ARGYLL AND BUTE COUNCIL **COUNCIL MEETING**
COMMUNITY SERVICES **23 AUGUST 2012**

INTEGRATION OF ADULT HEALTH AND SOCIAL CARE IN SCOTLAND CONSULTATION RESPONSE

1. SUMMARY

1.1 The Scottish Government has launched its consultation on Integration which will run until 11 September 2012. The consultation document outlines the impact on current legislation and details two options for Partnerships to consider across Scotland; the Lead Agency model and the Integrated Governance model.

1.2 The objective of the consultation is to seek views on new legislation that will be introduced in order to achieve the changes that Ministers have been proposing. This report highlights the key points in the consultation document and includes a proposed draft response **(Annex G)**.

1.3 The focus on the outcomes for service users that may be achieved through health and social care integration are to be welcomed. The key to this approach will be legislation that introduces the maximum flexibility to partnerships to determine a model that is right for their locality rather than a prescribed one size fits all approach. With a co-terminus Community Health Partnership (CHP) currently in Argyll and Bute, there is potential to develop a partnership that focuses on Argyll and Bute as the place and has our residents at the heart of an integrated health and social care system.

1.4 In presenting the ”Case for Change”, Chapter 1, the document cites the Christie Commission report as well as the public engagement exercise of Reshaping Care for Older People and sets the debate within the context of demographic changes, the current Change fund proposals, working with the third and independent sectors, diminishing resources and the need to improve outcomes.

2. RECOMMENDATIONS

2.1 The Council is asked to note the consultation proposals.

2.2 The Council is asked to endorse the draft response for submission.

3. DETAIL

3.1 Chapter 2: Outline of Proposed Reforms

The objectives and principles of reform are based on:

1. Consistency of outcomes
2. Statutory underpinning
3. An integrated budget
4. Clear accountability
5. Professional leadership
6. Simplification of structures

The proposed legislation will place a duty on statutory partners to deliver nationally agreed outcomes for adult Health and Social Care. Health Boards and Local Authorities will be jointly and equally accountable to Scottish Ministers, Local Authority Leaders and Health Board Chairs for the delivery of those outcomes.

3.2 **Chapter 3: National Outcomes for Adult Health and Social Care**

The proposed legislation will place a duty on statutory partners to deliver nationally agreed outcomes for adult Health and Social Care. Health Boards and Local Authorities will be jointly and equally accountable to Scottish Ministers, Local Authority Leaders and Health Board Chairs for the delivery of those outcomes. The next chapter of the consultation document outlines the development of these national outcomes recognising the need for different delivery mechanisms

3.3 **Chapter 4: Governance and Joint Accountability**

The consultation document describes what Ministers strive to achieve through these Legislative changes and how this will be achieved.

1. Community Health Partnerships will come off the statute book.

2. Health Board and Local Authorities will be required to set up a Health and Social Care Partnership, the scope of which can be locally agreed but there must be an integrated budget and a governance Committee to oversee the running of the Health and Social Care Partnership.

3. A senior Jointly Accountable Officer for the Health and Social Care Partnership will be appointed reporting to the two Chief Executives. They will be responsible for commissioning and managing services with delegated authority to make decisions regarding the use of the integrated budget. Further detail on the role and responsibility of this Officer is included in Chapter 6 of the consultation document.

4. A Partnership Agreement will be drawn up between the Local Authority and Health Board detailing the services to be delivered, outcomes to be achieved, the financial input from each partner and the mechanism to effect integration of budgets. The Chair and Vice Chair of the Health and Social Care Partnership and the Health Board and Local Authority Chief Executives will be jointly held to account by the Cabinet Secretary, Local Authority Leader and Health Board Chair. This will deliver a *community of governance* overseeing the effectiveness of the Partnership especially in relation to early intervention and prevention, community planning processes and engagement of stakeholders.

The main differences are expected to be:

1. Joint and equal responsibility of the NHS and Local Government with the Health and Social Care Partnership being a Committee of Health Boards and Local Authorities.

2. Delegation of financial authority for achievement of joint outcomes and the requirement to demonstrate value for money.

3. Decision making authority in relation to delivering outcomes.

4. Joint accountability of Health Board and Local Authorities in relation to performance.

3.4 Chapter 5: Integrated budgets and resourcing

As the starting point to these proposals is to improve outcomes and utilise resources to best support individual need, Health Boards and Local Authorities will be required to integrate resources for adult services as a minimum and beyond as they deem fit. The resource should lose its identity to allow it to be appropriately used and robust information and evidence will be shared to enable joint managing of the risks and the facilitation of planning and service design.

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There are two options for integrating budgets:

1. Delegation to the Health and Social Care Partnership established as a body corporate of the Health Board and Local Authority. Functions and resources will be agreed by the partners and captured in the Partnership Agreement. Jointly Accountable Officer will manage the integrated budget under delegated authority from the two Chief Executives.

2. Delegation between partners under the current legislation - Community Care and Health (Scotland) Act 2002. The delegating partner retains its legislative responsibility for the functions that have been delegated and the financial governance system of the host partner applies to the integrated budget. A Partnership Agreement will establish the functions and resources. (This reflects the Lead Agency model that has been established between NHS Highland and Highland Council).

3.5 Chapter 6: Jointly Accountable Officer

The proposal for an integrated Health and Social Care Partnership identifies the creation of a new post of Jointly Accountable Officer who will be a senior appointment, at senior executive or equivalent, and will report directly to the Chief Executives of the Health Board and Local Authority. The post is presented as central to the potential success of an integrated approach in that the post-holder will carry sufficient authority to make decisions about resource prioritisation without the requirement of referring “back up the line” within either Health Board or Local Authority.

3.6 **Chapter 7: Professionally led locality planning and commissioning of services.**

The consultation document outlines a Commissioning approach as one which refers to the activities involved in:

- assessing and forecasting needs
- agreeing desired outcomes
- considering options
- planning the nature, range and quality of future services
- working in partnership to put these in place

The document goes on to emphasise the importance and benefits of strong clinical and professional leadership. It is anticipated that the Health and Social Care Partnership will afford better opportunities for professionals than was evidenced in the Community Health Partnerships. This should enable the development of local plans which will have a key input to the Joint Strategic Commissioning Plan.

The proposed legislation will place a duty on Health Boards and Local Authorities to consult local professionals across extended multi-disciplinary Health and Social Care teams and the third and independent sectors. Scottish Government will also work to support changes in workforce and leadership development to ensure this engagement can be realised, including consideration of workload, recruitment and retention issues.

3.7 **Annexes**

The consultation document concludes with a number of annexes detailing draft National outcomes, impact on other areas of services, workforce issues, Equality Impact Assessment (EQIA) and Business and Regulatory Impact Assessment (BRIA). This is work in progress which is intended to further clarify the context in which this consultation is set and how the changes can be most effectively put in place.

3.8 **Summary of Argyll & Bute Response**

The key issues highlighted in the draft response are as follows:

1. The proposal is comprehensive and Argyll & Bute Council would support the view that there is no need to be prescriptive in which model should be used to drive forward with the implementation. The model should be developed locally within the boundaries of Argyll & Bute and should primarily be a partnership between the Council and NHS staff based in Argyll & Bute as delegated by NHS Highland. The focus on the outcomes for service users that may be achieved through health and social care integration are to be welcomed. The key to this approach will be legislation that introduces the maximum flexibility to partnerships to determine a model that is right for their locality rather than a prescribed one size fits all approach. With a co-terminus Community Health Partnership (CHP) currently in Argyll and Bute, there is potential to develop a partnership that focuses on Argyll and Bute as the place and

has our residents at the heart of an integrated health and social care system

2. While the consultation specifically refers to integration across Older Person's services, it would be appropriate to integrate across all Adult Care services within Argyll & Bute in the first instance.

3. Having integrated across Adult Care services, further consideration of those services outwith the scope of the consultation - Children's Services, Criminal Justice, Education and Housing - is required in order that a robust operational and strategic relationship is sustained in order to manage issues such as Adult and Child Protection and the Transition from Child Care to Adult Care services for Children with Disabilities. On a phased basis this may involve a consideration as to whether the integration should extend to include aspects of children's health and social care services. If, as proposed, the CHP is to be removed from the statute books, clarity is required as to where NHS Child health services will be managed if the CHP no longer exits.

4. A strong national message would be helpful to clarify where the integration proposal fits within the review of the Community Planning Partnership framework.

   The responses to the consultation will highlight how the two parties, Health and Social Care, differ and consideration can follow to give greater clarity on how the differences will be resolved. The move towards outcomes, integrated budgets and practitioners being empowered to make operational and strategic decisions is welcome. The organisational, management and professional issues that could work against smooth implementation are key to developing a successful integrated model. These include:

   - The partners have very different management and accountability regimes with the NHS accommodating clinical autonomy which is not always consistent with strategic policy.

   - NHS operates different terms and conditions that make it more difficult to re-design services from scratch and use revenue flexibly in order to meet client outcomes. While recognising the responsibility for the provision of employment for existing staff, it is noted that such constraints applied to any public sector organisation can significantly impact on the ability to re-design services around the principles of client need. This is particularly the case in rural areas where the opportunities for re-deployment tends to be more limited.

   - Each partner has different levels of information and analysis on activity and spend for services. Work to date including the Joint Commissioning Strategy for older people via the Integrated Resource Framework highlighted these issues. Extending Joint Commissioning Strategies across a wider service area will need to address these issues.

- There is no significant history of the NHS commissioning services outwith the wider NHS family as opposed to Local Government where commissioning from the independent sector is further established. This will also have a bearing on the development of a joint commissioning strategy across Health and Social Care provision.

  These four key issues are illustrative of the issues that will require to be addressed in developing an integrated model in Argyll and Bute featuring integrated budgets, joint commissioning and service re-design services. As highlighted earlier the key is ensuring flexibility within the legislation to enable partnerships to develop a local partnership model that reflect local circumstances and is supportive of addressing the issues above.

5. The proposal for a National Outcomes framework for Health & Social Care is supported and central to the development of any partnership.

6. Greater clarity would be helpful as to how disputes within partnerships will ultimately be resolved.

7. Given that Health Boards tend to be larger than Councils territorially and yet have a relatively small number of Non-Executive Directors (meaning it will be harder for Boards to appoint to Partnership Committees), whereas the democratic sovereignty of Councils lies in the collective body of Elected Members, it is recommended that a higher minimum number of Elected Members on a integrated governance framework is agreed in order to avoid a democratic deficit.

8. Greater clarity would be helpful in relation to the process of budget setting , the development of 3-5 year Service Plans and how budget deficits and under spends are managed. This also relates to ongoing contractual disputes such as cross boundary purchasing from other Health Boards.

9. The Performance Management Framework is clear; however for it to be fully effective it would be helpful to have greater clarity as to how the clinical community are also accountable to performance management arrangements.

10. The legislation should not set minimum categories of spend as the danger is the minimum becomes the norm. Focus should continue to be on outcomes framework which in turn will create a financial framework that is required to achieve the agreed outcomes.

11. Given the present commissioning framework and staff terms and conditions within the NHS, the Jointly Accountable Officer may be presented with a significant and flexible source of revenue from the Local Authority partner while the NHS partner may present a fixed resource and limited commissioning opportunities that may limit the ability to shift investment as required to shift the balance of care. Greater guidance and clarity is required on how these issues should be resolved and more

specific guidance is required on how the Jointly Accountable Officer is empowered to manage such potential organisational issues if consistency of approach is to be achieved.

12. The Jointly Accountable Officer would be appointed at Executive Director level or equivalent.

13. It would be helpful to have greater clarity as to how the post of Jointly Accountable Officer links / does not link to the roles and responsibilities of the Chief Social Work Officer.

14. The locality planning framework should be determined locally within the partnership as should the relationship between the integrated governance framework and the Community Planning Partnership.

15. It would be helpful to have greater clarity on how consultation with clinicians and Social Work professionals then translates into active involvement in decision making and the expected organisational and professional ownership that goes with this process. Professional autonomy without accountability for performance can distance clinicians from strategic agreements and participation in the process.

16. The primary focus for participation in locality planning and local service development with clear delegation of decision making and budget management is required to supplement the attendance at Strategic Committees. It is considered that participation in the development of models of care and delegated authority to spend promotes greater ownership of the task.

17. There should not be any prescriptive instructions relating to organising around GP practices; individual partnerships should be empowered to make local decisions on this matter.

18. Operational locality groups should work within a strategic framework while being delegated to develop models of care that are consistent with the population needs of that area. There should be budgetary control that encourages local ownership and participation in service planning.

3.9 Discussions with NHS Highland to Date

The Council sought to progress discussions with NHS Highland prior to the announcement on the consultation by the Cabinet Secretary. A number of scoping documents and a formal Project Initiation Document (PID) were produced to facilitate this discussion between Chief Executives and Council Leader/NHS Board Chair over a two year period. The Project is intended to consider the preferred model for integration.

Both organisations formally adopted a statement of intent during 2011 and most recently agreed to engage a Jointly Appointed Officer to take forward the integration agenda. The details around this role remain to be confirmed and the post remains to be filled however it is expected as one of the earliest stages in the integration process.

In advance of the passing of the anticipated legislation, negotiations with NHS Highland will continue towards the development of the project and options appraisal on the preferred integration model. This process will follow the business case approach supported by project management methodology adopted by council for major change/ service review projects.

4. CONCLUSION

4.1 The consultation document on Integration of Adult Health and Social Care sets out the proposals being progressed by Scottish Government in considerable detail. It highlights the responsibilities of Local Authorities and Health Boards and details how the proposed Health and Social Care Partnerships should be configured and report.

4.2 Two options are described for consideration one of which reflects the delegated model developed in Highland and the other the integrated model. These are illustrative and not the only options available.

4.3 The draft response supports the view that the legislation should not be prescriptive in relation to which model is used and emphasises that local partners within Argyll & Bute should be responsible for developing a partnership governance framework as appropriate to the service needs of the population of Argyll & Bute while meeting the requirements of the proposed national outcomes framework.

5. IMPLICATIONS

Policy:	Consistent with National Agenda for the Integration of Health and Social Care services for Older People
Finance:	Implementation would create a pooled budget between the partners that would require a significant change in the council's management of the annual budget and service planning process.
Personnel:	Implementation has significant potential for Re-design of Management and workforce.
Legal:	New legislation being drafted.
Equal Opportunities:	None.
Risk:	Implementation assists in managing the risks associated with supporting vulnerable people in the community.
Customer Service:	Implementation assists in improving the quality of services associated with supporting vulnerable people in the community.

Cleland Sneddon
Executive Director – Community Services
July 2012

For further information contact: Jim Robb
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Annex F Respondent Information Form

Integration of Adult Health and Social Care in Scotland

RESPONDENT INFORMATION FORM

Please Note this form **must** be returned with your response to ensure that we handle your **response appropriately**

1. Name/Organisation

Organisation Name **Argyll & Bute Council**

Title Mr

Surname **Sneddon**

1. ***Postal Address:***
Argyll and Bute Council Community Services
Kilmory
Lochgilphead
Argyll and Bute
PA31 8BA

2. ***Please indicate which category best describes your role/group or interest in health and social care integration. (Tick one only)***

Permissions **- I am responding as…**

Individual ☐ / **Group/Organisation** ☐

Please tick as appropriate

(a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

Please tick as appropriate ☐ **Yes** ☐ **No**

(b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

Yes, make my response, name and address all available ☐

or

Yes, make my response available, but not my name and address ☐

or

Yes, make my response and name available, but not my address ☐

(c) The name and address of your organisation ***will be*** made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your ***response*** to be made available?

Please tick as appropriate ☐ **Yes** ☐ **No**

(d) We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Please tick as appropriate ☐ **Yes** ☐ **No**

Annex G Consultation Questionnaire The case for change

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

Yes

Comments:
In a practical sense the issues relating to integration will apply across the different client groups. Within Argyll & Bute the preference would be to plan the integration across all Adult Care services, Older, Learning Disability, Mental Health, Physical Disability, Substance Misuse and Sensory Impairment. Thereafter, consideration should be given to how the Adult Care services maintain robust operational and strategic links with, including consideration of the links with Children's Services, Criminal Justice Education and Housing.

Specifically:

1. Greater clarity would be helpful to highlight the impact and implication for the integration on Children's Services Criminal Justice, Housing and Education services. On a phased basis this may locally include consideration on whether the integration should extend to include aspects of children's health and social care services.

2. Further consideration on the impact of potentially breaking up the component parts of Social Work, Adult, Children & Criminal Justice and the potential risks around Child & Adult Protection issues that may follow if the different component parts are managed in isolation.

3. If, as proposed, the CHP is to be removed from the statute books, clarity is required as to where NHS Child health services will be managed if the CHP no longer exists.

Outline of Proposed Reforms

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

Yes

Comments:
The proposal is comprehensive and Argyll & Bute Council would support the view that there is no need to be prescriptive in which model should be used to drive forward with the implementation. The model should be developed locally.

1. A stronger message would be helpful as to where the integration proposal fits within the review of the Community Planning Partnership framework. This could provide an opportunity to give expression to the broader contribution of partners to the single outcome agreement and linkages to other joint enterprises such as tackling health inequalities.

2. The move towards outcomes, integrated budgets and practitioners being empowered to make operational and strategic decisions is welcome. The organisational, management and professional issues that could work against smooth implementation are key to developing a successful integrated model. These include:

- The partners have very different management and accountability regimes with the NHS accommodating clinical autonomy which is not always consistent with strategic policy.

- NHS operates different terms and conditions that make it more difficult to re-design services from scratch and use revenue flexibly in order to meet client outcomes. While recognising the responsibility for the provision of employment for existing staff, it is noted that such constraints applied to any public sector organisation can significantly impact on the ability to re-design services around the principles of client need. This is particularly the case in rural areas where the opportunities for re-deployment tends to be more limited.

- Each partner has different levels of information and analysis on activity and spend for services. Work to date including the Joint Commissioning Strategy for older people via the Integrated Resource Framework highlighted these issues. Extending Joint Commissioning Strategies across a wider service area will need to address these issues.

- There is no significant history of the NHS commissioning services outwith the wider NHS family as opposed to Local Government where commissioning from the independent sector is further established. This will also have a bearing on the development of a joint commissioning strategy across Health and Social Care provision.

  These four key issues are illustrative of the issues that will require to be addressed in developing an integrated model in Argyll and Bute featuring integrated budgets, joint commissioning and service re-design services. As highlighted earlier the key is ensuring flexibility within the legislation to enable partnerships to develop a local partnership model that reflect local circumstances and is supportive of addressing the issues above.

National Outcomes for Adult Health and Social Care

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

Yes

Comments:
Agreed and fully support that a nationally agreed outcomes framework is implemented and supplemented by local indicators as appropriate. It would be helpful to have greater clarity around audit, accountability and sanctions. For example, as noted, the clinical community within the NHS have exercised clinical autonomy which is often at odds with organisational accountability within the NHS. It is not clear how this will be resolved within a new partnership arrangement and exactly how disputes will ultimately be resolved.

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

Yes

Comments:
Agreed on the basis that the volume and detail of outcomes are consistent with the Single Outcome Agreements continuing to be a strategic document.

Governance and Joint Accountability

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

Comments:

Given that Health Boards tend to be larger than Councils territorially and yet have a relatively small number of Non-executive Directors (meaning it will be harder for Boards to appoint to Partnership Committees), whereas the democratic sovereignty of councils lies in the collective body of elected members, it is recommended that a higher minimum number of elected members on a integrated governance framework in order to avoid a democratic deficit.

It is also noted that the role of the Council Leader is to lead the administration of the Council. It is not a statutory role and that individual requires the agreement of Council in order to progress policy and strategic issues. At present it is the Council who are responsible and accountable rather than one individual. Further consideration is required on this issue before a satisfactory solution can be agreed however the primary accountability should be to the full Council and full Health Board rather than individuals to retain the principle of collective responsibility.

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

Yes

Comments:
Agreed that such an option may be appropriate depending upon whether the Local Authority and NHS areas are co terminus or not. Argyll & Bute Council and the Argyll & Bute CHP is co terminus and a partnership framed around that relationship is considered the appropriate partnership for the area. To move into a partnership with either West Dunbartonshire or Highland Council would not be consistent with local partnership planning for the Argyll & Bute area or practical in operational terms.

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

Yes

Comments:
In general terms yes. However,

- More detail would be helpful in relation to the budget setting arrangements and the management of any subsequent efficiency or over spend.

- More detail would be helpful on how the partnership moves to 3-5 year strategic budget planning and how such a proposal is managed within the existing management of annual budgets and deficits

- As previously noted, woulld be helpful on how disputes are resolved.

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

Comments:
The framework is clear; however for it to be fully effective it would be helpful to have greater clarity as to how the clinical community are also accountable to performance management arrangements.

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

Comments:
The National Framework should allow and encourage local arrangements that lead to improved operational outcomes.

Integrated Budgets and Resourcing

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

Yes

Comments:
The legislation should concentrate on the outcomes agenda rather than highlight two organisational options. Partnerships should be empowered to develop organisational arrangements, which may be different from the two mentioned, which reflect local operational and service management issues that will deliver good outcomes for clients/patients. The danger of highlighting organisational options is that partners will focus their activity around one of the two rather than concentrating on outcomes which will form the basis of the future organisational arrangements.

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

Yes

Comments:
The established practice in Argyll & Bute over the previous 10 years is one of re-designing in partnership, pooling resource release and delayed discharge revenue and investing in services in the context of a joint performance framework for older people. In general this has seen the development of constructive working relationship between the council and the CHP and is evidenced by the creation of a number of community services across health and social care and significantly improved performance in the area of delayed discharge.

Whilst significant progress has been made, the progress is affected by the significant differences in the management and behaviour of the partner organisations as highlighted in question 2.

- Very different management and accountability regimes with the NHS accommodating clinical autonomy which is not always consistent with strategic policy.

- NHS operates different terms and conditions that make it more difficult to re-design services from scratch and use revenue flexibly in order to meet client outcomes. While recognising the responsibility for the provision of employment for existing staff, it is noted that such constraints applied to any public sector organisation can significantly impact on the ability to re-design services around the principles of client need. This is particularly the case in rural areas where the opportunities for re-deployment tends to be more limited. There have been a number of instances within Argyll & Bute where the opportunities for the re-design of services have been limited due to the requirement to continue to employ existing NHS staff.

- Each partner has different levels of information and analysis on activity and spend for services. Work to date including the Joint Commissioning Strategy for older people via the Integrated Resource Framework highlighted these issues. Extending Joint Commissioning Strategies across a wider service area will need to address these issues.

- There is no significant history of the NHS commissioning services outwith the wider NHS family as opposed to Local Government where commissioning from the independent sector is further established. This will also have a bearing on the development of a joint commissioning strategy across Health and Social Care provision.

Question 12: *If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?* **No**

Comments:
The danger in setting minimum categories of spend is that the minimum becomes the norm. Focus should continue to be on outcomes which in turn will create a financial framework that is required to achieve the outcomes.

Jointly Accountable Officer

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

Yes

Comments:
The main issues that require further scrutiny again relates to the availability of flexible revenue from the NHS partner. Given the organisational constraints within the NHS, staff terms and conditions issues and limited external commissioning, the Jointly Accountable Officer maybe presented with a significant and flexible source of revenue from the Local Authority partner while the NHS partner may present a fixed resource and limited commissioning opportunities that may limit the ability to re-direct investment flexibly as required to shift the balance of care.

Greater guidance and clarity would be helpful on how these issues should be resolved and more specific guidance is required on how the Jointly Accountable Officer is empowered to manage such potential organisational issues if consistency of approach is to be achieved. This is balanced by the need for strong and effective oversight of the Jointly Accountable Officer by the Health and Social Care Partnership especially where major investment decisions are involved.

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

Yes

Comments:
Seniority is appropriate, however it would be helpful to have greater clarity as to how this post links / does not link to the roles and responsibilities of the Chief Social Work Officer. In particular the role of the Chief Social Work Officer requires to be revised in statute to ensure an appropriate integration of services across potentially different management and governance structures for children and families, adult services and criminal justice social work services.

Professionally Led Locality Planning and Commissioning of Services

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

Comments:
The locality planning framework should be determined locally within the partnership as should the relationship between the integrated governance framework and the Community Planning Partnership. Locality planning however must sit within the wider partnership framework to ensure strategic direction and priorities are maintained.

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

Yes

Comments:
- It would be helpful to have greater clarity on how consultation with clinicians and Social Work professionals then translates into active involvement in decision making and the expected organisational and professional ownership that goes with this process. Professional autonomy without accountability for performance can distance clinicians from strategic agreements and participation in the process.

- GP's in particular note that they find it difficult to attend meetings unless locum cover is provided for them to do so. Will additional revenue be made available to partnerships to facilitate the consultation envisaged? In a rural area such as Argyll & Bute the cost of travel in addition to the costs of attending meetings can be significant. If it is agreed to provide GP's with additional revenue to facilitate consultation will the NHS and Local authorities also receive additional revenue in order to widen their scope of staff consultation?

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

Comments:
A primary focus for participation in locality planning and local service development with clear delegation of decision making and budget management is required to supplement the attendance at strategic committees. It is considered that participation in the development of models of care and delegated authority to spend promotes greater ownership of the task.

As noted in question 16 the issues of how to encourage participation, create accountability to strategic policy while retaining capacity in relation to service delivery whether it be GP's, Community Nurses or Social Workers requires further clarification.

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

No, There should not be a prescriptive policy based around GP practices

Comments:
There are well established locality and island grouping in existence within Argyll & Bute which

are consistent across Social Work and Community Nursing and are recognised as natural geographical areas that are understood by the public and partners alike. There should not be any prescriptive instructions relating to organising around GP practices; individual partnerships should be empowered to make local decisions on this matter.

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

Comments :
Operational locality groups should work within a strategic framework while being delegated to develop models of care that are consistent with the population needs of that area. This should be budgetary control that encourages local ownership and participation in service planning.

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

Comments:
See response to question 18. In an area such as Argyll & Bute it is recommended that we do not commit to any prescriptive models whether it is around population or GP practice

Do you have any further comments regarding the consultation proposals?

Comments:

- The focus on the outcomes for service users that may be achieved through health and social care integration are to be welcomed. The key to this approach will be legislation that introduces the maximum flexibility to partnerships to determine a model that is right for their locality rather than a prescribed one size fits all approach. With a co-terminus Community Health Partnership (CHP) currently in Argyll and Bute, there is potential to develop a partnership that focuses on Argyll and Bute as the place and has our residents at the heart of an integrated health and social care system

- The focus of the consultation is on the integration across older people's services. As noted in the response it would be helpful to have greater clarity on the future of those services outwith the scope of the consultation and how the operational and strategic links between for example adult care, criminal justice, children's services and housing are maintained.

- There is no reference to how the Charging Policy for social care services may or may not be maintained within an integrated framework. It would be helpful to have clarification on this issue.

- The future management of the Mental Health Officer is not mentioned within the consultation document. It would be helpful to have a statement on this matter in order to avoid inconsistency on this matter.

- Clarity is required on the impact of Self Directed Support on the redesign and provision of social care services and how that impacts on the provisions of a pooled budget and the development of a joint commissioning strategy.

- On conclusion of this consultation, it would be helpful to have some clarity as to the level of local public consultation that is expected as partners move towards creating an integrated framework.

Do you have any comments regarding the partial EQIA? *(See Annex D)*

Comments: None

Do you have any comments regarding the partial BRIA? *(See Annex E)*

Comments: None

Annex H How to respond

The Integration and Service Development Team welcomes responses to this consultation paper by **31 July 2012.** Please send your response with the completed Respondent Information Form to:

adulthealthandsocialcareintegration@scotland.gsi.gov.uk

or

Integration and Service Development Division (Consultation) The Scottish Government 2ER, St Andrew's House Edinburgh EH1 3DG

We would be grateful if you would **use the consultation questionnaire provided in the consultation document or clearly indicate in your response which questions or parts of the consultation paper your are responding to** as this will aid our analysis of the responses received.

This consultation, and all other Scottish Government consultation exercises, can be viewed online on the consultation web pages of the Scottish Government website at http://www.scotland.gov.uk/consultations .

The Scottish Government now has an email alert system for consultations SEconsult: http://www.scotland.gov.uk/consultations/seconsult.aspx This system allows stakeholder individuals and organisations to register and receive a weekly email containing details of all new consultations (including web links). SEconsult complements, but in no way replaces, SG distribution lists, and is designed to allow stakeholders to keep up to date with all SG consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We would encourage you to register.

Handling your response

We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please complete and return the **Respondent Information Form** which forms part of the separate consultation questionnaire as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential and treat accordingly. All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

If you tell us we can make your response public, we will put it in the Scottish Government Library and on the Scottish Government consultation web pages. We will check all responses where agreement to publish has been given for any wording that might be harmful to others before putting them in the library or on the website. If you would like to see the responses please contact the Scottish Government Library on 0131 244 4565. Responses can be copied and sent to you, but a charge may be made for this service.

What happens next?

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us reach a decision on the Legislation on the Integration of Adult Health and Social Care. We will issue a report on this consultation process in the Autumn of 2012, which will be published on the Scottish Government's website at:

http://www.scotland.gov.uk/Publications/Recent

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to:

Forename

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