

Response to consultation on proposals on Integration of adult health and social care

By Audit Scotland on behalf of the Auditor General for Scotland and the Accounts Commission

September 2012

Introduction

The **Auditor General for Scotland** is the Parliament's watchdog for helping to ensure propriety and value for money in the spending of public funds. The Auditor General is responsible for investigating whether public spending bodies achieve the best possible value for money and adhere to the highest standards of financial management. The Auditor General is independent and not subject to the control of any member of the Scottish Government or the Parliament. The Auditor General is responsible for securing the audit of the Scottish Government and most other public sector bodies except local authorities and fire and police boards.

The **Accounts Commission's** role is to help ensure that public money is spent properly, efficiently and effectively. It is responsible for the audit of all local authorities, police and fire and rescue joint boards and other similar public bodies. The Commission operates independently of local authorities and of the Scottish Government, and it reports in public.

Audit Scotland was created to support both the Accounts Commission and the Auditor General for Scotland in carrying out their work.

The Auditor General and the Accounts Commission welcome the opportunity to contribute to the consultation on the future integration of adult health and social care in Scotland. This submission refers to the experience and audit evidence gathered through the work Audit Scotland has carried out on our behalf.

This response draws on a wide range of audit work, but in particular Audit Scotland's reports on *Review of Community Health Partnerships* (June 2011) and *Commissioning social care* (March 2012).

The consultation paper sets out how the Scottish Government intends to achieve better integration of adult health and social care in Scotland and invites comments to contribute views on the proposals and on the new legislation that the Government will be bringing forward. The consultation paper sets out a number of questions and our response is in relation to those which are most relevant to our roles.

Chapter 1 – the case for change

General comments - The case for improving how health and social care services work together to meet the needs of the people of Scotland has been made for a number of years, not least through the work of Audit Scotland. Given the increasing demands and pressures

on these services, and the need to meet the health and care needs of people who are often quite vulnerable, it is essential that services are able to work well together to respond to needs whilst making the best use of existing resources and delivering high quality services. We have highlighted in several reports the need for barriers to partnership working to be addressed. It is also essential that sound governance and accountability arrangements are in place, that organisations are able to respond flexibly to local needs and that there is some national monitoring of progress in improving services in line with policy intentions. Any new governance and accountability arrangements should be effectively aligned with existing arrangements to avoid further complicating approaches to governance and accountability. Effective democratic scrutiny of these new arrangements will also need to be in place. The Scottish Government, together with NHS boards and councils, should also work to ensure there is minimum disruption to existing services and service users during the move to better integration. NHS boards and councils need to continue to deliver services to those who need them during this period of change and must ensure that people are not adversely affected.

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

1. The consultation sets out the potential benefits the Scottish Government hopes to see for older people by implementing these changes. We know that services for older people are under increasing pressure and that improving services for older people is a Scottish Government priority. However, there is a risk of fragmentation within the system by focusing initially on services for older people. We know from our previous work that people find the transition between services difficult, for example moving from services provided for children to those provided for adults.¹ Targeting these changes initially on services for older people could have a detrimental affect, taking the focus away from a whole-system approach. We also recognise that it will be challenging to disaggregate the costs associated with specific client groups.
2. In taking forward the proposed changes, it will be important to think about how a focus on services for older people rather than on the whole system could potentially affect the preventative agenda. For example, preventative interventions for conditions such as diabetes need to involve action being taken before people are old enough to access services for older people.

¹ *Overview of mental health services*, Audit Scotland, May 2009; *Getting it right for children in residential care*, Audit Scotland, September 2010.

3. Whilst we recognise the need for local discretion, the relationship between these new partnerships and the existing Community Planning Partnership (CPPs) is not clear from the consultation document. This relationship will need to be very clearly set out to avoid potential confusion but also to ensure that partners are very clear about their respective roles, responsibilities and priorities. We noted in our report on *Community Health Partnerships* that:

“Approaches to partnership working have been incremental and there is a cluttered partnership landscape. CHPs were set up in addition to existing health and social care partnership arrangements in many areas. This has contributed to duplication and a lack of clarity of the role of the CHP and other partnerships in place in a local area. There is scope to achieve efficiencies by reducing the number of partnership working arrangements”

4. It is important that the various partnership arrangements for health and social care in Scotland are clearly set out by both the Scottish Government and by local organisations, as well as the relationship between them, to ensure that they are efficient and effective and add value.
5. It is encouraging that the importance of carers and the third and private sectors are recognised as significant partners in the consultation document. It is important that their involvement is real and substantial, for example it may be helpful to have mechanisms in place to ensure that local partnerships are taking proper account of the views of these groups. These groups need to have the opportunity to make a real contribution to how this agenda moves forward as we highlighted in our report prepared for the Auditor General and the Accounts Commission on *Commissioning social care*.

Chapter 2 – outline of proposed reforms

General comments - The characteristics set out in this section of the consultation include consistency, accountability and professional leadership, and the consultation states that that the arrangements will help to simplify existing bodies and structures. In taking this forward consideration should be given to how this will be achieved in practice, and the extent to which the degree of local flexibility will lead to different approaches across the country. Similar issues have been raised in previous Audit Scotland reports, particularly for issues where there is clear evidence of a lack of consistency or professional leadership.

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

6. In our recent audits of CHPs and CPPs, we highlighted the need for certain key principles to be applied to underpin successful partnership working (see **Appendix 1** for further details).² It is encouraging that the consultation document recognises the importance of these key issues. In summary, there is a need for clear leadership and vision about what the partners hope to achieve through partnership working. Roles and responsibilities need to be well defined and risks identified and managed. Accountability arrangements and processes also need to be clear. Partners should have a shared understanding about what success looks like and that there are arrangements in place to monitor and publically report on progress. Finally, budgets and resources must be set out and agreed by all partners. The partners should be clear about the rationale for how money is allocated and spent, and efficiencies should be sought through sharing of resources and improved ways of working. It is key that there is real transparency about how devolved budgets have been determined and what resources are included in the devolved budget. Our work has shown that these key principles have not been applied fully in partnerships in Scotland to date.
7. The characteristics set out in the consultation document go some way to recognising the importance of the above issues. However, in particular there is a need for a clear articulation of how these arrangements fit with Community Planning Partnerships, specifically how accountability and outcomes/performance management will be linked.
8. Integrated budgets are a feature of the proposed approach. In our work we have found evidence of aligned budgets but few examples of integrated budgets. This suggests this is new territory for local partnerships and it will be essential that they are supported with this change. Many partnerships will find agreeing on the resources to devolve to the integrated budget extremely challenging. Our recent report on *Commissioning social care* found that there was a way to go to develop how services are planned and commissioned within a single agency, not least between partners. We recognise the support the Scottish Government has provided to partnerships, for example through the Integrated Resource Framework (IRF), but there is a need for significant development in this area. In terms of the IRF, such tools need to be fully implemented in all partnerships but we understand that this is not yet embedded in all areas.
9. One final point in terms of integrated budgets. We welcome that the consultation recognises the importance of other services, for example housing, to the integration of health and social care. It will be challenging to determine to what extent these other services could be or should be included within the integrated budget arrangements. It is essential that the reporting and accountability arrangements for the integrated budgets are clearly set out and that partners

² *Review of community health partnerships*, June 2011; *The role of community planning partnerships in economic development*, November 2011. Reports are available at www.audit-scotland.gov.uk.

are held to account for the efficient and effective use of the integrated budget. This, of course, will be dependant on shared priorities between all partners.

10. The consultation document sets out the intention to replace Community Health Partnerships (CHPs) with Health and Social Care Partnerships. Whilst these changes are under way it will be important to maintain the progress made by CHPs at a local level. It is also important that these new partnerships lead to a streamlining of existing partnership arrangements. As highlighted in our review of *Community Health Partnerships*, new partnership initiatives over the years have added to, rather than moved on, the partnership arrangements in some local areas.
11. We note the intention that the strategic commissioning of services for adults will be strengthened by these new arrangements. It would be interesting to know if the Scottish Government intends to review plans by these local partners to ensure that there is a comprehensive approach to developing strategic commissioning. We would also ask what role the Care Inspectorate will take in scrutinising commissioning and in ensuring that there is a step change to improve how partners commission services. This is particularly of interest as we noted in our report on *Commissioning Social Care* that progress with developing strategic commissioning has been slow. We also commented that there is a risk that people who need a small amount of support are not being offered the preventative services that might help delay or avoid their needing more costly intensive support, such as being admitted to hospital or into residential care. Given that this trend is not new and we have reported the risks in previous audits, it is important that a move to better integration addresses these gaps.
12. It is important to consider fully the implications for staff groups involved, including how the roles of staff need to change and develop to meet the needs of this new model. The consultation states that, by integration what is meant is 'services that are planned and delivered seamlessly from the perspective of the patient, service user or carer, and systems for managing those services that actively support such seamlessness.' There are wider implications for this change than are included within the consultation, some of which are long-standing problems. For example, a multitude of different staff going into a person's home to provide care services, and assessment processes which are not joined-up and are burdensome for the person who needs care or for their carer. There are clear benefits from having integrated teams, but some clear challenges, for example aligning terms and conditions and cultures.
13. We would also welcome more clarity about how these partnerships will be held to account and how transparent this will be to the public. We cover this point in more detail in following sections. Finally, it is unclear how this planned approach will link to Self-directed Support (SDS), for example how SDS relates to the health sector, or to other services which may become involved.

14. There will clearly be a change to how services are planned and managed as a result of these proposals. The document sets out high-level proposals for a system which includes a Jointly Accountable Officer, a Health and Social Care Partnership and a locality structure with planning led by clinical staff and care professionals. The Scottish Government, and local agencies, will need to consider the potential cost implication of these changes and the impact on professional staff who deliver frontline services.

Chapter 3 – National outcomes for health and social care

General comments - Decisions about services should be made on the basis of good evidence about costs, quality, outcomes and risks for users. We have highlighted in many of our previous performance audit reports that there is a lack of key data in terms of activity and costs, especially for social care and community care services. These data are essential to know what impact these changes are having for people who need access to these services. NHS boards and councils need to know whether services are making a difference to people's independence and quality of life so that services are planned and procured on the basis of evidence of what works. However, it is hard to specify and measure outcomes for individuals because they are personal and subjective, for example feeling safe, feeling valued, and having fulfilling social relationships. Any outcome measures must be transparently reported and available to the public and this information should be used to drive improvement. National measures are useful but partners also need a mechanism for measuring the difference that specific services are making to the individual.

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

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

15. We have commented in a number of our reports about the lack of joined-up, transparent and comparable performance measures for health and social care services.³ This makes it very difficult to build a clear picture of relative performance and does not help the public or the Scottish Parliament to be assured about the quality and efficiency of the service. Therefore

³ *Review of Community Health Partnerships*, June 2012, *Commissioning social care*, March 2012.

we welcome the proposal for a set of nationally agreed outcome measures, although it is unclear how these will fit with existing measures in frameworks such as SOAs and HEAT. Having a clear baseline will also help to measure the impact of these changes on costs and overall performance. There is a risk that the focus on adult services may lead to the development of outcome measures for children lagging behind and so the Scottish Government may also wish to consider including children's services in the development of national outcomes. It would be helpful to know more about how the various organisations will be held to account for their individual contribution to performance against these measures to determine whether or not they will be effective in reality.

16. We note the intention to 'appropriately align' external scrutiny processes to support integration of health and social care, but would welcome more clarity about what is meant by this. The work of the Care Inspectorate and Healthcare Improvement Scotland will be affected by the proposed changes and we will be interested to see more detailed plans. Similarly there are potential implications for Audit Scotland's work, particularly in relation to points raised at paragraph 34 in this response.

Chapter 4 – Governance and joint accountability

General comments - In our report on Community Health Partnerships we highlighted that partnership working between one or more organisations is challenging due to the differences in accountability arrangements and differences in organisational cultures, planning and performance and financial management. The proposals set out in the consultation appear to address some of these challenges but the real test will be how this works in practice. Good governance is essential to ensure that decision making is clear and appropriate and that public money is properly accounted for.

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

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

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

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

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

17. Setting the integrated budget will be challenging for many partnerships. More clarity is needed about how local partners will determine which funds to allocate to the integrated budget. Measures need to be taken to ensure that services do not become fragmented if, for example, only services for adults are integrated as is currently proposed. There is a risk that this will lead to a fragmentation in services between adults and children. We know from our work that this is already a problem in some areas.⁴
18. The respective partners will need to be assured about how the resources are being used. We understand that a partnership agreement will be in place, but clear dispute resolution mechanisms need to be in place. Rather than 32 separate models of a partnership agreement, there may be scope to provide a framework for these agreements to ensure that major risks are mitigated.
19. The consultation document notes that a Governance Committee will oversee the running of the Health and Social Care Partnership but it is unclear if this is the Partnership Committee or a sub-committee of the Partnership Committee. At paragraph 4.9 the document notes that 'The Cabinet Secretary for Health, Wellbeing and Cities Strategy, the Local Authority Leader and the Health Board Chair will together hold the Chair and Vice Chair of the Health and Social Care Partnership, and the Health Board Chief Executive and the Local Authority Chief Executive, to account...' Further consideration needs to be given to issues arising from local democratic accountability, in that the Chief Executive is accountable to the whole council, not just the Council Leader. The consultation document implies that the Local Authority Chief Executive can act autonomously from the council, in reality this is not the case. The council will need to determine the Local Authority Chief Executive's contribution to the Health and Social Care Partnership. This challenge is not properly addressed in the consultation document. It is also important to clarify how these arrangements will fit with the existing remits of the NHS board, Local Authority and Community Planning Partnership, including where the Jointly Accountable Officer fits in to this arrangement.
20. At paragraph 4.11 the consultation document notes that 'the NHS Chair and Local Authority Leader will form a "community of governance" overseeing the effectiveness of the Partnership'. It would be helpful to know more about how this will link to other governance arrangements for the partnership and what this means in practice. In particular, it will be

⁴ Including *Overview of mental health service* (May 2009) and *Getting it right for children in residential care* (September 2010).

important that the relationship between this “community of governance” and formal schemes of delegation within the council and NHS board are clear and well understood.

21. At paragraph 4.14 the consultation document notes that the Chair and Vice Chair of the Partnership Committee will ‘rotate on an annual basis’. Given the scale of the issues under consideration by the Partnership we would question whether this time period is sufficient to develop a sustained approach.
22. There are many features of the consultation document that are achievable under existing legislation, for example partners working together to ‘... deliver services that support wider community planning processes, particularly in relation to promoting early intervention and prevention ...’ The Scottish Government will need to ensure that the proposed legislation and subsequent implementation make a step change in how partners perform and how they work together and mitigates against the risk that there are still some partnerships in Scotland which do not fully engage with these changes.
23. We are keen to stress the importance of good information to underpin the decisions made by the Health and Social Care Partnerships. We have raised concerns about the quality of management information about cost, quality and performance in many of our reports. It is essential that partners have the information they need to inform their choices, including good information about needs. It is also important that performance information is transparent and that the public and Parliament are clearly able to see how well a partnership is performing and if there is scope for improvement. Benchmarking in this regard is also very helpful. We would urge the Scottish Government to ensure that good quality information on costs, activity and local needs is central to the development and ongoing work of these new partnerships.
24. There is a balance between having a Committee which represents all of the key parties involved in the partnership against having one of a manageable size where real decision making and oversight can happen constructively. We have seen in our previous work that there is a risk of committee members being unclear about their role and remit and in some cases committees which are too big to function effectively. Appropriate induction and training for members are also essential so that they are clear about their role and responsibilities.
25. We note the intention at paragraph 4.23 that partners may choose not to integrate the budgets for other services along with adult health and social care and that governance for other services might be provided by another committee. This raises the risk that these reforms will add to rather than reduce the already cluttered partnership landscape.
26. We note the proposal at paragraph 4.26 that the ‘financial authority for achieving outcomes, and the requirement to demonstrate value for money, will be delegated to Health and Social Care Partnerships by the Health Board and the Local Authority’. In our report *Community*

Health Partnerships we stressed the critical importance of good working relationships and clear leadership for effective partnership working. The consultation document does not mention Best Value which is a statutory duty on councils.

27. The effect of poor working relationships and disputes about partnership working can be severe. We would stress the need to ensure that there are some controls in place to mitigate against these risks.
28. We welcome that the consultation states that Health Boards and Local Authorities will be jointly held to account for performance. It would be helpful to be clearer about what this will mean in practice and how this will sit with the delegated authority arrangements.
29. It is encouraging that the consultation notes the intention for the proposed changes to 'streamline arrangements significantly'. The changes will see a shift from 34 CHPs to 32 Health and Social Care Partnerships but there are likely to be other committees required to oversee services which are not part of the new partnership arrangement, and the potential for body corporate arrangements to be put in place. It is not clear from the consultation how the Scottish Government envisages that the new arrangements will streamline existing cluttered partnership arrangements and add value for local communities. The consultation mentions that other strategic partnerships may no longer be required, but from our previous work we found that it is important to be clear about the added value from partnership working. In some cases partners had not refreshed their local arrangements when new partnerships were introduced and sometimes local bodies were not clear about the added value or role of the partnership, particularly where they felt they had to have a certain structure in place because of legislation.

Chapter 5 – Integrated budgets and resourcing

General comments - A more systematic and joined-up approach to planning and resourcing health and care services is needed to ensure that health and social care resources are used efficiently. In our report on Community Health Partnerships we saw very few examples of good joint planning underpinned by a comprehensive understanding of the shared resources available. This message was echoed strongly in our work on Commissioning social care where we found slow progress with strategic commissioning and limited joint working. One of our concerns about CHPs related to their lack of strategic influence over how resources were used in the local area. We also highlighted the importance of improving how clinical staff are made a key part of decision-making and stressed the need for more transparent management and monitoring of available resources.

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

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

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

30. The consultation notes that the integrated budget will include ‘some acute hospital services’. This will be challenging for partners to define, not least as the services included may vary across the country, and NHS boards and councils will need to consider carefully the potential implications of any decision making on the local population. This section of the consultation document introduces the role of the single accountable officer and we have comments on this approach under chapter 6.
31. From the information in the consultation document there are clear potential risks and tensions around how organisations will determine which budgets will be included in the integrated budget and the implications of this for their own governance and accountability arrangements. It is essential that effective dispute resolution arrangements are in place locally.
32. In our CHP report we note that, whether budgets are aligned or pooled, organisations should be very clear about what they are trying to achieve by joining up resources. Each model has advantages and disadvantages, but it is how these risks are managed that is important. We set out the respective risks and benefits of both approaches in our 2011 CHP report (page 27, exhibit 9). It is important that where pooled arrangements are put in place that there are clear and tight legal agreements surrounding these arrangements. There is scope to learn lessons from some of these issues in England where pooled budgets are more common.
33. The consultation document sets out the option of delegation between partners. It is unclear how the governance arrangements set out elsewhere in the document, including the role of the Jointly Accountable Officer, will apply in this situation.
34. There are of course potential issues for auditing and other scrutiny arrangements as a result of these proposals. Specifically, if local partners opt to establish a body corporate there will be implications for internal and external audit arrangements. For example, the VAT status of the new body will need to be clarified and it will need to be established whether the new body is a local government or NHS body. These issues have implications for audit and inspection arrangements as well as Parliamentary scrutiny. Furthermore, the different budgeting cycles

and imperatives which apply in local government and the NHS may have implications for integrated budgets.

Chapter 6 – Jointly Accountable Officer

General comments - Current governance and accountability arrangements for CHPs are complex and not always clear. It is therefore important that transparent governance and accountability arrangements are in place for the new Health and Social Care Partnerships and existing arrangements are amended to take account of these changes. We found in our previous work that few CHPs and councils have comprehensive partnership agreements in place for delegated or joint services. It is important that the role and remit of the Jointly Accountable Officer are very clear, setting out what resources are available to the partnership and how the officer will be held to account for their use.

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

Question 14: Have we described an appropriate level of seniority for the jointly accountable officer?

35. The consultation sets out the aim of shifting the balance of care. In progressing this agenda the Scottish Government, NHS boards and councils will need to give proper consideration to the resources needed to invest in home care and preventative services, while at the same time ensuring the quality of other services is sustained, including acute NHS services, and that these services are available to those who need them.
36. The consultation sets out the proposals for a Jointly Accountable Officer who will report directly to the Chief Executives of the Health Board and Local Authority. This does address one of our concerns that the existing CHP model was not given sufficient weight to lead on key decisions about how resources were used in the local area. However, there are challenges and tensions with this proposed approach and the role and remit of the Board of the NHS board and the council elected members. For example, what happens if there are disagreements between the NHS board and council as to the performance of the Jointly Accountable Officer? What are the differences in accountability of the Jointly Accountable Officer from that of the Chief Executive of the NHS board or council? It would be useful to know how the role of the Jointly Accountable Officer will work in the event of a Body Corporate being created. As we have noted previously it is also unclear what resources the Jointly Accountable Officer will be accountable for, how these will be determined and how this arrangement fits with the existing remit of the NHS management board and the Local Authority. We are interested in how the Jointly Accountable Officer model will fit with the Lead

Agency approach in Highland. Finally, it is not clear from the consultation to whom staff will report, whether it is the Jointly Accountable Officer or to the Local Authority or NHS board.

37. It is interesting that, although not clearly set out, the Jointly Accountable Officer may be accountable for significant resources, therefore the leadership dynamic within both the NHS board and the Local Authority will be shifted by this arrangement. It is essential that there is more clarity about how the Accountable Officer will report into the NHS board and into the Local Authority and that clear performance management and accountability arrangements are put in place.

Chapter 7 – Professionally led locality planning and commissioning of services

General comments - To date, GPs, clinical professionals and social care staff have not been fully involved in service planning and resource allocation for health and social care services. The lack of influence that CHPs have had over overall resources has been a barrier to professional staff engaging with CHPs. This needs to be addressed because these professional staff influence a large proportion of the health and care budget as a result of their decisions.

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

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

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

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

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

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

38. The proposal to give clinical staff a greater role in decision making is encouraging. We found in our report on CHPs that GPs were not well engaged, therefore we welcome the proposals

for a greater role for GPs. In addition there needs to be a focus on other professional staff, for example staff with the social care service.

39. The document provides little detail about how locality arrangements might work in practice, making it difficult to respond to the questions. Although the consultation sets out a proposal to consult with local professionals about arrangements, there needs to be a real contribution from these groups to informing how resources are used and services improved. Again, there is much mention of GPs but little about social work staff and other staff in this regard. Rather than consultation, professional staff need to have a much greater and consistent role in contributing to decision making in order to improve joint working.

Appendix 1: Good governance principles for partnership working

There are several key principles for successful partnership working.

Key principles	Features of partnerships when things are going well	Features of partnerships when things are not going well
Behaviours		
<p>Personal commitment from the partnership leaders and staff for the joint strategy</p> <p>Understand and respect differences in organisations' culture and practice</p>	<ul style="list-style-type: none"> • Leaders agree, own, promote and communicate the shared vision • Leaders are clearly visible and take a constructive part in resolving difficulties • Be willing to change what they do and how they do it • Behave openly and deal with conflict promptly and constructively • Adhere to agreed decision-making processes • Have meetings if required but focus of meetings is on getting things done 	<ul style="list-style-type: none"> • Lack of leader visibility in promoting partnership activities (both non-executive and executives) • Be inflexible and unwilling to change what they do and how they do it • Adopt a culture of blame, mistrust and criticism • Complain of barriers to joint working and do not focus on solutions • Take decisions without consulting with partners • Have numerous meetings where discussion is about process rather than getting things done
Processes		
<p>Need or drivers for the partnership are clear</p> <p>Clear vision and strategy</p> <p>Roles and responsibilities are clear</p> <p>Right people with right skills</p> <p>Risks associated with partnership working are identified and managed</p> <p>Clear decision-making and accountability structures and processes</p>	<ul style="list-style-type: none"> • Roles and responsibilities of each partner are agreed and understood • Strategies focus on outcomes for service users, based on analysis of need • Have clear decision-making and accountability processes • Acknowledge and have a system for identifying and managing risks associated with partnership working • Agree a policy for dealing with differences in employment terms and conditions for staff and apply this consistently to ensure fairness • Review partnership processes to assess whether they are efficient and effective 	<ul style="list-style-type: none"> • Roles and responsibilities of each partner are unclear • Unable to agree joint priorities and strategy • Lack of clarity on decision-making processes • Partnership decision-making and accountability processes are not fully applied or reviewed regularly • Risks are not well understood or managed through an agreed process • Deal with differences in employment terms and conditions for staff on an ad hoc basis

Key principles	Features of partnerships when things are going well	Features of partnerships when things are not going well
Performance measurement and management		
<p>Clearly defined outcomes for partnership activity</p> <p>Partners agree what success looks like and indicators for measuring progress</p> <p>Partners implement a system for managing and reporting on their performance</p>	<ul style="list-style-type: none"> • Understand the needs of their local communities and prioritise these • Have a clear picture of what success looks like and can articulate this • Have clearly defined outcomes, objectives, targets and milestones that they own collectively • Have a system in place to monitor, report to stakeholders and improve their performance • Demonstrate that the actions they carry out produce the intended outcomes and objectives 	<ul style="list-style-type: none"> • Prioritise their own objectives over those of the partnership • Unable to identify what success looks like • Fail to deliver on their partnership commitments • Do not have agreed indicators for measuring each partner's contribution and overall performance or do not use monitoring information to improve performance • Unable to demonstrate what difference they are making
Use of resources		
<p>Identify budgets and monitor the costs of partnership working</p> <p>Achieve efficiencies through sharing resources, including money, staff, premises and equipment</p> <p>Access specific initiative funding made available for joint working between health and social care</p>	<ul style="list-style-type: none"> • Integrate service, financial and workforce planning • Have clear delegated budgetary authority for partnership working • Identify, allocate and monitor resources used to administer the partnership • Understand their service costs and activity levels • Plan and allocate their combined resources to deliver more effective and efficient services • Assess the costs and benefits of a range of options for service delivery, including external procurement • Have stronger negotiating power on costs • Achieve better outcomes made possible only through working together 	<ul style="list-style-type: none"> • Do not integrate service, financial and workforce planning • Unable to identify the costs of administering the partnership • Deliver services in the same way or change how services are delivered without examining the costs and benefits of other options • Have duplicate services or have gaps in provision for some people • Plan, allocate and manage their resources separately • Fail to achieve efficiencies or other financial benefits • Unable to demonstrate what difference the partnership has made

Source: Audit Scotland, 2011

Contact details

If you would like to contact us in relation to this response please contact:

Barbara Hurst
Director of Performance Audit
Audit Scotland
18 George Street
Edinburgh
EH2 2QU

Email: bhurst@audit-scotland.gov.uk