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Your Ref: Health and  
Social Care  
Our Ref:

Date 29 August 2012

**Scottish Government Health and Social Care Integration Proposal**

Thank you for the opportunity to respond to your proposal on Health and Social Care Integration.

East Renfrewshire Council is supportive of the proposals in principle and this is reflected in our response. The Minister for Health, Wellbeing and Cities Strategy has recognised East Renfrewshire's CHCP as an example of best practice when launching the consultation. We have included examples of our successes and practice within our response. Three other councils in Scotland operate a similar model to ourselves and will be able to share their own examples of best practice. We have some concerns about the proposals as they stand. If introduced they would require us to make significant changes which could damage our success moreover they do not reflect the legal structure of councils.

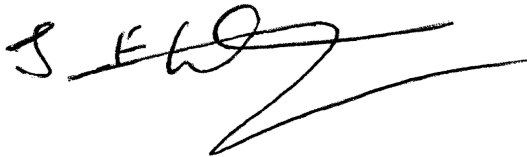
The key points we would suggest require further consideration are;

- Governance arrangements and in particular the democratic representation of locally elected members on the partnership.
- We agree in principle with the role of the accountable officer but we would suggest that it may not be appropriate for the accountable officer to make strategic decisions to refocus significant amounts of resource without reference to the committee.
- Clarification on the partnership status of 'distinct bodies corporate' as this indicates that there may be a separate entity required which may discourage partnership working and we would strongly advise against a separate organisation.

Our response to the consultation follows with more detailed comments regarding the points above, demonstrates the excellent partnership arrangements that we have in East Renfrewshire, and provides good practice examples that other areas may be able to learn from.

Once again thank you for providing us the opportunity to respond to the consultation and I trust that you find our comments helpful to inform the development of the proposals.

Yours sincerely

A handwritten signature in black ink, appearing to read 'J Fletcher', with a large, sweeping flourish underneath.

Councillor Jim Fletcher  
Leader of East Renfrewshire Council

## Health and Social Care Integration Proposal Draft East Renfrewshire Council Response to Questionnaire

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### 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?

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Yes  No

The proposal is a practical way forward for those areas that do not already operate a partnership delivery model. However, based on our experience of developing and running a fully integrated health and social care partnership over the last six years, we would encourage partnerships to move as quickly as possible to all areas of health and social care including criminal justice and children's services.

A fully integrated partnership arrangement makes it easier for the Chief Social Work Officer to carry out their proper officer role without having their responsibility fragmented across the council.

We would suggest that there should be some flexibility for local areas to develop the model of integration that best meets their local needs and circumstances. In East Renfrewshire we are well placed to exceed the proposals and to dis-integrate could potentially present a number of difficulties.

From the outset East Renfrewshire CHCP has focused on improving outcomes for East Renfrewshire residents, improving health and wellbeing and reducing inequalities. Whilst much of this work has been through strategic commissioning and redesign of CHCP's services, an equally important element has been achieved through the community planning partnership and wider Council, in partnership with the third and independent sector.

As we move towards more of a focus on early intervention and prevention,

the importance of the new integrated health and care partnership being fully comprehensive and embedded within the community planning partnership cannot be under estimated. As a part of a fully integrated CHCP, our Health Improvement Team has provided support and encouragement to the wider Council and community planning partners with our public health role and we suggest this is a model that others might wish to adopt.

## 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?

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Yes  No

Clearly we are of the view that the proposal would be more comprehensive if it included children and family services, health improvement and criminal justice. We have in place many of the elements outlined in the framework

- East Renfrewshire CHCP is a concurrent partnership it operates as a sub committee of both East Renfrewshire Council and NHS Greater Glasgow and Clyde
- East Renfrewshire CHCP is accountable to both organisations for its performance. This is reported to the Scottish Government through the SOA and for HEAT by NHSGGC.
- The CHCP Director is jointly appointed and accountable to both the East Renfrewshire Council and NHSGGC Chief Executives
- Through care group planning and commissioning the CHCP has shifted resource from institutional to community provision and is working to increase community capacity building.
- Clinical and social care professionals and public partnership representatives are members of the CHCP Committee currently with voting rights although these have not been formally used. Representatives of all these groups along with third and independent sector are part of care group planning arrangements

However we would look for clarification on the partnership status of 'distinct bodies corporate' – does this mean they will be a separate entity rather than

a joint Council and NHS arrangement? We believe that the setting up of a separate organisation may actually discourage partnership working, with the new organisation being seen as separate from the Council and NHS rather than a core part of both organisations therefore we would strongly advise against a separate organisation.

When East Renfrewshire CHCP was established, the Council and NHS partners agreed that it would bring together NHS and local authority responsibilities to form an integrated partnership but in a way that retained clear individual agency accountability for statutory functions, resources and employment issues. It is a partnership organisation not a separate, new entity. We believe the model developed and working in East Renfrewshire provides a proven model on which to base the new partnerships.

### **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?

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Yes  No

We would welcome this approach as it streamlines performance reporting requirements and enables the integrated service to focus on achieving one set of outcomes.

Locally, this will improve our 'golden thread' approach to performance planning and management that we currently have in operation across the CHCP and other council services. When the CHCP was established in East Renfrewshire, the CHCP Committee became a formal part of the community planning structures. The Director represents the NHS at community planning meetings (in Glasgow and Clyde NHS, it would be impossible for NHS GGC Chief Executive to attend all 8 community planning partnerships). The Director leads the NHS contribution to the SOA, making this a very simple and efficient process.

We are concerned that there is a move towards developing additional HEAT targets, which will skew the focus of our NHS partners away from the single

set of outcomes suggested in this proposal.

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

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Yes  No

We would welcome the identification of national outcomes for adult health and social care and that these should be included in the Single Outcome Agreement. However we should emphasise that the national outcomes should truly be outcome measures, not detailed activity measures as is often the case for HEAT targets, allowing local partnerships to determine the best way to improve outcomes in their local areas. Local Partnerships as part of the SOA process should also be able to set indicator targets that reflect the needs and challenges in their local communities.

### **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?

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Yes  No

Whilst the overall principles of joint accountability are sound, the specific proposals are not workable in terms of the legal framework for councils in Scotland. No councillor including the leader can take a formal decision making role in isolation. All accountability is through the Council (or a committee of the Council). Whilst it is reasonable to expect the leader and board chair to represent their organisations, this is different from an accountability role with an expectation that they can instruct action.

We cannot see the advantage of the complex tripartite arrangements in the proposals and do not believe that they fully reflect the role of the council leader. Also the potential loss of the Council leader on the CHCP Committee as a result of these proposals would be a disadvantage. The proposed joint accountability arrangements seem overly complex and unworkable. For example, if a joint meeting between the minister, leader and board chair is required each year, this will involve a large number of meetings. We feel that a risk based "by exception" model whereby the various parties meet if required to jointly consider how to improve performance would be more appropriate.

The proposal also confuses the role of the accountable officer for delivery and the role of the committee for strategic decision making. The proposal could be interpreted as giving the accountable officer a level of delegated authority well in excess of any other officer in the public sector. The accountable officer will need a very clear reporting line to the committee. The committee should have responsibility for setting the strategic direction and then scrutinising performance and the accountable officer responsible for ensuring delivery of the agreed programme of work.

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

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Yes  No

Our experience to date has been successful therefore we do not believe there is a requirement to establish a partnership across more than one authority. Our current arrangements are detailed in question seven below.

We can see no merit in extending beyond a single Local Authority either in terms of outcomes for local people or local accountability and believe that such arrangements would lead to increased bureaucracy.

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

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Yes  No

On balance, we agree with the proposed committee arrangements to ensure governance, but we are concerned that these must ensure local accountability through elected member representation. We have detailed our current approach which works successfully and would suggest that a localised approach be taken in governance.

Our CHCP committee has five elected members. One of whom is the Leader of the Council. The five elected members act as a committee of the Council that meets concurrently with the overall CHCP committee. The five elected members represent the political spectrum of the Council and are very involved in the work of the Committee, ensuring it is a very important part of the Council's governance structure. The Leader's involvement as a committee member is also crucial. The NHS CHCP Committee membership includes two non-executive directors of the Board of NHS Greater Glasgow and Clyde and a number of others from professional, staff, and public

representative groups.

Our CHCP committee Chair is an elected member of our Cabinet as the Convenor of Social Work and Health and is also a non-executive Board Member of NHSGGC. He is therefore accountable to both organisations. We feel that this avoids the need for alternating chairs.

At the meeting there is no distinction between social care and health papers with elected members contributing equally to both agendas. Indeed most papers involve both social work and health input.

Our Public Partnership Forum is a key element to our current arrangements and we would not want to lose this benefit. Likewise with the engagement and input from a range of professionals. The proposal suggests that they will still have a role to play but not have voting rights.

We agree that Health Boards and Local Authorities should be held jointly and equally accountable however we are concerned about the potential limit of three elected members and the impact of this on our existing successful governance structures. Whilst we acknowledge that this may present some difficulties for our NHS partner, we do feel that partnerships should be given local discretion in terms of membership.

**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?

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Yes  No

We believe that public reporting of progress towards agreed national outcomes is the best way of ensuring accountability. We do not believe that the proposals provide enough clarity on reporting.



Performance reporting is well established within East Renfrewshire, we report six monthly at a joint meeting with the Chief Executive of the local authority and the Chief Executive of NHSGGC, any areas of concern have an action plan agreed to improve performance. The results of this scrutiny along with quarterly performance reports form part of the performance reporting to CHCP committee. We also have performance scrutinised by external bodies such as the Care Inspectorate.

We would wish to continue with this successful arrangement however the proposals on performance management require some further clarity regarding scrutiny arrangements.

**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?

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Yes  No

Partnerships must have the opportunity to include all health and social care functions. A number of very successful partnerships already operate with this model and they must be allowed to continue.

Currently our CHCP covers all social care and local health care services and has the budget for these areas. This arrangement works well and we wish to continue with this model. We endorse the proposal to provide flexibility to local partners to determine the scope of arrangements but would encourage all partnerships to move towards a fully integrated model.

### **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?

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Yes  No

1. We consider that it is helpful for the partnership to oversee local health and care budgets including budgetary mechanism to move resources from acute hospitals into the community. We are attracted by the idea of resources losing their badge and the ability to focus money on the needs of local residents. East Renfrewshire CHCP manages aligned health and care budgets as detailed in Question 11. Whilst there are some complexities and

bureaucratic difficulties, there are areas where modifications to current arrangements would deliver more effectiveness and transparency, and with commitment from both partner organisations the issues can be reviewed and remedied. They should however be regarded as marginal in comparison to the scale of the consultation proposals. Essentially current arrangements within East Renfrewshire CHCP operate well and subject to their modification and development may not require the extent of change as suggested within the consultation to achieve the objectives of the consultation.

**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?

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Yes  No

East Renfrewshire CHCP is allocated funding on an agreed basis for the defined range of functions, by the Council and NHSGGC. Those budget allocations are based on synchronised planning processes and a transparent approach to addressing identified pressures and issues. The CHCP Committee sets budgets for its activities within the overall allocation. The CHCP Health and social care budgets are not pooled but aligned, allowing a clear track of expenditure to the allocating body. The scheme of establishment and subsequent financial agreements allows for a process to be agreed for virement between these budgets provided this is justified, reported for approval to the Council Cabinet and notified to NHSGGC. Through constructive partnership working it has not been necessary to utilise this facility. In addition East Renfrewshire Council and NHSGGC have worked together through different capital planning processes to agree investment in two major capital projects for Barrhead and Eastwood Heath and Care Centres.

The CHCP Finance Business Partner manages both budget meetings regularly with Council and NHS Finance Managers. Regular budget meetings held with CHCP Heads of Service and their management teams incorporate discussions on both NHS and Council budget allocations, allowing a view across the full extent of their aligned budget.

There are some complexities within the current set-up however as the NHS and Council operate different financial systems and reporting cycles, and follow different procurement and VAT rules. As the budgets are held within the separate systems of the allocating body. This necessitates cross-

charging between the NHS and Council, and along with management of Resource Transfer funding can be argued to be an inefficient use of finance team resource. We would welcome opportunities for streamlining this.

While the overall financial position is monitored and reported to CHCP Committee, separate monitoring and reporting arrangements exist for NHS and Council. Within each of these separate reporting arrangements, variances across care groups are reported however the net expenditure position is the focus.

**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?

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Yes  No

Our Scheme of Establishment sets out in exact detail the services and budgets delegated by the partners to the CHCP. This process was very helpful in setting parameters for the CHCP's responsibilities, from this experience we would support clarity at the outset. Subsequently the range of NHS services managed locally has increased with changes agreed through negotiation and joint planning across NHSGGC, Therefore we would recommend that any direction is not embedded in the legislation but in the supporting guidance. However we would ask for greater clarity re the acute hospital resource and that there be a transparent, consistent, robust and workable approach to its allocation and how local partnerships are enabled to shift the balance of care

### **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?

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Yes  No

In principle we agree but more work needs to be done on developing and defining the details of the financial authority of the accountable officer and the role of the committee also requires to be taken into consideration. Whilst it is appropriate for the accountable officer to make operational decisions based on the best interest of the patients/residents, it may not be appropriate for the accountable officer to make strategic decisions to

refocus significant amounts of money without reference to the committee, especially if this would change the strategic direction, previously agreed by the committee.

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

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Yes  No

We currently have a joint accountable officer and the post is successful. The Director of the CHCP is employed by the Council and is a Director of the Council. She also has an honorary contract with the NHS. She is directly accountable to the CHCP committee, the Chief Executive of the Council and the Chief Executive of NHSGGC. Six monthly departmental reviews and individual objective setting and reviews are carried out jointly.

Our experience demonstrates that this arrangement works particularly well and we would suggest that this and an integrated management team is critical to the success of the integration.

For the Joint Accountable Officer job role to be successful it is important that there is agreement on the role and responsibilities between the Health Board and Local Authority. The accountable officer needs to have the appropriate authority to discipline Health Board and Local Authority staff. In East Renfrewshire this is managed by the Director holding an honorary contract with NHSGGC.

There are issues with regards to dealing with employees on two different sets of terms and conditions and job evaluation schemes. How do we fairly advertise jobs which when processed through two different job evaluation schemes give different salary ranges? It would be beneficial to have guidance in this area of job evaluation, job transfer and secondments between the Health Board (NHS) and Local Authority (COSLA).

### **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?

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Yes  No

We accept the principle of locality planning and service delivery. In East Renfrewshire we have begun to develop proposals to redesign our older people's and rehabilitation services around clusters of GPs and a number of natural communities. However we are unclear as to what is meant by locality commissioning of services and how this relates to self directed support, strategic commissioning and procurement. We would look for further clarification on this matter in guidance.

**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?

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Yes  No

We are committed to genuine GP and professional engagement and believe that all professionals including independent contractors have a role to play in delivering the best service locally. Placing this within a duty will ensure that this is undertaken.

Locally capacity, time and finance have been barriers in the engagement of clinicians, and specifically GPs. We have financed GP involvement in our Reshaping Care for Older People's agenda, but it is difficult to ensure that all contractors are actively engaged. We would expect that if independent contractor involvement is made a duty that this would be appropriately resourced.

**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?

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In terms of our experience, capacity, time and finance have been barriers to the engagement of clinicians. We would suggest that planning at local level focus on the patient/customer pathway and outcomes for meaningful engagement.

In addition to funding for clinical involvement there is a need for additional resourcing; organisational development; and training and education for partners' and partnership management and front line staff.

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

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Yes  No

We believe that there needs to be the right balance of practice and resident population for service delivery. In East Renfrewshire we have begun to develop proposals to redesign our older people's and rehabilitation services around clusters of GPs and a number of natural communities. It should be noted that 15,000 of our 90,000 residents have GPs outwith East Renfrewshire and that there is a health centre in our geographic area which is currently part of South Glasgow CHP as the majority of its patients are from that area. We would suggest that due to these complexities that there is need for local flexibility to determine the most appropriate locality arrangements

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

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We believe that locality planning is useful for operational planning but not suitable for agreeing strategic directions. Clarification of the matters raised in question 15 will help us form a view.

From our experience of strategic commissioning for Reshaping Care for Older People we would note that this is resource intensive for a variety of organisations and that independent and third sector organisations do not have the capacity or the resource to sustain this on a locality basis.

Equally we have a strong relationship with our Public Partnership Forum and we envisage their role will be paramount to the successful delivery of the proposals and in line with the principles of co-production. Duplicating strategic planning processes at a locality level will pose difficulties for their volunteer base.

**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?

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Yes  No

In East Renfrewshire, we are currently working to three cluster areas with population sizes of approximately 25,000-35,000 but again would suggest that this is left to the determination of local partnerships.

**Do you have any further comments regarding the consultation proposals?**

East Renfrewshire Councillors have been very happy with the commitment there has been given over the last six years to embed an integrated CHCP in East Renfrewshire and the results have been improved outcomes for local people. There is concern that this success could be lost if the guidance from Scottish Government affected the current arrangements in East Renfrewshire and we would propose that local areas who have demonstrated a significant commitment to this agenda and can evidence the characteristics of successful integration are given flexibility so they can implement and continue in a method that fits with their own circumstances.

**Do you have any comments regarding the partial EQIA?**

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**Do you have any comments regarding the partial BRIA?**

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