



The Scottish Parliament
Pàrlamaid na h-Alba

HEALTH AND SPORT COMMITTEE

AGENDA

24th Meeting, 2013 (Session 4)

Tuesday 3 September 2013

The Committee will meet at 10.00 am in Committee Room 6.

1. **Decision on taking business in private:** The Committee will decide whether to take item 3 in private and whether its consideration of the Committee's approach to scrutiny of the Scottish Government's draft budget 2014-15 and its report to the Finance Committee should be taken in private at future meetings.
2. **Public Bodies (Joint Working) (Scotland) Bill:** The Committee will take evidence on the Bill at Stage 1 from—

Ian Crichton, Chief Executive, Simon Belfer, Director of Finance and Business Services, and Professor Marion Bain, Medical Director, NHS National Services Scotland;

Peter Reekie, Director of Finance, The Scottish Futures Trust.

3. **Draft Budget Scrutiny 2014-15:** The Committee will consider a list of candidates for the post of adviser in connection with its forthcoming scrutiny of the Scottish Government's Draft Budget 2014-15.

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SPICe Briefing

Public Bodies (Joint Working) (Scotland) Bill

30 August 2013

13/50

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The Public Bodies (Joint Working)(Scotland) Bill is attempting to implement the Scottish Government's commitment to achieve greater integration between health and social care services. Integration is seen as a way of improving both the quality and efficiency of services.

This briefing sets out the back ground to the Bill and its key provisions. It also provides a summary of the evidence received to the Health and Sport Committee's call for evidence.



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EXECUTIVE SUMMARY

The Bill seeks to achieve greater integration between health and social care services in order to improve outcomes for individuals and to improve the efficiency of services.

There is no single definition of what constitutes integrated care but the term is commonly used to refer to the joined up delivery of health and social care services. Integration is viewed as a way of tackling a number of problems such as unscheduled admissions to acute care, delayed discharges, budgetary battles between bodies, delays in accessing care and duplication of efforts. It is also seen as a way of 'shifting the balance of care' from the expensive acute sector, to care in less expensive community settings. More money is spent by the NHS in caring for emergency admissions in people over 65, than local authorities spend on social care for the same group (£1.32bn versus £1.27bn).

The concept of integration is not new to Scotland and the Bill is the latest in a line of attempts to achieve integrated care. Previous attempts have included the Joint Futures Group and the creation of Community Health Partnerships. The research evidence on integration has shown that there is little evidence that integration improves outcomes for individuals or that structural integration delivers the anticipated service improvements. However, research has found some key factors for success. These have included leadership, a clear vision and involvement of service users.

The Bill proposes to require health boards and local authorities to create an integration plan for the local authority area. This will be required for adult services but other services may also be included. The integration plan would be required to detail which model of integration had been chosen. The bill outlines two models available, these are: 1.) The body corporate model, where the health board and local authorities would delegate functions to a joint board headed by a chief officer, and 2.) The lead agency model, where local authorities and health boards can delegate functions to each other under the oversight of a joint monitoring committee.

The Bill also sets out principles that should guide the creation of integration plans and Ministers would regulate for the creation of national outcomes which will be used to hold health boards and local authorities to account. The Bill would also require the new integration authorities to create a strategic plan every 3 years. The strategic plan would also establish at least two locality areas in each local authority.

The Bill would also allow National Services Scotland to extend its services to public bodies beyond the NHS. It also proposes to allow health boards to form companies for joint venture purposes and enable boards to act on behalf of each other.

The majority of respondents to the Health and Sport Committee's call for evidence were supportive of the Bill. Respondents viewed the key strengths of the Bill as; the focus on outcomes, the involvement of stakeholders and the policy ambition of the Bill.

Areas that caused concern included the lack of mention of other stakeholders on the face of the Bill, the interaction with other legislation, the effect on non-integrated services and the potential for a confusing landscape.

INTRODUCTION

The Public Bodies (Joint Working) (Scotland) Bill was introduced in the Scottish Parliament on 29th May 2013 and aims to enact the Scottish Government's commitment to integrate adult health and social care (Scottish Government, 2011).

The policy ambition of the Bill is to:

“...improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.” (Scottish Parliament, 2013c, pg 1)

The Bill is split in to 3 parts with the main policy objective of integration provided for in Part 1. As a result the focus of this briefing is on that part of the Bill.

PART 1: INTEGRATION OF HEALTH AND SOCIAL CARE

WHAT IS INTEGRATED CARE?

There is no single definition of what ‘integration’ or ‘integrated care’ is. The policy memorandum to the Bill states that what is meant by integration is that:

“...services should be planned and delivered seamlessly from the perspective of the patient, service user or carer, and that systems for managing such services should actively support such seamlessness” (Scottish Parliament, 2013c, pg2)

Commonly in Scotland the terms are used to refer to the joined up delivery of NHS and social care services. Integration may be vertical between the different parts of the NHS, or horizontal between different statutory and non-statutory services. It may also occur at different levels, for example, at the structural level (macro), the service level (meso) or the service user level (micro) (Petch, 2011).

THE CASE FOR INTEGRATION

The quest for integrated care is replicated internationally and it is a burgeoning discipline within health research. So what are the perceived benefits of integrated care?

Recent impetus around integration policy in Scotland has come as a result of various pieces of work that have considered the impact of demographic change, the forecast increased demand for health and social care over the coming decades, and declining levels of public expenditure. In addition, at the present time, Scotland experiences problems that it is felt greater integration could help address, for example:

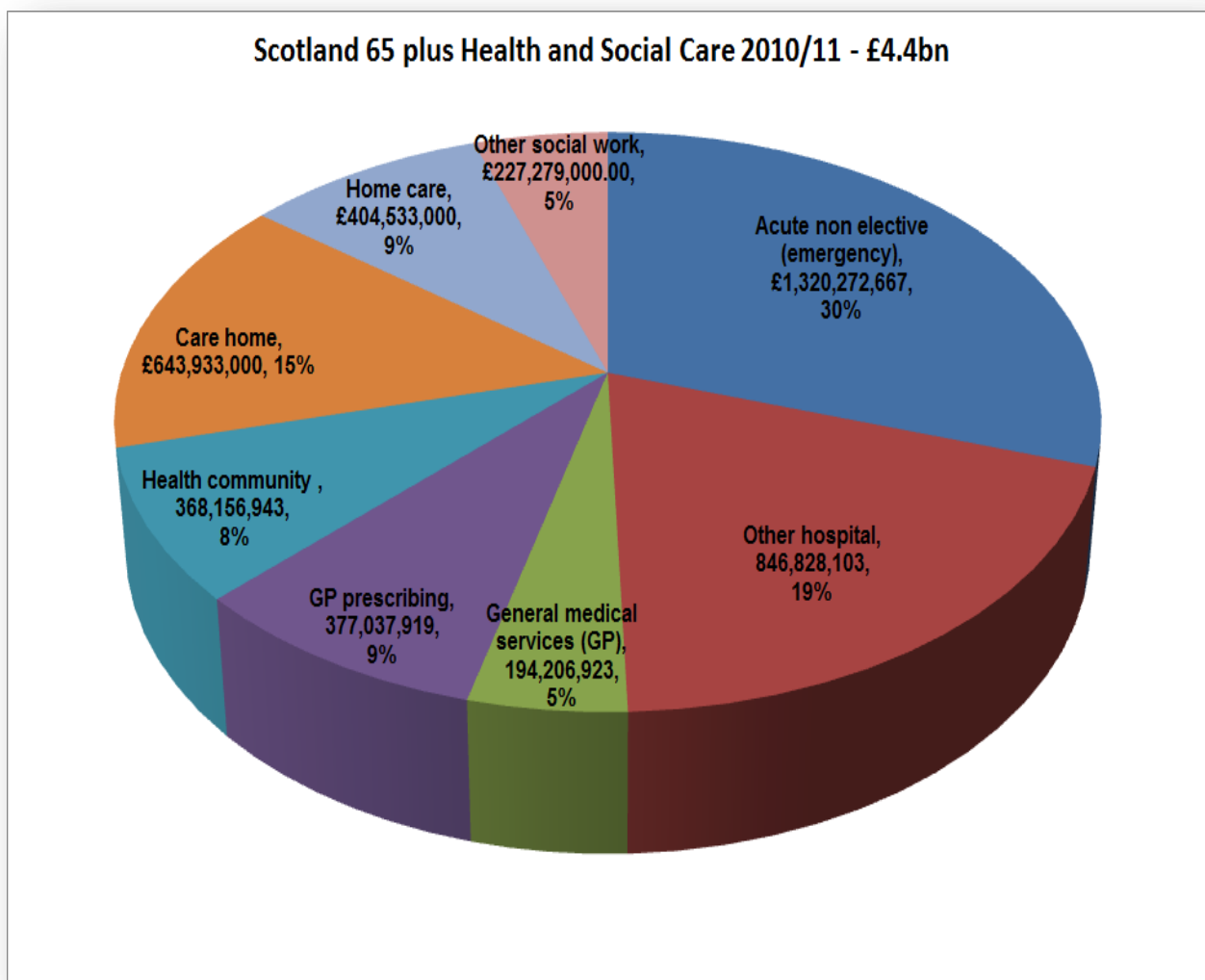
- Unscheduled, emergency admissions to acute care that may otherwise have been prevented
- Delayed discharges from acute care to a community setting
- Delays in accessing required support due to a disconnect between different services
- ‘Cost-shunting’ between services

- Duplication of efforts, for example, individuals having to retell their story to different professionals

This has led to calls for an increase in more preventative and personalised care, support in community settings and less emphasis on acute services (often referred to as 'shifting the balance of care'). Greater integration is viewed as one way of achieving this, and also as a way of improving both the quality and efficiency of services.

The most recent data from the 'Integrated Resource Framework' shows that of the total £4.4bn spent on the health and social care of people aged over 65, £3.2bn is spent on health care (71% of the total). Within this, the total spend by the NHS on emergency care for this group of people (£1.32bn) exceeds the total spend on social care by local authorities (£1.27bn).

Figure 1: Breakdown of total expenditure on health and social care in people aged 65+, Scotland, 2010/11 (Source: Scottish Government, 2013)



THE HISTORY OF INTEGRATED CARE IN SCOTLAND

Greater integration of health and social care is not a new concept to Scotland and there have been many attempts to achieve greater integration dating back to the 1970s (Woods, 2001). [Figure 2](#) outlines a timeline of some of the key policy developments in this area since devolution. Such work has included the Joint Futures Group and the '[Commission on the Future Delivery of Public Services](#)' (the Christie Commission)(Commission on the Future Delivery of Public Services, 2011) both of which envisaged greater integration of health and social care services.

Previous structure which attempted to achieve greater integration included Local Healthcare Cooperatives (LHCCs) and Community Health Partnerships (CHPs). LHCCs were part of Primary Care Trusts (PCTs) and organised round groups of GP practices in distinct geographical areas. They were not provided for through legislation but they were intended to bring health and social care providers together to deliver services.

CHPs were created under the National Health Service Reform (Scotland) Act 2004 and replaced LHCCs. They were established as committees of the health boards and were to bridge the gap between primary and secondary healthcare, and between health and social care.

However, despite such initiatives, there have been persistent concerns that joint working between partners has not been as effective as it could be, or that it has at least been patchy across the country.

THE EVIDENCE FOR INTEGRATION

In recent years, there have been a number of reviews of the evidence for integration. Some of the key studies are outlined below. For an examination of international models of integration please see [SPICe Briefing SB 12-48 Integration of Health and Social Care: International Comparisons](#).

In 2011, the Royal College of Nursing published a review of the literature and international models of integration (Robertson, 2011). This found that there are a large number of different models of integration and no single agreed definition of integrated care. The review found that the body of research on integration is extensive but contains little evidence of improved outcomes for individuals. Most measures of success use proxy indicators and infer benefits to individuals but robust evidence of the impact on health outcomes is lacking.

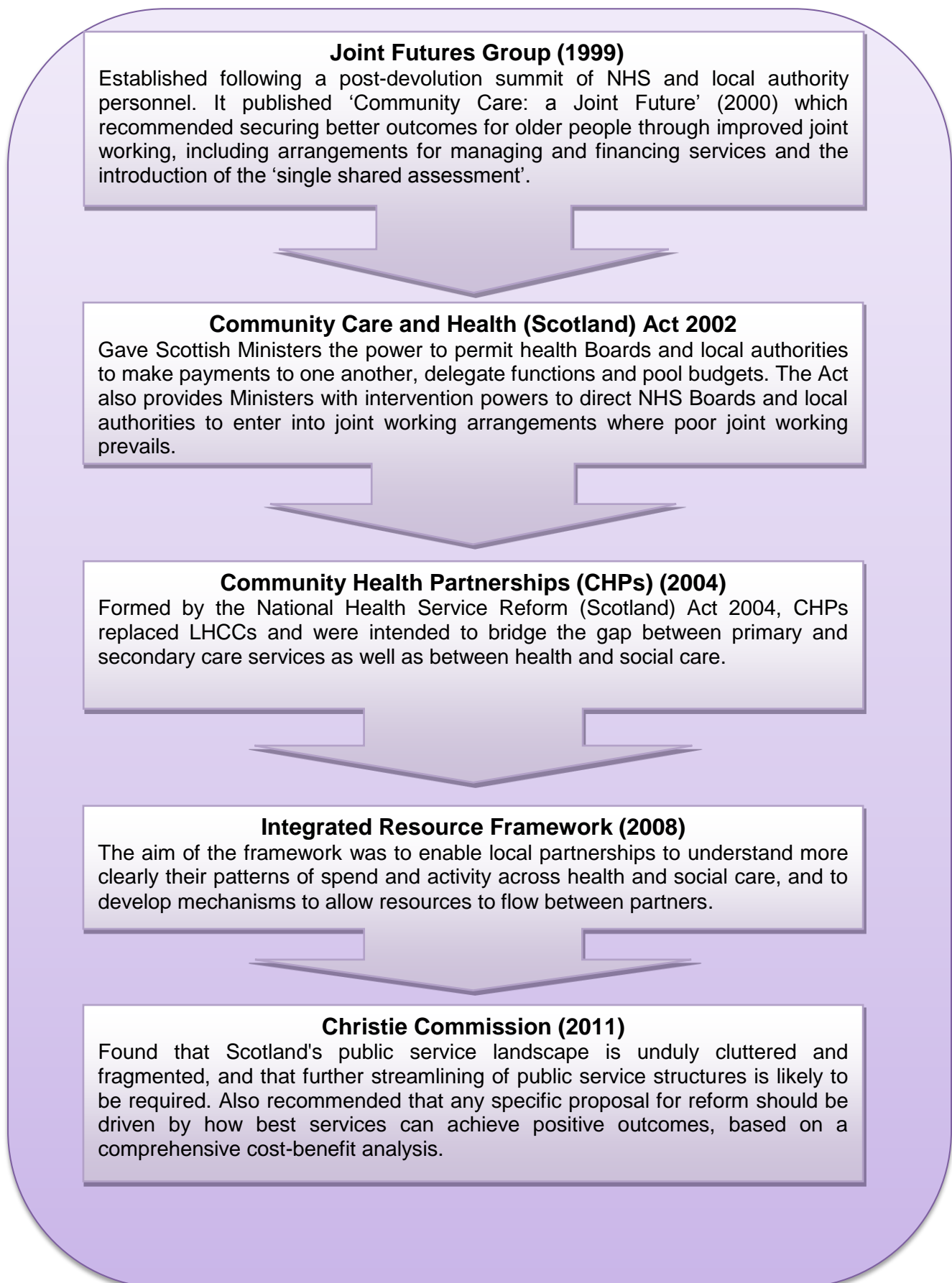
Around the same time, a review of the evidence by Petch (2011) found that “there is a strong body of evidence demonstrating that *structural* integration between health and social care does not deliver the effective service improvements that had been anticipated”. Petch found that it was not the structures per se that determined the success of integration, but rather the detail of local implementation and a focus on outcomes for service users. She also highlighted a number of dimensions that are key to success. These are:

- the importance of culture
- the role of leadership
- the place of local history and context
- time
- policy coherence
- the need to start with a focus on those who access support
- a clear vision

- the role of integrated health and social care teams

A briefing for the Social Care Institute for Excellence (SCIE) (2012) also found the evidence base underpinning joint working and integration as 'less than compelling', including from an economic perspective. However, the briefing did review the factors that promote and hinder joint working. SCIE found that the factors that aided joint working could also become the factors that hindered it if they were not given enough attention. Crucial factors included; securing the understanding and commitment of staff to the aims and desired outcomes of the partnership (especially among health professionals), defining outcomes that matter to service users and carers, and involving service users and carers in care planning and influencing future care options.

Figure 2: A timeline of some key integration policy developments in Scotland since devolution



A review of the evidence on financial integration found “tentative evidence that financial integration can be beneficial” but also that “robust evidence for improved health outcomes or cost savings is lacking” (Social Research, 2010).

However, it did identify critical success factors for integration. These were a clear, joined up vision and avoiding a one-size fits all approach.

HEALTH AND SPORT COMMITTEE INQUIRY

In anticipation of the Bill, the Health and Sport Committee of the Scottish Parliament undertook an inquiry into the integration of health and social care (Scottish Parliament Health and Sport Committee, 2012). The findings of the Committee’s inquiry included that changes should avoid being driven by structures and instead they should have a focus on outcomes. The Committee also welcomed the plan for integration to extend beyond adult services and to have a clear line of accountability in the shape of a single accountable officer. For a full list of the Committee’s findings please see [Annex 1](#).

CURRENT LEGISLATIVE POWERS

As mentioned in figure 2, the Community Care and Health (Scotland) Act 2002 (‘the 2002 Act’) gives health boards and local authorities the ability to make payments to each other, delegate functions to each other, transfer staff and to pool budgets. It also gives Ministers a regulatory power to require the delegation of functions between local authorities and NHS bodies.

Therefore some legislative powers to bring about greater integration already exist. However, there is no requirement in the primary legislation to use these powers. This remains entirely voluntary and there are limited examples of their use since the 2002 Act came in to force. In addition, the 2002 Act would only allow for the adoption of one model of integration i.e. the delegated function model, sometimes also known as the ‘lead agency’ or ‘lead commissioning’ model (see below).

THE BILL’S PROVISIONS IN PART 1

Integration Plans

The Bill requires the 14 area health boards and 32 local authorities to jointly submit an integration plan for each local authority area. Where there are 2 or more local authorities in a board area, the Bill would allow for the submission of a joint plan. Plans would be subject to the approval of Scottish Ministers.

The policy memorandum accompanying the bill details that integration would be required for adult health and social care at a minimum, although this is not specified in the Bill.

At the moment North and South Lanarkshire Councils are the only 2 local authorities that deal with 2 area health boards. However, recently announced changes¹ to ensure the co-terminosity of board boundaries will mean that each local authority will share its boundary with just one health board.

¹ Scottish Government News Release (4 June 2013) Health Board Boundaries. Available at: <http://news.scotland.gov.uk/News/Health-board-boundaries-d0.aspx>

The Bill would give local authorities and health boards the choice of 4 options for integration, however these 4 options can be summarised in to 2 broad models:

1. **The body corporate model** – under this model local authorities and health boards will delegate functions to a joint board. This will be separate from local authorities and health boards and led by a chief officer.
2. **The lead agency/delegated function model** – under this model, functions will be delegated from one body to another. The Bill outlines 3 potential options; delegation from a local authority to a health board, delegation from a health board to a local authority, or delegation of functions to both a health board and a local authority. This model would require the establishment of a joint monitoring committee to oversee delivery.

The Bill would remove Community Health Partnerships from statute.

The local authority and the health board must consult on the integration plan prior to submission. Who should be consulted is not specified in the Bill other than to say it could include anyone the partner bodies see fit and anyone specified by Scottish Ministers.

Regulations would also be made detailing the required content of the integration plans but the Bill contains provisions requiring that integration plans would have to set out which model is being used, the functions which are to be delegated and - where the lead agency model is being used - the functions of the person who is being delegated to. The plan must also set out the method by which payments will be made for the funding of the services. When creating an integration plan, local authorities and health boards must also have regard to:

- The integration planning principles, and
- The national health and wellbeing outcomes

National outcomes will be specified by Ministers in regulations and would be used to hold health boards and local authorities jointly accountable.

At present, performance management differs considerably between health boards and local authorities. Health boards are responsible for delivering 'HEAT targets' while local authorities have moved towards 'Single Outcome Agreements' via Community Planning Partnerships.

Ministers would be required to carry out a consultation on the outcomes prior to making the regulations. Those to be consulted would include:

- Health and social care professionals
- Health care and social care users
- Carers
- Commercial and non-commercial providers of health care and social care

The integration planning principles and draft health and wellbeing outcomes are outlined in [Figure 3](#).

Figure 3: Integration Planning Principles and Draft Health and Wellbeing Outcomes

Integration Planning Principles - Section 4(1)

4(1) The integration planning principles are –

- (b) That, in so far as consistent with the main purpose, those services should be provided in the way which, so far as possible –
 - (i) Is integrated from the point of view of recipients,
 - (ii) Takes account of the particular needs of different recipients,
 - (iii) Takes account of the particular needs of recipients in different parts of the area in which the service is being provided,
 - (iv) Is planned and led locally in a way which is engaged with the community and local professionals,
 - (v) Best anticipates needs and prevents them arising, and
 - (vi) Makes the best use of the available facilities, people and other resources

Draft National Health and Wellbeing Outcomes (Scottish Government, 2012)

- 1. Healthier living** - Individuals and communities are able and motivated to look after and improve their health and wellbeing, resulting in more people living in good health for longer, with reduced health inequalities.
- 2. Independent living** - People with disabilities, long term conditions or who become frail are able to live as safely and independently as possible in the community, and have control over their care and support.
- 3. Positive experiences and outcomes** - People have positive experiences of health, social care and support services, which help to maintain or improve their quality of life.
- 4. Carers are supported** - People who provide unpaid care to others are supported and able to maintain their own health and wellbeing.
- 5. Services are safe** - People using health, social care and support services are safeguarded from harm and have their dignity and human rights respected.
- 6. Engaged workforce** - People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.
- 7. Effective resource use** - The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation.

If an integration plan was not approved by Scottish Ministers, the local authority and the health board would be required to modify the plan and resubmit it. Health boards and local authorities would be able to vary some of the terms of an approved integration plan (such as the functions delegated or the method of payment) but this would require resubmission for the approval of Scottish Ministers (though no further consultation with stakeholders would be required). If the integration plan was to change the local authority area or the model of integration, this would require an entirely new integration plan.

In the event that a local authority and a health board fail to submit an integration plan, Ministers could impose the body corporate model on the partners. The partners would then be required to delegate functions to the joint board and make payments in accordance with the specifications of Ministers.

The Body Corporate Model

The body corporate model is where the functions that are to be integrated are delegated to a joint board. If a partnership chooses this model then a 'joint board' would be established by Ministerial order. After consulting with the 'constituent authorities' (i.e. the health board and local authority), the joint board would appoint a 'chief officer' who would be an employee of either the health board or local authority and seconded to the joint board. Membership of the joint board would be set out in secondary legislation.

The chief officer's responsibilities would be subject to the approval of Scottish Ministers but the policy memorandum details that the chief officer would lead the development of the strategic plan (see [Strategic Planning](#) below) and manage the integrated budget and the integrated planning and delivery of services (para 55b). The services the joint board would be responsible for would be those specified in the integration plan agreed by the health board and local authority.

The policy memorandum outlines that it is envisaged that the joint board will arrange for the provision of services from the health board or the local authority, rather than providing services itself, although there is a regulatory power in the Bill for Ministers to allow this and to allow the joint board to employ its own staff (para 59). The intention is that joint boards will be responsible for:

- Overseeing the development and preparation of the strategic plan (see [Strategic Planning](#) below) for the area covered by the integration plan
- Allocating resources at a high level, between the health board and the local authority in accordance with the strategic plan and the integration plan
- Ensuring the delivery of the national and local outcomes

The resources of the joint board would be calculated in accordance with the method set out in the approved integration plan.

This model builds upon the approach of CHPs but differs in that the joint board would be equally accountable to local authorities and health boards (via the strategic plan), whereas CHPs were constituted as committees of the health board alone.

The financial memorandum to the Bill notes that, based on feedback on the preferences of partners, the likely case is that "all partners, with the exception of Highland, will opt for delegation to a body corporate" (para 44).

The Lead Agency Model

The lead agency model is where functions are delegated from one partner body to the other. If a partnership chooses to follow the lead agency model, then the local authority and health board must establish a 'joint monitoring committee' to monitor the delivery of the functions that have been delegated. Membership of the Committee would be determined in secondary legislation. The role of the joint monitoring committee would be to:

- Hold the lead agency to account for the agreed resources/budgets on behalf of the health board and the council (and do so in a way designed to ensure integrated provision of services in a person-centred way)
- Report to the health board and council in relation to those matters using a robust reporting mechanism specified in the integration plan

Unlike the body corporate model, this model would not require the appointment of a chief officer as the chief executive of the lead agency would act as chief officer. The policy memorandum to the Bill outlines that the chief executive of the lead agency would be responsible for the management of integrated services and the development of the strategic plan (see [Strategic Planning](#) below) (para 57). It also states that the integration plan will establish that the chief executive of the lead agency will be jointly accountable to the health board and the local authority.

This is the model that is being used by NHS Highland and Highland Council. NHS Highland has delegated responsibility for adult health and social care services and Highland Council is responsible for children's social care and community health care services.

Transfer of Staff

The Bill does not require the transfer of staff between the partner bodies for the purposes of integration, but it does contain provisions to permit it. Staff being transferred would have the option of refusing to work for the new employer, though this would mean that their contract would be terminated. Employees would not be able to claim unfair or constructive dismissal purely by the change of employer, but could still do so if there were any substantial detrimental changes to their contract of employment or working conditions.

Staff agreeing to the transfer would be employed under the same contract terms as agreed with their original employer. The new employer would also assume all of the rights, powers, duties and liabilities of the original employer.

The financial memorandum to the Bill details that where staff transfers do take place, they will do so under TUPE arrangements² (para 112). However, the memorandum points out that staff would be free to migrate to the same terms and conditions as their new colleagues. The memorandum highlights that transfers are likely to happen under the lead agency model and goes on to point out that staff transferring from a local authority to the NHS are likely to want change because the NHS terms and conditions would be more advantageous. It also highlights the possibility that where staff transfer from the NHS to a local authority that this may result in an equal pay claim.

² Transfer of Undertakings (Protection of Employment) Regulations – these regulations allow staff to transfer to a new employer on their existing terms and conditions of employment and with all their existing employment rights and liabilities intact

Strategic Planning

The integration authorities created under integration plans (i.e. the joint board or the lead agency) would be required to prepare a strategic plan for their area covering a period of 3 years. This would effectively require the new integration bodies to undertake what is known as joint 'strategic commissioning'.

Strategic commissioning involves agreeing outcomes, assessing present and future needs, examining options, deciding how best to meet those needs and outcomes and then commissioning and delivering the necessary services. It is viewed as being of crucial importance for providing effective care. In 2012, Audit Scotland published Commissioning Social Care which found that:

"Councils and NHS Boards have been slow to develop strategic commissioning. Only 11 of the 32 council areas had commissioning strategies covering all social care services"...Of the commissioning strategies that do exist, most relate to the council rather than reflecting the interdependence of health and social care services" (Audit Scotland, 2012, pg16).

In preparing the strategic plans, the integration authorities must have regard to both the national health and wellbeing outcomes and the 'integration delivery principles'. These principles have the same wording as the integration planning principles (see [page 11](#) above).

The integration authorities would also be required to establish a group to consult on the strategic plan. Who should be a member of the group is not on the face of the Bill, but would be prescribed by Ministers. The Bill gives integration authorities the power to pay any expenses and allowances to members of the consultation group. This is intended to facilitate the involvement of stakeholders in the development of the strategic plan.

Integration authorities would be required to outline proposals for the strategic plan and seek the views of the consultation group. The consultation group would express their views and the integration authority would draw up a first draft of the plan for comment. The consultation group would then have the opportunity to comment on the draft. However, subsequent drafts would only have to be sent to the health board and council, and to any others the integration authority thinks fit or that may have been prescribed by Ministers. The integration authority would have to take account of these views in finalising the strategic plan.

A strategic plan developed under the lead agency model would need to be approved by the other partner. For example, if the health board was the lead agency, the local authority would need to approve the plan and vice versa. If it is not approved then the lead agency would have to modify the plan and re-submit it for the other partner's approval.

Under the body corporate model, the strategic plan would not require the approval of either the health board or local authority, though their views must be taken account of in the final version.

The Bill would require a public consultation on any proposals to significantly change services out-with an agreed strategic plan.

Localities

Under the Bill, the strategic plan would identify at least two 'localities' for the area and outline separately how the integrated services will be delivered in each.

The Bill does not prescribe any models for locality planning. The policy memorandum details that this is because it is believed “that arrangements that work best locally are developed and agreed upon locally” (para 126).

The Scottish Government envisages that locality planning will be led by and involve local professionals as well as directly involve local elected members, services users, carers and third and independent sector representatives. This is intended to bring about a ‘co-production’³ approach to planning and reflect the principles of the Christie Report (Commission on the Future Delivery of Public Services, 2011).

PART 2: SHARED SERVICES

This part of the Bill proposes to enable National Services Scotland (also known as the Common Services Agency) to extend its services to other public bodies. The following functions of National Services Scotland have been identified as having the potential to be extended to other public bodies:

- Central Legal Office,
- Counter fraud services,
- National Procurement,
- National Information Systems Group (IT services), and
- Information Services Division

The sharing of these services would be entirely voluntary for either party.

The Bill also proposes to extend the NHS’ indemnity scheme (known as CNORIS – the Clinical Negligence and Other Risks Indemnity Scheme). Health boards contribute an annual amount and CNORIS covers the expenses arising from any loss or damage to property and any liabilities to third parties for loss, damage or injury. The Bill proposes to allow local authorities and joint integration Boards to participate in the scheme.

PART 3: HEALTH SERVICE FUNCTIONS

The Bill’s Financial Memorandum states that Part 3 of the Bill:

“aims to address two barriers to efficient procurement of infrastructure projects and address differences in the approaches available to Health Boards and local authorities to manage and maximise value from surplus assets.” (para 104)

Part 3 of the Bill has two aspects:

- Enabling Health Boards to form a wider range of corporate structures
- Enabling Health Boards to exercise functions outwith their own Health Board area

Formation of companies

Under existing legislation, health boards are only able to form companies for joint venture purposes using structures contained within the Companies Act (1985). The Bill would enable

³ The delivery of public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.

Health Boards to form other types of corporate structures. This would put them in the same position as local authorities and would provide opportunities for collaborating with local authorities in the strategic disposal of surplus assets.

Exercise of functions outwith Health Board area

At present, health boards are not able to carry out activities outwith their geographical area. The Bill would change the current arrangements, allowing Health Boards to exercise powers on behalf of other Health Boards. The policy memorandum explains that this would bring benefits in terms of the procurement of infrastructure projects (para 148).

At present, health boards use the “Hub initiative” to facilitate the procurement of capital projects which are to be financed through the non-profit distributing (NPD) model. The Hub initiative is led by the Scottish Futures Trust (SFT) and provides an opportunity for local partners, including health boards and local authorities, to take forward capital projects, either individually or collaboratively, using revenue financing. The policy memorandum states that for such projects:

“there requires to be a critical mass of capital investment in order to deliver value for money. One key method of creating such a critical mass is to aggregate or bundle a number of projects together either within a single Health Board Area or across the broader hub territory (which can incorporate a number of Health Board areas).” (para 149)

At present, if a bundle of projects involves more than one health board, then there needs to be a separate corporate structure (“Special Purpose Vehicle” or SPV) for each health board. The Bill’s provisions would allow there to be a single SPV, led by one of the health boards, which would reduce both the upfront and on-going costs associated with the projects. According to the Bill’s financial memorandum, the Scottish Government would anticipate there being one project every 2-3 years involving a bundle of projects situated in more than one health board area. It is estimated that the new provisions would generate financial savings of £15.9m over 25 years as a result of being able to create one SPV rather than multiple SPVs.

Under the proposed arrangements there would be a legal agreement in place to ensure each health board had a responsibility to fulfil its obligations under such contracts.

The Bill does not restrict the delegation of functions between boards to the procurement and management of capital projects.

FINANCIAL MEMORANDUM

The following is a summary of the estimated costs arising from the Bill:

Table1: Estimated Costs Arising from the Bill

Part 1	
Transitional non-recurring costs to the Scottish Government over 5 years (2012/13 – 2016/17)	£16.315m
Recurrent costs to health boards and local authorities arising from the different models	<p>If all partners choose the lead agency model = £4.55m per annum</p> <p>If all partners choose the body corporate model = £5.6m per annum</p>
Consequential cost implications of staff transfers	<p>Low cost scenario = £0 per annum, Mid-cost scenario = £13.5m per annum, High-cost scenario = £27m per annum</p>
Joint Inspections by the Care Inspectorate and Healthcare Improvement Scotland	£173,362 per inspection with an estimated 6 inspections per annum = £1.04m per annum
Additional resources for scrutiny of strategic commissioning	£670,000 per annum

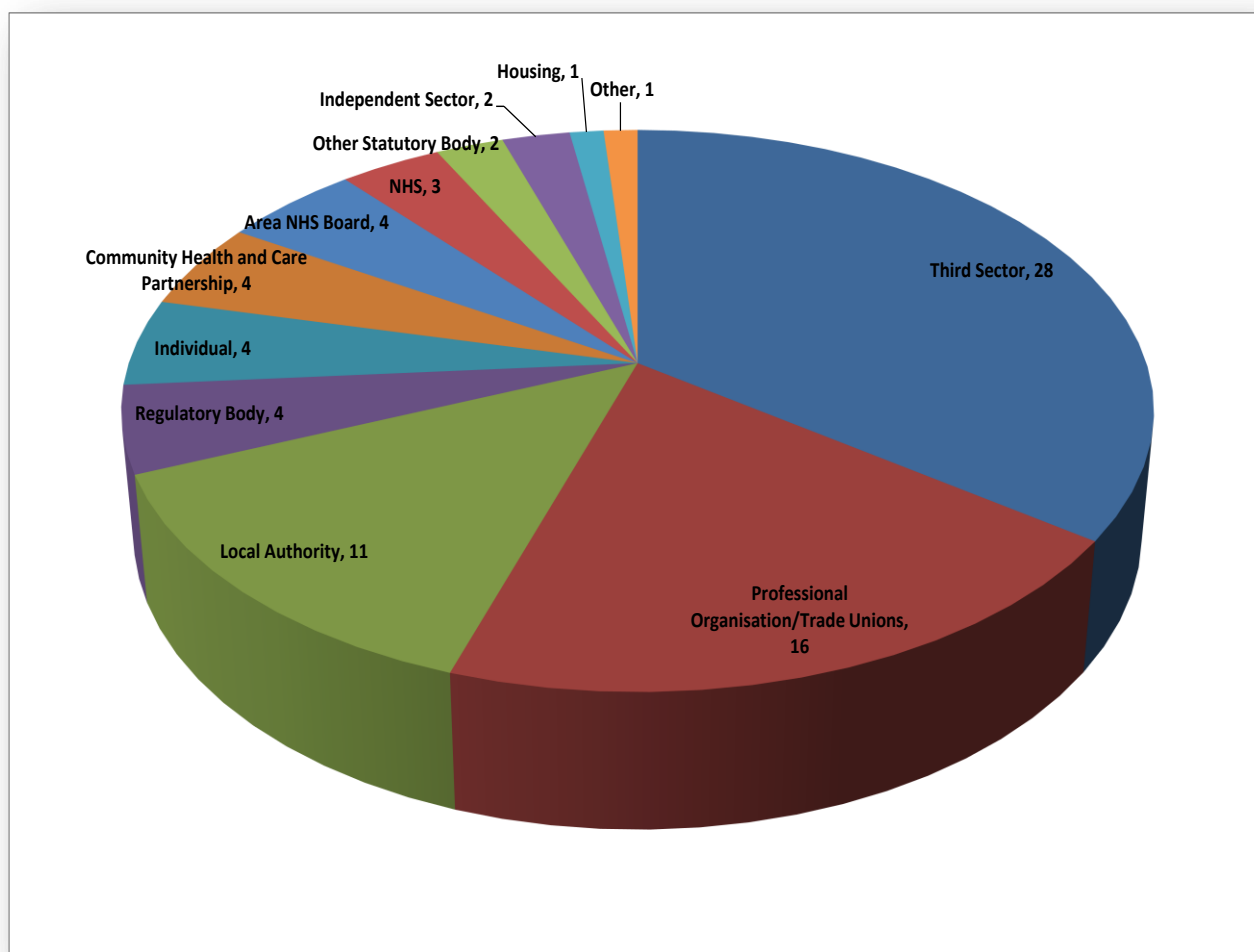
The financial memorandum discussed the potential for savings that could arise from the Bill. This included areas such as the rationalisation of capital and assets between partners. However, no estimate was provided due to insufficient evidence to estimate the potential benefits. In addition, the financial memorandum also speculated on the potential for efficiency savings resulting from anticipatory care plans, reducing delayed discharges and reducing variation, estimating that this could be between £138m and £157m per annum. However, the memorandum notes that there is considerable uncertainty around these estimates and much will be dependent on local decisions by partners (para 53).

Estimates of savings were also provided in relation to part 3 of the Bill which would allow one health board to act on behalf of another in contracting for capital projects. The potential savings were estimated at £15.9m over 25 years.

SUMMARY OF EVIDENCE

The Health and Sport Committee's call for evidence on the Bill received 80 responses⁴. Figure 4 illustrates who responded.

Figure 4: Respondents to the Health and Sport Committee's Call for Evidence by Respondent Type



Respondents were asked whether they agreed with the general principles of the Bill and its provisions. Few respondents answered with an outright yes/no and 15 respondents either did not answer or did not express a clear opinion. However, of the remaining 65 that did address the question, almost all (n=64) responded positively and expressed general support for the Bill and its policy objectives. Only one submission⁵ clearly did not support the Bill and this was on the grounds that they felt the case for legislation had not been made.

While most respondents answered the question positively, it would be fair to say that most of these responses could be categorised as a 'qualified yes', that is, they agreed with the policy objectives of the Bill but they had concerns about its implementation or some of its provisions. The reasons behind this are outlined in more detail below (see [Concerns/Areas to be Strengthened](#)).

⁴ Please note that further submissions were received after the close of the call for evidence and these have not been included in this analysis. However, they are available to read on the Committee's webpage.

⁵ Chartered Institute for Public Finance and Accounting

This was also reflected in the responses to the question “to what extent do you believe the Bill will achieve its policy objectives?” The question was left open and therefore it is difficult to quantify responses. However the responses can best be categorised in to those who thought the Bill would achieve its objectives, those who thought it might achieve its objectives, and those who thought it would not achieve its objectives

By far the largest proportion of respondents felt that the Bill might achieve its objectives, with just a handful of responses unequivocally of the opinion that the Bill either would or would not work.

Of those who thought the Bill might achieve its objectives, the main reasons given for this were:

- integration requires more than just structural change, cultural change is also required
- the Bill has the potential to help so long as certain other things happen (e.g. effective local leadership, effective strategic commissioning, greater focus on co-production and stakeholder involvement)
- it will depend on the detail of implementation, much of which will be within regulations and guidance
- it has the potential to help but concerned about specific aspects of the Bill (e.g. may make services and structures more complex, may increase fragmentation, will not address integration within the NHS)

Some of these issues are discussed in more detail below (see [Concerns/Areas to be Strengthened](#)).

STRENGTHS

Respondents were asked what they thought were the key strengths of the Bill. The main themes to emerge are outlined below.

- **Outcomes** - The most commonly perceived strength of the Bill was the focus on outcomes. It was felt that the outcomes could lead to improvements in the consistency of care and re-orientate investment and activity. They were also welcomed as a way of aligning the priorities of health boards and local authorities and providing a clear measure for holding partners to account.
- **Involvement of non-statutory stakeholders** - The next most welcomed aspect of the Bill is the intention to involve other stakeholders beyond the statutory bodies. It was felt that this would help ensure a personalised and person-centred ethos and that the intention to ‘involve’ rather than just ‘engage’ would bring about a real sense of partnership.
- **Policy ambition/aspiration/intent** - Many respondents simply welcomed the policy ambition of the Bill and the willingness to attempt something new. In particular, respondents welcomed the focus on achieving better outcomes for individuals.
- **Requirement for strategic commissioning** – seen as key to improving service quality
- **Requirement to integrate** – the fact that the Bill requires partners to integrate was considered by some as an improvement on the current voluntary arrangements

- **Locality Planning** – viewed as important for securing change and making the best use of available resources
- **Person-centred approach** – welcomed by respondents who felt that effective services should be designed with and for people and communities
- **Planning principles** – seen as important for driving improvement and embedding a person-centred approach to integration.
- **Flexibility** – some respondents welcomed the flexibility the Bill offered (for example, in the choice of model) as it would allow partnerships to build on what has been done to date and what best meets the circumstances of their particular area. The fact that some details will be in guidance and regulations was welcomed by some as allowing a flexible approach over time.

CONCERNS/AREAS TO BE STRENGTHENED

Respondents were also asked if there were any aspects of the Bill they believed needed to be strengthened. This resulted in a wide range of suggestions and concerns. The most commonly mentioned issues are outlined below.

Stakeholder and Public Involvement

By far the most common concern with the Bill was in relation to the involvement of various stakeholders in the different provisions outlined in the Bill. Concerns about involvement tended to be in relation to the role of the third sector, patients and service users, carers and the different health professionals.

There are a number of aspects to the Bill that respondents expressed a desire, or an assurance, for more involvement in. These included:

- Membership of joint monitoring committees and the joint boards
- Signing off integration and strategic plans
- Membership of the consultation groups
- Voting rights on joint monitoring committees and joint boards
- Locality Planning

The accompanying documents to the Bill highlight the Scottish Government's intention to fully involve other stakeholders (including provisions in secondary legislation). However, when discussing membership and voting rights in the policy memorandum, the Scottish Government highlights the need for the regulations to respect local democratic accountability as well as the significant statutory and budgetary responsibilities of health boards and local authorities.

Nevertheless, some respondents expressed a desire for the specific inclusion of various stakeholders to be placed on the face of the Bill. Some also felt that concerns this may hinder local authorities and health boards in executing their public duties could easily be mitigated (for example, through the provision of clear terms of reference to board/committee members).

Greater clarity was also called for in relation to public involvement, including what will happen to Public Partnership Forums once Community Health Partnerships no longer exist.

Interaction with other legislation

The next most common concern was in relation to how the Bill might interact with other legislation. This was mainly raised in relation to:

- the Social Care (Self Directed Support)(Scotland) Act 2013,
- the Patient Rights (Scotland) Act 2011, and
- the Children and Young People (Scotland) Bill.

The Social Care (Self Directed Support)(Scotland) Act 2013 allows recipients of social care services to direct how the funding for their care is used. Some respondents questioned how this could work once services were integrated, budgets pooled and the money had lost its health or social work identity:

“There needs to be much more recognition of the impact of self-directed support in terms of delivering outcomes and strategic commissioning; and an urgent need to address potential conflicts between joint working and self-directed support. This bill is progressing through Parliament at the same time as self-directed support is being prepared for social care. Despite this, the policy memorandum barely mentions [self directed support] and how it will operate in terms of budgeting decisions, commissioning and care delivery in the wake of health and social care integration.” (Scottish Association for Mental Health, 2013)

Others questioned whether people would be able to direct the health element of their care and called for greater clarity.

Others also questioned how the Patient Rights (Scotland) Act 2011 would sit within integrated services. The Act gives patients a number of rights when receiving NHS care and it also introduced the Charter of Patient Rights and Responsibilities, which brings together in one place a summary of the rights and responsibilities patients have when using NHS services. Respondents wondered if it could cause confusion and questioned whether the Act would be extended to social care services.

Finally, some responses were unclear how the Children and Young People (Scotland) Bill would interact with the Bill. The Children and Young People (Scotland) Bill would require local authorities and health boards to develop joint children’s services plans every 3 years. Some questioned the need for 2 separate planning processes and wanted greater clarity on how the 2 bills would work together.

Impact on non-integrated services

The impact of the Bill on services that are not included in integration plans was also raised. This was most often in relation to children’s services. Some felt that children’s services were not being given equal priority and that the impact of the Bill on these services had not been adequately thought through. There was a fear that the ‘whole family’ approach could be lost and that, if children’s service were not included, this may actually result in a ‘disintegration’ of services. Others questioned how transitions between children and adult services would be affected.

Similar points were raised in relation to housing services and criminal justice social work.

Confusing Landscape

While some respondents valued the flexibility within the Bill and viewed it as a strength, others felt this flexibility has the potential to create a confusing landscape if partnerships choose different models and have the discretion to choose what is, and is not, included in the integration plan. It was felt that this could create greater inconsistencies in service provision ('post-code lotteries') and lead to the fragmentation of services. It was suggested that it may also create confusion for the public.

Some called for greater guidance centrally, for example, establishing a minimum set of services that must be integrated.

Quality Assurance and Scrutiny

Some respondents expressed concern that 'quality' was not mentioned anywhere in the Bill despite being a key policy objective. The most common suggestion to rectify this was the inclusion of quality assurance within the integration and strategic planning principles. The Royal College of Nursing wrote:

"Quality and safety should be paramount, and deserve to be embedded in the heart of the primary legislation, not left to regulation or guidance alone." (Royal College of Nursing, 2013)

Similarly, some respondents noted there was no mention of scrutiny in the Bill. The policy memorandum does outline that the Care Inspectorate and Healthcare Improvement Scotland would retain their responsibilities for scrutinising health and social care services (para 131)). However, some respondents wanted to see scrutiny on the face of the Bill and others called for robust scrutiny of specific aspects of the new arrangements, for example, strategic commissioning, performance towards the outcomes and public involvement.

Ethos and Guiding Principles

A number of submissions expressed disappointment that a particular ethos or approach was not adequately reflected in the Bill. Most commonly it was felt that the Bill did not adequately reflect:

- Co-production
- An asset-based approach
- A human rights based approach
- Person-centredness, and
- The Christie Commission's vision

These comments tended to be linked to a belief that the Bill was more concerned with structures, and that the role of the public, patients and service users was missing from the face of the Bill. Some of these respondents expressed a desire for the Bill to have a set of guiding principles at the start, in line with the approach of other Acts, such as the Mental Health (Care and Treatment)(Scotland) Act 2003.

Acute Care

Some respondents called for greater clarity on where the acute sector fits in to the Bill. This was in relation to acknowledging not only the disconnect between social care and health care, but

the disconnect between primary and secondary care too. Some respondents commented that it was unclear how the Bill would improve this vertical integration.

Secondly, the acute sector was raised as being pivotal to the success of integration. This was in relation primarily to the funding locked up in providing acute care, and in particular, unscheduled admissions. Respondents commented that without unlocking and redirecting these resources, then the improved outcomes that would come with the consequent shift in the balance of care, would not be achieved.

Charging and Cost-Creep

Some respondents highlighted the discrepancy in charging powers that exists between the partner bodies (i.e. the NHS is free at the point of use while local authorities have the power to charge for some services). Respondents suggested that if service users cannot discern the interface between health and social care provision, it could become increasingly difficult to explain and justify charging.

Others had a fear that integration may lead to what they termed 'cost-creep'. What they meant by this is that the boundaries between health and social care may become increasingly blurred, and care which may previously have been provided free by the NHS, may start to incur charges. These respondents pointed to the current review of NHS continuing care which was prompted by instances of people paying for what should have been NHS continuing care and therefore free of charge.

Complaints

At the present time, local authorities and health boards operate entirely separate complaints procedures. Users of social care services can also complain to the Care Inspectorate about specific services. Some questioned how these systems would interact once integration took effect and suggested that the complaints procedures need to be integrated too. The Scottish Public Services Ombudsman wrote:

“Ensuring complaints processes are accessible, simple and clear is important in ensuring the quality and consistency of public service delivery. The complaints landscape across health, social work and social care remains complex and the move to enable organisations to provide integrated services in this area should include the provision to the public of easily accessible, straightforward complaints processes.”

Others reiterated this point, viewing it as a risk to service users and something that the Bill needs to address.

Power of Ministers

Some respondents (mainly local authority respondents) expressed concern that the Bill gives ministers extensive powers which were not previously included in the Scottish Government consultation. Examples of the powers that caused concern were that:

- Ministers can prescribe the local authority functions which can and cannot be delegated under an integration plan and that they can do this without recourse to primary legislation. There was concern this could include other functions such as housing and education
- The Bill would give Ministers wide-ranging powers such as the powers to establish the membership of joint boards and make provisions about its proceedings, give joint boards

general powers such as the ability to contract and acquire/dispose of property and assets, make provisions about the supply of services to a joint board from local authorities and health boards and any other matter as Ministers 'think fit'

- Integration plans to be approved by Ministers rather than by local agreement
- Responsibilities of Chief Officers are subject to the agreement of Scottish Ministers rather than local partnerships

One respondent highlighted what they perceived as a shift in power from local government to Scottish Ministers and a dilution of local democratic accountability.

Linked to this, was the feeling of some respondents that the Bill is too prescriptive, with one respondent questioning how much control a partnership has over its integration plan. They felt that the bill contains a lack of scope for partnerships to determine the arrangements that best suit local circumstances, instead of being forced to choose from one of two models. It was also felt that this lack of choice did not sit well with the focus on outcomes, given that the parent bodies would be held accountable for delivering the outcomes. It was suggested by one respondent that the Bill could simply require partnerships to focus on, and be accountable for, the outcomes.

Governance and Accountability

Some respondents requested greater clarity on governance arrangements as some of the detail relating to governance is being left to secondary legislation.

Specific concerns around the governance of the body corporate model were also raised, with respondents seeking clarification on the membership of the joint board, who the joint board would be accountable to and how it would be held to account. Some respondents felt that the body corporate model is significantly different from the one proposed in the consultation:

"We have been working on the understanding that the body corporate model is a vehicle that is accountable to the parent bodies, whose chief officer is directly accountable to the chief executives of the parent bodies, and whose strategic plans must be consistent with and led by the strategic plans of the parent bodies. The Bill appears to suggest something quite different. When the body corporate model is taken, the body corporate becomes the Integration Authority...and leads the strategic planning process with the parent bodies becoming mere consultees." (NHS Lothian, 2013)

North Lanarkshire Council (2013) also noted that under the body corporate model, the joint board would assume responsibility for a budget that is likely to exceed that which remains in the control of a council but without any need to refer back to the parent bodies.

ANNEX 1: CONCLUSIONS OF THE HEALTH AND SPORT COMMITTEE INQUIRY INTO INTEGRATION

The Committee welcomes the principles proposed by the Scottish Government as the foundation for the integration of health and social care services. It will examine in detail the principles contained in the forthcoming bill.

On the basis of the evidence it has received, the Committee agrees that the Scottish Government's plans for integration should avoid being driven by structures and structural change. Furthermore, the Committee believes that any necessary change should have at its core, a clear focus on outcomes.

The Committee welcomes the intention of the Scottish Government to provide flexibility within a legislative framework which will prescribe minimum standards.

The Committee also welcomes the assurance received from the Cabinet Secretary that there will be no requirement for wholesale transfer of staff between employers.

The Committee notes the intention of the Scottish Government to establish a legislative framework which will allow local partnerships to extend the principles of integration beyond adult services.

The Committee encourages all interested parties to highlight any issues arising from this approach when responding to the forthcoming Scottish Government consultation.

The Committee welcomes the Cabinet Secretary's commitment to ensure that there will be strong national leadership for the integration process as a whole. The Committee considers that this must be allied to the development of strong and collaborative leadership from representatives of all sectors in commissioning services at a local level.

The Committee welcomes the Scottish Government's focus on outcomes as the starting point for its legislative proposals for the integration of health and social care.

The Committee acknowledges the findings of Audit Scotland that governance and accountability arrangements for CHPs have been "complex" and "not always clear". The Committee therefore welcomes the Scottish Government's proposal for a clear line of accountability to rest with a single individual for each health and social care partnership.

The Committee also considers it essential that the governance arrangements for each local partnership should retain strong links with local government through representation of councillors on partnership boards.

The Committee considers that an inability to establish genuinely integrated budgets has, in the past, acted as a barrier to efforts to integrate health and social care. The Committee notes the legal obstacles which require to be overcome in order to change this position, but hopes that this can be achieved by legislative means.

The Committee also shares the Cabinet Secretary's desire to see a shift in the balance of care for older people away from the acute sector and into the community. The Committee does not underestimate the challenge that this represents. It expects to examine this issue again as part of its scrutiny of the forthcoming Scottish Government bill.

The Committee acknowledges that the purpose of the Change Fund is to stimulate and support a shift in the balance of care for patients at a local level. Several witnesses were able to provide specific examples of such changes. However, the Committee was concerned by the evidence from

representatives of the third and independent sectors which suggested that, in some areas, their input to planning and decision making had not been embraced wholeheartedly by statutory partners.

The Committee therefore recommends that as part of its preparations for the primary legislation which will establish health and social care partnerships, the Scottish Government should conduct a review of third and independent sector partner involvement in Change Fund planning in order to ensure their full involvement in the future design and commissioning of new services and wider partnership arrangements.

The Committee considers that the third and independent sectors have a crucial role to play in local partnerships if the plans for more effective integration of health and social care are to be realised in practice.

The Committee considers that in order to be effective, the new health and social care partnerships must re-engage general practitioners and other health and social care professionals in locality planning. The Committee welcomes the commitment from the Cabinet Secretary to include this as part of a locality planning approach.

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