,

therefore that there is an issue within the overall health resource in terms of flexibility that will clearly not be addressed through the implementation of Health and Social Care Partnerships. There may in fact be a threat that resources could shift towards more institutional care than community care – a clear opposite of what these proposals aim to achieve.

CHCPs were characterised by poor financial management of council resources. There were a number of reasons for this which will need to be addressed in any successor arrangement. It is clear that the successful integration of services requires that the budget setting arrangements for both organisations are aligned. Again this will not be possible within the current arrangements for health budgets which are largely set. These significant issues need to be addressed, otherwise we are trying to achieve flexibilities across shared resources that are just not possible to achieve.

Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

No, there needs to be local flexibility to enable partnerships to meet the needs of their differing populations.

Jointly Accountable Officer

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

No, this remit should not be specific to a particular individual. Cognisance needs to be taken of existing decision making structures.

The current proposals include fundamental issues around accountability. Local authorities are locally and democratically accountable. It is the fundamental basis of their legitimacy. Decisions (including around finance) are made in a transparent manner with significant checks and balances in place. The proposal appears to suggest a very significant level of responsibility where the JAO is enabled to make decisions around resource prioritisation without going back through the respective accountability structures within the NHS and local authorities.

Financial accountability and delegations are clearly articulated within our operating policies. How would the financial authority awarded to the JAO relate to the delegated authority of the Executive Director of Social Work, or to the Chief Executive of the council?

It is possible within the current proposal that the JAO could in effect have a more significant level of financial authority than either the Chief Executive of the council or health board.

The current proposal suggests that there will be a duty on local authorities to appoint a JAO. Within GG&CNHS there could be 6 JAOs relating to the authorities within that boundary and another 2 whose geographic boundary is partially within the area. Clearly a number of NHS facilities cover more than one local authority area. It is difficult to see how a JAO can make decisions about resources which are not within their geographic boundary but to which they have a shared use and therefore a shared responsibility for the resource.

Section 7 of the proposal refers to the role of locality planning groups. In particular 7.7 states *"We will need to ensure that locality planning groups have the right level of delegated authority, including influence over locality shares of the integrated budget, to make decisions that impact on local service provision".* It is not clear from the proposal how the delegated

authority awarded to the locality planning groups relates to the financial authority of the JAO, or to any other accountability structure within the local authority or health board.

The issue of accountability for decision making seems to be potentially contradictory between the role of the JAO and the locality planning groups whilst bypassing the current accountability processes of the NHS and local authority.

The description of the JAO and his/her level of authority and reporting arrangements appear confused. The proposal suggests that where a body corporate is the favoured model, the financial authority of the JAO to manage budgets from both organisations could be articulated in a Service Level Agreement (SLA) between both organisations. However, earlier in the document the (5.6) it refers to there no longer being health or social care money, i.e. it would lose its identity and there would be no need to refer back up the line for decisions (4.6). Therefore within this proposed model it is unclear what the contents of an SLA would be.

In the current economic climate local government is required to make major reductions in funding. If the resources allocated to an integrated budget are ring-fenced this will hinder the council's ability to make future savings.

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

There are confusing messages about the authority and seniority of the JAO within the proposal. It is noted that the post

holder will report to the Chief Executives of the Health Board and Local Authority. However, the financial authority of the post holder as described in the proposal appears to be at a higher level than that of the Chief Executive of the council. That is, there is no post within the council which enables an officer to move budgets around between one organisation and another without going through the decision making structures of the council.

The proposal to impose a duty to appoint a Jointly Accountable Officer is not supported. Staffing arrangements should be agreed locally and not by the Scottish Government.

The powers associated with the post of the JAO cannot be reconciled with the post of the Chief Financial Officer, who is a statutory appointment under Section 95 of the Local Government (Scotland) Act 1973.

Professionally led locality planning and commissioning of services

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

Local authorities have a wide range of locality planning arrangements already in place, for example in Glasgow we have local community planning arrangements within the authority area.

The local authority and health board have agreed a joint planning structure for adult health and care services.

Locality planning arrangements should be for local determination; these cannot be prescribed, to do so would ignore the clear evidence that exists which demonstrates that effective partnerships are not imposed ones.

Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

The duty to consult is clear although not necessary. It is unlikely that the placing of a duty on Health Boards and Councils will in itself lead to effective involvement of professionals.

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

From a social care perspective the involvement of professionals in a Glasgow setting has not been problematic. The managers of our social care services are social care professionals. Therefore our management and professional arrangements intertwine.

The engagement of health professionals should be addressed locally, although there are clearly issues around the engagement of GPs, a fundamental issue which needs to be addressed and which is generally outwith the control of local partnerships. Given that this is a critical issue we would welcome clarity from the Scottish Government on how this will be addressed.

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

No. GP boundaries do not represent natural communities. In addition the number of GP practices within Glasgow would make this approach impossible. Locality planning should be considered based on local circumstances and determined within the local area.

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

This area of the proposal needs further attention. As noted at question 13 we can see a number of contradictory factors with regard to accountability and governance, e.g. between the JAO and locality planning and between the JAO, locality planning and the accountability / governance arrangements in the NHS and local authorities.

There needs to be clear reasoning and articulation of what we mean by central and local planning and justifications for the routes chosen.

The proposal makes reference to locality planning groups having control over locality shares of the integrated budget. This aim sounds relatively simplistic. However, health and social care service needs are not dictated by locality and therefore the proposed allocation of budgets requires further thinking.

We would welcome clarity on the governments thinking on locality planning as proposed, for example;

- What kind of services are envisaged as being appropriate for the associated budgets to be devolved?
- How will delegated authority to localities relate to the financial authority of the JAO – is the thinking that some budgets

would remain under the authority of this post holder with others being delegated to localities?

As mentioned above, the proposals do not take account of current locality planning arrangements within local areas. Any new arrangements need to take account of these and this should be determined locally to ensure relevance to local circumstances.

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

No, this should be for local determination taking account of current arrangements, scale, geography, demography and the associated needs of the local populations.

Committee	Membership	Terms of reference
Executive Committee	17 members – 10 Labour, 5 SNP, 2 Green	To discharge all of the council's functions, except those reserved to the council and those matters specifically designated to other committees.
Children & Families Policy Development Committee	15 members – 8 Labour, 5 SNP, 1 Green, 1 Liberal Democrat	To examine and undertake development reviews on behalf of the Council on the various policies, strategies and plans in draft and reporting on these to the Executive Committee.
Health & Social Care Policy Development Committee	15 members – 8 Labour, 5 SNP, 1 Green, 1 Liberal Democrat	To examine and undertake development reviews on behalf of the Council on the various policies, strategies and plans in draft and reporting on these to the Executive Committee.
Operational Delivery Scrutiny Committee	15 members – 8 Labour, 5 SNP, 1 Green, 1 Glasgow First	To scrutinise and monitor the operations of all council services in relation to the council policy objectives and performance targets including monitoring the SOA and council output; and holding Executive Members to account for the operational performance of their service area.
Finance & Audit Scrutiny Committee	15 members – 8 Labour, 5 SNP, 1 Conservative, 1 Green	To monitor the financial operations of the council and its trading operations, the performance of audit and inspection within the council, and for promoting the observance by councillors of high standards of conduct.

APPENDIX 2

Adult Services Joint Planning Structure

The **Joint Partnership Board**, consisting of elected members and non-executive NHS Board members performs the role of monitoring performance and budgets, and oversees service planning processes for joint adult services in the City. This Board undertakes the same role for joint children's services in the city.

The **Adult Services Executive Group** oversees the development of city-wide joint planning for adult services and reports to the Joint Partnership Board on progress against agreed priorities, guides the development of annual work plans for each care group, and monitors the performance of these work plans. Membership includes the Glasgow NHS Community Health Partnership Director, the GCC Executive Director for Social Care and relevant Senior Management and Finance leads from both parent organisations.

The Joint Adult Services plan currently out for consultation.

Care Group PIGs
(reporting 6-monthly to ASEG)

Cross-Cutting Thematic PIGs
(reporting annually to ASEG)

Older People/ Reshaping Care
(NHS Chair)

Service User Involvement (Voices for Change/ PPFs)

Homelessness
(GCC Chair)

Alcohol and Drugs
(GCC Chair)

Mental Health
(NHS Chair)

Adults with Disabilities
(GCC Chair)

Adult Services Executive Group (ASEG)
*(*Meeting quarterly, reporting 6 monthly to JPB. Chaired by NHS)

Joint Partnership Board (JPB)
(Meeting quarterly, Joint NHS & GCC Chair)

Joint Resource Group
(Joint NHS & GCC Chairs)

Employability
(GCC Chair)

Carers
(GCC Chair)