Integration of Adult Health and Social Care in Scotland

Consultation: Scottish Government Response

February 2013

The Scottish Government
Riaghaltas na h-Alba

Foreword

My predecessor as Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon MSP, set out clearly in her foreword to the consultation on integrating adult health and social care her support for this ambitious, necessary and important programme of reform. I wholeheartedly endorse that vision and commitment to improvement, and I want to take this opportunity to affirm my support for the proposals that have now been thoroughly consulted upon.

The shape of Scottish society is changing. The 2011 Census[1] shows us that, for the first time, our population aged over 65 is greater in number than the population aged under 15. People in Scotland, as in other developed nations, are living longer, healthier lives, and we are benefitting from the great strides that have been made in healthcare and standards of living over recent decades. Such a significant change in our population inevitably brings challenges too, however, which are well recognised and were described in detail in the consultation.

As responses to the consultation make clear, the Scottish Government is not alone in recognising that, as society's needs change, so too must the nature and form of public services. Only by making sure that public services evolve effectively can we ensure that people receive the support they need, and that resources are used to best effect across all population groups, whatever their age or circumstances.

That is why integration of adult health and social care is a key part of the Scottish Government's commitment to public service reform in Scotland, and why what we achieve with this programme of reform matters to everyone in Scotland.

Our population may be getting older, but integration of adult health and social care is about far more than looking after older people better, as important as that is:

[1] http://www.scotlandscensus.gov.uk/en/

- It is about improving outcomes for people who have a range of complex support needs, and for their carers and families as well. Too often in these circumstances people are admitted to hospital, or to a care home, when a package of care and support in the community could deliver better outcomes for them. When that happens, the costs are human and financial, and the consequences are not just personal; they are felt across the whole system and by other people, as resources are tied up inappropriately in care that is not best suited for the individual.

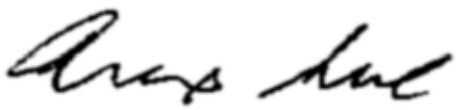
- It is about putting the leadership of clinicians and care professionals at the heart of service delivery for people with health and care support needs.

- Perhaps most ambitiously, it is about establishing a public service landscape in which different public bodies are required to work together, and with their partners in the third and independent sectors, removing unhelpful boundaries and using their combined resources, to achieve maximum benefit for patients, service users, carers and families.

Later this year the Scottish Government will introduce a Bill to the Scottish Parliament to integrate adult health and social care. This response, which has been agreed with my Cabinet colleagues, will give you further insights on my plans for the Bill. We are clear that legislation alone will not be sufficient to achieve our aims in this area, but it will provide the national leadership necessary to create the context within which our ambitions can be achieved.

I am very grateful to everyone who has responded to this consultation, whether via a written reply, or by taking part in the wide-ranging discussions that contributed to the development of the proposals, in the discussions of the proposals that followed publication of the consultation, or in the work that is ongoing to turn the proposals into practical reality.

We have a great deal more to do to make good on our ambitions. I am looking forward to working with you to improve the services we deliver, and the outcomes we achieve, for the benefit of people who use health and social care services and for the improvement of public services generally in Scotland.



ALEX NEIL, MSP
CABINET SECRETARY FOR HEALTH AND WELLBEING

Introduction

1. In May 2012, following an announcement by the then Cabinet Secretary for Health, Wellbeing and Cities Strategy in December 2011, the Scottish Government published a consultation on proposals to integrate adult health and social care[2].

2. The consultation concluded in September 2012, and the Scottish Government published an analysis report of responses[3] in December 2012.

3. This paper provides a summary of the Scottish Government's response to the key points made by respondents to the consultation, and describes Ministers' thinking with regard to the Bill that will be introduced to the Scottish Parliament later in 2013. It addresses points made in the written responses that were submitted and also draws together a number of key observations that have been made to Ministers and officials during the period of consultation, during public discussion events and at other meetings.

4. The Scottish Government notes its thanks to all individuals, groups and organisations that provided a response to the consultation.

How this response is organised

5. This response is organised to match the chapter headings of the consultation document:

- The case for change – whom to legislate for?;
- Outline of proposed reforms – what to legislate for?;
- National outcomes for adult health and social care;
- Governance and accountability;
- Integrated budgets and resourcing;
- Jointly Accountable Officer; and
- Professionally led locality planning and commissioning of services.

6. In each section, we summarise the main points that have been made by respondents and then describe Scottish Ministers' response.

[2] Integration of Adult Health and Social Care in Scotland: Consultation on Proposals http://www.scotland.gov.uk/Publications/2012/05/6469
[3] Integration of Adult Health and Social Care Consultation Analysis Report http://www.scotland.gov.uk/Publications/2012/12/1068

The case for change – whom to legislate for?

7. The consultation proposed that legislation should apply to adult health and social care services, with a particular focus at first, via performance management, on improving outcomes for older people.

What we heard

8. In general terms, respondents agreed that there is variation in the quality of service for people and their support networks across Scotland.

9. Respondents observed, clearly and consistently, that it would not be a good idea to restrict integration to services for older people as defined by age. While acknowledging that there is a strong correlation between long-term conditions and age, respondents felt that it would be better if approaches to integration were considered in terms of people's wellbeing and state of health, and the complexity of their needs, rather than in terms of chronological age.

10. Many respondents also said that it would be better to consider taking a whole system approach to integration, and therefore including children's and young people's services, rather than solely focussing on integration of older people or adult services.

The Scottish Government Response

11. We recognise that there is variation in terms of support provided to people, as noted by respondents. This programme of change seeks to address those concerns and challenges by reinforcing the importance of effective partnership working within a statutory context. By making these proposed changes, we are looking to remove the bureaucratic and financial barriers that exist within the current system for delivering adult health and social care services, and to ensure clear accountability for the delivery of national outcomes, providing transparent performance information for different areas in Scotland.

12. Whilst legislation cannot address all the organisational and cultural issues that currently challenge delivery of these services it can ensure that all communities in Scotland are set within a single outcomes framework. Improvement, performance and scrutiny mechanisms will also play an important role in enabling the public sector and its partners to judge progress, share best practice and address poor performance.

13. We recognise that the point about focussing on people's wellbeing and state of health is well made, and provides a stronger approach than one that depends on groupings defined by chronological age.

14. There is nevertheless an important early priority for us to address in terms of improving outcomes for adults with multiple long-term conditions and complex support needs. Many of those people are older. It is important that we improve outcomes for people with such needs, for their wellbeing and also

to ensure that the whole health and social care system works effectively for everyone who needs support. That is why our proposals put the person at the centre of service planning and delivery, and will look to ensure that health and social care support is integrated around their needs.

15. Current arrangements around Scotland provide a range of examples of models of children's services, some standalone, some successfully integrated with adult health and social care services, and others where links are closer with education services.

16. The Scottish Government believes that local partners (Health Boards and Local Authorities) will be best placed to decide whether children's services should fall within the scope of these new arrangements. **It is therefore our intention to legislate to require Health Boards and Local Authorities to integrate health and social care services for all adults.** We believe that integration of service planning and delivery is the most effective way to support person-centred care. We intend to legislate so that, in future, the Scottish Government can extend the range of areas of service provision that must be included in the integrated arrangement.

17. Whichever approach is taken to integration in different areas – to integrate only adult services, or adult and children's services at the same time, or in sequence – we will look for focussed improvement in outcomes, and a shift in provision of care from institutions to communities, for adults with multiple support needs. This is not to diminish our focus on assuring good outcomes for other groups of people as well, but to achieve parity of focus on the needs of frail older people and other adults with multiple complex needs for care and support. This outcomes-focused approach will be applied to children's services through provisions in the Children and Young People Bill on the joint planning of services to support children's well-being by local authorities and health boards.

18. Criminal justice social work has important relationships with both adult and children's services. Community Justice Authorities have responsibility for reducing reoffending, but criminal justice also features in the work of other partnerships including the small number of Community Health and Care Partnerships that currently exist. The Scottish Government is currently consulting on the future of community justice structures and a consultation paper was published on 20 December 2012 which sets out possible options for change. The consultation period will last until 30 April 2013 with a view to the Scottish Government making an announcement on the way forward in late 2013, and subject to Parliamentary approval, implementation from 2016 onwards. Local partners will need to take into account developments in criminal justice, as it progresses, when determining the scope of services to be included in their local arrangements.

Outline of proposed reforms – what to legislate for?

19. We asked whether the proposed scale of the framework for integration was comprehensive enough.

What we heard

20. There was general consensus that, if the integration agenda is to be community driven, its scope should be widened to include other services beyond health and social care, particularly housing services. In particular, it was felt that early intervention, preventative and anticipatory care could be planned for better and more effectively if a wider range of services were included within the framework for integration.

21. Urban areas in particular were concerned about the future location of homelessness services, especially when this function was part of the Local Authority's social work service. This was usually the case when the Local Authority's housing stock had been transferred to an external body.

The Scottish Government Response

22. We recognise the importance of public, third and independent sector partners working together more effectively, with users and carers, to plan for and provide services that take account of people's broader circumstances.

23. As with whom to legislate for, we do not in general terms want to limit the potential benefits of integration by creating legislation that only applies to certain areas of service planning and provision. At the same time, however, we do not want to undo current arrangements for joint and collaborative working that already function well, and are aware that there is a particular challenge we must address urgently in relation to the interface between health and social care for adults with multiple support needs.

24. We know from examples of well integrated services in Scotland and elsewhere that, where there is good local leadership and commitment to partnership working, strong and effective links are maintained across the wide scope of public service delivery. Integrating adult health and social care in order to address the 'fault line' described in the consultation should not mean that effective working arrangements with other areas of service are diminished or marginalised.

25. **It is our intention to legislate to require Health Boards and Local Authorities to integrate health and social care services for all adults, and to leave it to local agreement to decide whether to include other areas of service, such as housing or children's services, within the scope of the integrated arrangement.** As we look for the improved outcomes and shift towards community provision previously described, we will expect to see evidence of strong partnership working with other relevant areas of service, and evidence that staff are supported to develop the necessary skills for an effectively integrated health and social care environment.

National outcomes for adult health and social care

26. We asked whether the proposed statutory mechanism of national outcomes, with their inclusion in Single Outcome Agreements, would be strong enough to deliver this change.

What we heard

27. Respondents were generally supportive of the proposed use of health and social care national outcomes, and their inclusion in Single Outcome Agreements to provide a consistent framework across Scotland.

28. There was general support for the principle of 'joint and equal accountability' for delivery of outcomes across Health Boards and Local Authorities.

29. Where concern was expressed regarding nationally agreed outcomes, it was generally to note that their existence should not crowd out the importance of local understanding of need, and local agreement of appropriate local outcomes and measures.

30. Third sector respondents in particular noted the importance of focussing on a rights-based approach rather than a needs-based approach.

The Scottish Government Response

31. We agree that it is important to achieve a balance of nationally agreed outcomes – in order to provide some assurance of consistency and quality – along with locally determined and agreed priorities. Local communities, and the professionals supporting them, are best placed to understand local needs.

32. In order to be meaningful and achievable, nationally agreed outcomes must be able to evolve over time.

33. We agree with the principle that nationally agreed outcomes should be defined in terms of individuals' experience of wellbeing, independence and control over how they wish to live their lives. We believe that this approach provides the most effective means via which to achieve a shift in outcomes for individuals in their day-to-day experience of health and social care support.

34. **It is our intention to legislate for the principle that Health and Social Care Partnerships should be held to account for their delivery of nationally agreed outcomes.**

35. The nationally agreed outcomes themselves will be agreed in partnership with partners in the public sector, and with input from stakeholders in the third and independent sectors.

36. There will be an expectation on Community Planning Partnerships to include the nationally agreed outcomes for adult health and social care in

Single Outcome Agreements, along with such other outcomes and measures as are agreed locally.

Governance and joint accountability

37. We asked for your views on arrangements for governance and joint accountability of Health and Social Care Partnerships.

What we heard

38. There was general support for the principle of joint and equal accountability, although we heard from many people that competing organisational and political priorities could create obstacles to improved delivery. Many people noted that effective dispute resolution mechanisms would be important, as would improvement support arrangements.

39. A number of responses highlighted the need for co-ordinated external scrutiny of the new arrangements to ensure that they deliver the expected improvement in outcomes, and to provide transparency in terms of the way outcomes are reported and compared.

40. Some respondents noted that the proposed committee arrangements for Health and Social Care Partnerships were dominated by the statutory partners, and did not provide for sufficient involvement from the third and independent sectors, or from carer, user and public representative groups. In particular, some respondents felt that the proposed committee arrangements should allow for voting by non-statutory members.

41. Some respondents asked for greater flexibility in terms of the number of committee members that could be appointed. This was particularly the case where respondents were providing views from larger Local Authorities.

42. Some respondents noted that it should be possible for more than one Local Authority to be part of a single Health and Social Care Partnership with a Health Board.

43. Many respondents noted that accountability for the effectiveness of the Health and Social Care Partnership should be to the full Council and Health Board, not to the Council Leader, Health Board Chair and Ministers.

44. We were asked whether, when the delegation to a body corporate model of financial integration is used, the new Health and Social Care Partnerships would in fact be ‘third bodies’ in addition to Health Boards and Local Authorities, to what extent they would operate autonomously from their parent bodies, and whether they would be employers of staff.

45. We were asked whether, when the delegation to a body corporate model of financial integration is used, the Scottish Government would distribute funding directly to Health and Social Care Partnerships, or whether it would flow via the Health Board and Local Authority.

46. We were not asked many questions about the delegation between partners model. We have, however, provided some further information here on this approach.

47. We were also asked about the relationship between Health and Social Care Partnerships and Community Planning Partnerships. Would one hold sway over the over?

The Scottish Government Response

48. In some areas, competing organisational and political priorities currently have a negative impact on effective delivery of services, and outcomes for people. Representatives of the third sector, users and carers, in particular, highlighted examples of this over the course of the consultation, and Audit Scotland note such tensions in a number of reports[4]. Statutory partners are also aware of the difficulties that exist within current configurations of service provision, and report experience of struggling to overcome them.

49. We recognise the very valuable role that is played by the third and independent sectors in providing good quality support to people, working in partnership with other partners. We believe that, by legislating to place Health Boards and Local Authorities under a duty to work together effectively and in collaboration with key stakeholders, such as the third, independent and housing sectors, to deliver nationally agreed outcomes, we can establish a public sector environment where there is the correct expectation that public bodies will overcome such difficulties in order to deliver better outcomes for individuals.

50. We agree that it will be important to ensure effective improvement support and dispute resolution mechanisms are in place. It is our intention to build these on the good groundwork that already exists, and on the role of Local Authorities, Health Boards, and Scottish Government itself, to ensure that difficulties are addressed and local leaders work together to resolve challenges.

51. An essential part of this process will be the role of external scrutiny. We are committed to working with statutory partners to ensure that co-ordinated scrutiny arrangements are in place to assure effective delivery of services, and to identify areas where improvements to outcomes should be made.

52. Effective, appropriate, joint governance of Health and Social Care Partnerships will be of key importance regardless of which model of integration is used. Work is ongoing with partners and stakeholders regarding the detail of how committee arrangements should work in each of the two models of integration described in the consultation, in order to ensure an

[4] Review of Community Health Partnerships, Audit Scotland, 2011
Transport for health and social care, Audit Scotland, 2011
The role of community planning partnerships in economic development, Audit Scotland, 2011
Commissioning social care, Audit Scotland, 2012
Health inequalities in Scotland, Audit Scotland 2012

appropriate balance of consistency and local flexibility. We are clear on a number of points at this stage, and these are described in greater detail below.

53. In terms of voting rights on the Health and Social Care Partnership Committee, we remain mindful of the significant statutory and budgetary responsibilities of the Local Authority and Health Board. It is also of particular importance that Health Boards and Local Authorities together devolve planning and decision-making for adult health and social care into the integrated Health and Social Care Partnerships. We believe that decision-making will only be effectively delegated to Health and Social Care Partnerships if Local Authorities and Health Boards remain confident that all voting Committee members are publicly accountable for their decisions.

54. Having said that, we do not want to confuse accountability with influence, or, indeed, insight and innovation. We recognise that current, effective integrated arrangements tend to see very few votes actually taken 'in committee'. In general, where there is strong local leadership and commitment to effective involvement of individuals and communities working across health and social care, agreement is reached via discussion and consensus, rather than by putting individual matters to a vote. We recognise that good discussion, and effective, positive consensus, will only be achieved where it is informed by the local expertise of professional, carer, user and public representatives.

55. **It is therefore our intention to legislate for committee arrangements that confer voting rights on statutory members of the Health and Social Care Partnership Committee, and to strengthen these arrangements by legislating to require additional membership of the committee covering professional, carer, user and public interests.**

56. Locality planning arrangements are also important in this context, and are covered later in this response.

57. In terms of numbers of committee members, we recognise the concerns of larger Local Authorities in particular about assuring appropriate breadth of membership, not least considering the sizeable proportion of their resources that are committed to the delivery of adult social care. We are also aware, however, that evidence[5] suggests that the size of committees is an important consideration in terms of ensuring their effectiveness. **We intend to legislate for the principle that Local Authorities and Health Boards will have parity of voting power on Health and Social Care Partnership Committees.** Further work is underway with COSLA, Local Authorities and Health Boards to consider how we can best ensure that Health and Social Care Partnership Committees are organised to optimise their effectiveness and efficiency, particularly in terms of numbers of members.

[5] http://www.audit-scotland.gov.uk/docs/central/2010/nr_100930_role_boards.pdf

58. In terms of more than one Local Authority forming a Health and Social Care Partnership with a Health Board, we note again that the purpose of these reforms is not to undo effective arrangements agreed locally, or already in place. **It is our intention to legislate on the basis that a Health and Social Care Partnership will be formed between one Local Authority and one Health Board, but to make provision for Ministers to consider applications for more than one Local Authority to form a single Health and Social Care Partnership with the same Health Board.**

59. We agree that accountability for the effectiveness of Health and Social Care Partnerships should be to the full Council and Health Board, and not to the Council Leader, Health Board Chair and Ministers, as stated in the consultation. Legislation will reflect this position.

60. Where a Health Board and Local Authority agree to use the delegation to a body corporate model of financial integration, the new Health and Social Care Partnerships will be new bodies in law. In these circumstances, the Partnership will be a joint Board of the Local Authority and NHS Board and will not be operating separately from the governance or influence of the two parent bodies. The parent bodies will also exercise influence over the Health and Social Care Partnership through a Partnership Agreement and joint strategic commissioning plan, which will set out the Partnership's plans to deliver the agreed services using the integrated budget.

61. Where a Health Board and Local Authority agree to put in place a delegation between partners arrangement, there will also be a Partnership Agreement and joint strategic commissioning plan. No new body is created in this situation however.

62. Where the delegation to a body corporate model is used, the body corporate will not employ staff in its own right. Staff will be employed by the parent bodies – the Health Board and Local Authority.

63. Where a delegation between partners arrangement is used, staff may transfer employment between the Health Board and Local Authority. Transfer of employment is not prescribed in this arrangement, though it may be decided locally that transfer of some staff may help to facilitate a truly integrated model of service planning and delivery.

64. Where the delegation to a body corporate model is used, funding will not be distributed to the Partnerships directly from the Scottish Government. It will flow via the Health Board and Local Authority, as per the terms of the Partnership Agreement.

65. Where a delegation between partners arrangement is used, funding is delegated from one partner organisation to the other to support delivery of delegated functions.

66. Whichever model of integration is used (delegation to a body corporate or delegation between partners), the Partnership Agreement will define the

functions that the Health and Social Care Partnership will deliver, the outcomes to be achieved and the financial input of each parent body to the integrated budget to deliver those outcomes. It will also set out the mechanisms that will apply locally to enable effective day-to-day working of the integrated budget, and local arrangements to assure accountability to the full Council and Health Board.

67. Guidance on establishing the Partnership Agreement will be provided. Work is already underway to introduce joint strategic commissioning plans in local partnerships, based on a single, integrated budget, building on the work of the Change Fund for Older People.

68. It is important to remember that the purpose of establishing these new arrangements is to deliver better, different outcomes. The imperative for change and improvement, and a shift in the balance of care, applies equally to both models of integration.

69. The relationship between Community Planning Partnerships and Health and Social Care Partnerships will not be hierarchical. Community Planning Partnerships provide a mechanism via which the different partners in public service delivery in a community come together to plan effective co-ordinated provision. Health and Social Care Partnerships, whose function will be to plan for and deliver, as a minimum, adult health and social care services, will be partners in the process of community planning. These different responsibilities must be acted upon so that they are complementary to one another in order for the improvements sought to be achieved.

Integrated budgets and resourcing

70. We asked whether you thought the models for financial integration proposed in the consultation could deliver the objectives described, whether Ministers should prescribe minimum budgets to be included in the integrated arrangements, and whether you had other suggestions for integrating resources.

What we heard

71. There was a general view that the two models could deliver the objectives described, allowing for previous comments regarding local challenges and competing priorities, and the need to overcome historic barriers to effective integrated working.

72. Of the two models for financial integration that were described in the consultation – delegation between partners and delegation to a body corporate – most respondents indicated a preference for the body corporate model.

73. A number of respondents, particularly from Local Authorities, noted that more than two models should be offered. No alternatives were proposed, however.

74. A consistent message came through that the choice of which model to use should be left to local determination.

75. There was a general view that Ministerial direction on budgets to be included in the integrated budget should be kept to a minimum, to allow for maximum local flexibility and decision-making. A few respondents noted a concern that, if Ministers prescribe a minimum, only that minimum would be included in the integrated budget.

76. At the same time, a strong view was reported on the importance of ensuring that sufficient and appropriate parts of hospital budgets were included in the integrated budget.

The Scottish Government Response

77. Ministers have invited COSLA to give further consideration to the question of whether further alternative models for integrating budgets are available and should be offered via legislation. We will consider suggestions in due course.

78. **It is our intention to legislate so that it is necessary for all local partnerships to reach agreement on integrated arrangements to be implemented locally, subject to the specifications described in legislation. It is our intention to make provision for arrangements to be put in place where there is local failure to agree.**

79. We are committed to including within the integrated budget resources used for the delivery of adult health and social care services, covering primary care and aspects of secondary health care and social care provision. Further work is underway to articulate services that should be included within this scope. In order to make sure that the resources allocated by the partners to the integrated budget are of sufficient scope, we intend to legislate for a minimum range of functions and associated budgets that must be included. It will be left to local determination to decide the scope of any other budgets for inclusion, potentially covering, for example, children's and housing services, as described previously.

80. Where partners agree to use the delegation to a body corporate model, the integrated budget will be formed by transfer of funding from each partner to the body corporate. Decisions on its use will rest with the Health and Social Care Partnership, within the context of the delegated arrangements defined in the Partnership Agreement. The Health and Social Care Partnership will allocate the integrated budget to the Health Board and Local Authority and, as appropriate, to third and independent sector partners, to deliver the services agreed in its joint strategic commissioning plan.

81. Where partners agree to use the delegation between partners model, the integrated budget will be formed by the transfer of funding from one partner to the other, combined with the lead partners own resource.

82. Work is ongoing with partners across health and social care to agree the detail of which categories of spend should be included within the minimum range, and to agree practical aspects of implementing integrated budget arrangements, which will be provided in guidance.

Jointly Accountable Officer

83. We asked whether you thought that our proposals for appointing a Jointly Accountable Officer in each Health and Social Care Partnership would enable the shift in outcomes we seek, and whether we had described an appropriate level of seniority and financial authority for the Jointly Accountable Officer.

What we heard

84. Respondents expressed a range of views regarding the appointment of Jointly Accountable Officers, and asked for further information on the role and remit of the post.

85. Some respondents thought that responsibility for planning and delivery of integrated services should sit with the Chief Executives of Health Boards and Local Authorities, and existing Community Health Partnership General Managers.

86. Some respondents agreed with the responsibilities of the role but questioned whether it was necessary to establish the position as a post in every Partnership. Along similar lines, we have been asked by a number of stakeholders whether the position of the Jointly Accountable Officer is to be a post, or whether it might be a role fulfilled in various ways according to different local circumstances.

87. Some respondents felt that such a role would be necessary in order to manage the integrated budget effectively.

88. There was general agreement that if Jointly Accountable Officers are appointed they need to be multi-skilled, experienced, knowledgeable and expert leaders and managers, able to operate with autonomy, wield influence and exercise authority within both statutory structures, as well as within the Health and Social Care Partnership. Many respondents expressed the view that the Jointly Accountable Officer post must be senior enough to reflect these requirements.

89. A few people have suggested to us that it is in practical terms impossible for a jointly appointed senior post to be held accountable by two different public bodies.

90. We were also asked about the impact of the Jointly Accountable Officer position on other statutory officer roles, and particularly on the role of the Chief Social Work Officer.

The Scottish Government Response

91. In the earlier consideration of governance and accountability arrangements, we reflected on the need to balance two aims: achieving real change, and a real shift in the balance of care, with the importance of assuring

proper governance of the new Health and Social Care Partnership arrangements via Local Authorities and Health Boards.

92. We are committed to the principle of integrating budgets to reflect population needs. A single budget, delegated from two partner organisations, can only be managed effectively via a single point of senior oversight and accountability.

93. In the integrated adult health and social care environment for which we plan to legislate, joint accountability at senior level is required, in simple terms, to achieve two objectives:

- To provide a point of joint accountability upwards, from the Health and Social Care Partnership, to the Partnership Committee, via which there is accountability to the full Council and Health Board; and
- To provide a single, senior point of joint and integrated management down through the delivery mechanisms in each partner organisation.

94. These arrangements work differently in the two different models of financial integration for which we plan to legislate.

95. In the delegation to a body corporate model, a single post of Jointly Accountable Officer will be required in order to fulfil both functions. We are not satisfied that the responsibilities we envisage for such a post can be effectively shared between different individuals employed by the partner organisations. That is a common situation now; its perpetuation would in all likelihood simply achieve a continuation of the status quo.

96. In the delegation between partners model, the first objective – accountability upwards, to the committee and thence to the full Council and Health Board – is provided via the Chief Executive of the host partner. So, for example, if, as in Highland, adult social care is delegated to the Health Board and children's community health services are delegated to the Local Authority, the Chief Executive of the Health Board is accountable to the Council and Health Board for delivery of adult services, and the Chief Executive of the Local Authority is accountable for delivery of children's services. Other arrangements would also be possible under this model, of course: the key point is that the Chief Executive of the 'host' partner in any such arrangement would be accountable to the Council and Health Board for delivery of the delegated services.

97. In the delegation between partners model, the second objective – joint and integrated management downwards through the delivery mechanisms of each partner organisation – is achieved via delegation of delivery of integrated outcomes from the Chief Executive to other senior staff in the host partner organisation.

98. In the delegation between partners model, therefore, joint accountability is a role fulfilled according to the delegation arrangements agreed locally.

99. We already know that it is practically possible for a jointly appointed senior post to be held accountable by two different public bodies. This kind of model is already in operation in a number of partnership areas in Scotland, albeit not yet with the full range of authority invested in the post that we envisage. In particular, we envisage greater authority and influence with respect to planning for provision of hospital services in the new arrangements.

100. Questions about the impact of the Jointly Accountable Officer position on other statutory officer roles, particularly the role of the Chief Social Work Officer, are important. We recognise the key importance of statutory roles as currently defined in legislation and have no intention of changing these.

101. This should provide firm reassurance of the Scottish Government's commitment to the Chief Social Work Officer role and to professional leadership in general. We are strongly of the view that the influence of high quality professional leaders in Health and Social Care Partnerships is central to the effectiveness of the new arrangements.

102. We are already working closely with professional leaders on this agenda, for example in revising the Scottish Government guidance on the role of the Chief Social Work Officer.

Professionally led locality planning and commissioning of services

103. We asked you for your views on how best to establish effective locality planning arrangements in communities.

What we heard

104. Respondents were in general very positive about the principle of establishing locality planning arrangements for the commissioning of services designed to meet the needs of local communities.

105. Most respondents felt that the best way to make locality planning work would be to allow local development and implementation of arrangements with local leaders and stakeholders.

106. There was agreement with our proposal to include within legislation a duty on Health and Social Care Partnerships to work with stakeholders to develop locality planning arrangements, but we have heard a consistent message that this duty should be stronger than suggested. The duty on Health and Social Care Partnerships should be to 'engage with and involve', rather than merely to 'consult' local professionals, across extended multi-disciplinary health and social care teams and the third and independent sectors, regarding how best to put in place local arrangements for planning service provision.

107. Respondents expressed the view that, in order to encourage active participation of clinicians and social care professionals in planning service provision, they would need to have a clear understanding of the requirements of their localities. Some respondents also added that Health and Social Care Partnerships should be strengthened by setting up joint professional and stakeholder advisory input to contribute to the development of joint strategic commissioning plans. It was suggested that structured support for stakeholder involvement would be required.

108. Opinions were split regarding locality planning being organised around clusters of GP practices. Whilst many supported this approach in principle, many respondents supported locality planning being developed at the level of 'natural communities'. There was also a consistent view that the size of localities should be determined locally. There was a mixed view of the level of devolved responsibility for decision-making to localities. The strongest proponents of devolved decision-making came from professional membership organisations, Local Authorities and public representative bodies.

The Scottish Government Response

109. We believe that the success of locality planning arrangements will be absolutely central to the success of these proposals in the round. The criticality of this part of the proposals also presents a challenge. We believe that locality planning, by definition, can only work effectively if its

arrangements are agreed and implemented locally. At the same time, it is important to us to make sure that we achieve some degree of consistency in terms of improved outcomes via locality planning.

110. We also believe that locality planning offers a particularly significant and important opportunity for the effective involvement and leadership of non-statutory partners in the delivery of services in the third and independent sectors, and for representatives of patients, people who use services, and carers.

111. These are high expectations for an aspect of the proposals over which we believe the role for centrally directed arrangements should be kept to a minimum, and they bring particular challenges for the creation of effective legislation.

112. **It is therefore our intention, as respondents have suggested, to legislate for a duty on Health and Social Care Partnerships to 'engage with and involve', rather than merely to 'consult' local professionals, across extended multi-disciplinary health and social care teams, the third and independent sectors, and for representatives of patients, people who use services, and carers regarding how best to put in place local arrangements for planning service provision.**

113. Beyond that requirement, we do not intend to legislate for the specific form or nature of locality planning arrangements, preferring to leave that to guidance and local determination.

114. However, we think there is an important role for central government in helping different Partnerships learn from one another about different approaches to locality planning and we will look for ways to support that flow and exchange of knowledge and experience.

115. We also believe that it is important to ensure that other arrangements are in place between central government and professionals – for example, development and implementation of the more Scottish GP contract. This and other initiatives support and encourage our aspirations for locality planning, and we will continue to work on these in partnership with stakeholders.

Conclusion and next steps

116. We are grateful for all of the input we have received on the important questions raised in this consultation.

117. As previously mentioned, a range of work is underway, with vital input from stakeholders across health and social care, to help ensure our ambitions become practical reality. We are also working to make sure we are fully alert to, and proactively addressing, any potential for wider impact or additional opportunities for improvement that may arise as we take forward this programme of reform.

118. There are various working groups overseeing this work[6].

119. The next step for this area of policy development will be introduction by the Scottish Government of a Bill to the Scottish Parliament before the summer of 2013.

[6] Scottish Government Integration of Health and Social Care web page http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration

ISBN: 978-1-78256-341-9 (web only)

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Produced for the Scottish Government by APS Group Scotland
DPPAS13808 (02/13)

Published by the Scottish Government, February 2013