# PUBLIC BODIES (JOINT WORKING) (SCOTLAND) BILL

---

## EXPLANATORY NOTES

## (AND OTHER ACCOMPANYING DOCUMENTS)

**CONTENTS**

As required under Rule 9.3 of the Parliament's Standing Orders, the following documents are published to accompany the Public Bodies (Joint Working) (Scotland) Bill introduced in the Scottish Parliament on 28 May 2013:

- Explanatory Notes;
- a Financial Memorandum;
- a Scottish Government Statement on legislative competence; and
- the Presiding Officer's Statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 32–PM.

# EXPLANATORY NOTES

## INTRODUCTION

1. These Explanatory Notes have been prepared by the Scottish Government in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

2. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

## THE BILL

3. The Bill provides the framework which will support the improvement of the quality and consistency of health and social care services in Scotland. This framework permits the integration of local authority services with health services. In addition, the Bill provides for the Common Services Agency commonly known as NHS National Services Scotland to provide goods and services to public bodies including local authorities; for the Scottish Ministers to form a wider range of joint venture structures than at present in order to make the most effective use of resources; and to extend the Clinical Negligence and Other Risks Scheme (CNORIS) indemnity scheme run by the Scottish Ministers.

### Outline of the Bill

4. In summary the Bill:

- Provides for national outcomes for health and wellbeing, and for delivery of which Health Boards and local authorities will be accountable to the Scottish Ministers and the public (note that the provisions of the Bill apply to area Health Boards and not Special Health Boards)
- Sets out principles for planning and delivery of integrated functions, which local authorities, Health Boards and joint integration boards will be required to have regard to. They set out that the main purpose of integrated services is to improve the wellbeing of recipients, as well as an expectation that planning and delivery will take account of key principles relating to integrated delivery; the requirement to balance the needs of individuals with the overall needs of the population; anticipation and prevention of need; and effective use of resources.
- Establishes integration joint boards and integration joint monitoring committees as the partnership arrangements for the governance and oversight of health and social care services. The Bill will remove Community Health Partnerships from statute.
- Requires Health Board and local authority partners to enter into arrangements (the integration plan) to delegate functions and appropriate resources to ensure the effective delivery of those functions. The Bill provides two options for integrating budgets and functions. First, delegation to an integration joint board established as a body corporate - in this case the Health Board and the local authority agree the

amount of resources to be committed by each partner for the delivery of services to support the functions delegated. Second, delegation between partners. In this case the Health Board and/or local authority delegates functions and the corresponding amount of resource, to the other partner.

- Requires integration joint boards to appoint a chief officer, who will through the board be jointly accountable to the constituent Health Board and local authorities, responsible for the management of the integrated budget and the delivery of services for the area of the integration plan. The chief officer will also lead the development and delivery of the strategic plan for the joint board.
- Requires integration joint boards, and Health Boards or local authorities to whom functions are delegated acting in the capacity of "integration authority" to prepare a strategic plan for the area, which sets out arrangements for delivery of integration functions and how it will meet the national health and wellbeing outcomes. The integration authority will be required to involve a range of partners in the development of the plan and consult widely. In addition, locality planning duties will require the integration authority to make suitable arrangements to consult and plan locally for the needs of its population.
- Delivers opportunities for more effective use of public services and resources by allowing for Health Boards to be able to contract on behalf of other Health Boards for contracts which involve providing facilities, and by allowing the Scottish Ministers to form a wider range joint ventures structures to collaborate effectively with local authorities and enable a joint approach to asset management and disposal.
- Provides for the extension of the Common Services Agency's ability to deliver shared services to public bodies including local authorities.
- Enables the Scottish Ministers to extend the range of bodies able to participate in the CNORIS scheme for meeting losses and liabilities of certain health service bodies. The scheme is established for relevant bodies to meet expenses arising from any loss or damage to their property; and liabilities to third parties for loss, damage or injury arising from the carrying out of the functions of the scheme members. The Bill amends the bodies able to participate in the scheme to include local authorities and integration joint boards.

## COMMENTARY ON SECTIONS

### Part 1

### FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

*Integration plans*

**Section 1 – Integration plans: same local authority and Health Board area**

5. Section 1 makes provision about integration plans and sets out the four models of integration from which local authorities and Health Boards are to choose for the purposes of integration planning and integrated delivery of services in accordance with the Bill.

6. Integration planning is predicated on the delegation of local authority and/or Health Board functions using one of the four models of delegation set out in subsection (4): (a) the local authority and the Health Board delegate functions to an integration joint board established as a body corporate by order by the Scottish Ministers; (b) the local authority delegates functions to the Health Board; (c) the Health Board delegates functions to a local authority, and (d) the local authority delegates functions to the Health Board and the Health Board delegates functions to the local authority.

7. By virtue of subsections (1) and (2), where the area of a local authority is the same as the area of a Health Board i.e. there is a single local authority within the Health Board area, the local authority and the Health Board are required to jointly prepare an integration plan for the area of the local authority.

8. Subsection (3) sets out what the integration plan must include. The required information is: (a) which model of integration is to be used, (b) the functions which are to be delegated in the way identified, (c) where functions are delegated to a Health Board, local authority or both, the functions of that body which are to be carried out in conjunction with the delegated functions, (the functions which may be set out in this part of the plan are described in subsection (5)), (d) a method of calculating payments which are to be made with respect to the delegated functions, and (e) any additional information that may be required by the Scottish Ministers by regulations.

9. Subsection (6) enables the Scottish Ministers to make provision in regulations about functions of local authorities and Health Boards which may, may not or must be delegated under integration plans. If no regulations are made local authorities and Health Boards will be free to choose which of their functions to delegate under the Bill. This provision will however give the Scottish Ministers flexibility to set parameters, including minimum requirements, for the delegation of functions.

10. Subsection (7), read with section 48(1)(Interpretation) defines what is meant by "Health Board" for the purposes of the Bill. Its effect is that the provisions of the Bill apply to area Health Boards only, not Special Health Boards.

**Section 2 - Integration plans: two or more local authorities in Health Board area**

11. Section 2 sets out integration planning requirements where more than one local authority sits within the boundary of a single Health Board area (in contrast to the requirements in section 1(2) which apply where there is a single local authority in a Health Board area).

12. By virtue of subsection (2), each local authority and the Health Board are to agree which of the alternative duties in subsections (3) and (4) they will comply with in respect of the local authority area (compliance with one or the other is mandatory). The options are for a local authority to jointly prepare an integration plan with that Health Board, for its own area only (subsection (3)), or for the local authority to join together with one or more other local authorities to, with the Health Board, jointly prepare an integration plan for the areas of those local authorities (subsection (4)).The result is that within a single Health Board area which houses more than one local authority there may be any number of single local authority plans and/or multiple local authority plans. For example, in an area with 3 local authorities there may

be a plan for a single area plus a plan covering the other two areas; or in an area with 6 local authorities there could be a plan covering three areas, plus a plan covering two areas, plus a plan for a single area. The effect is to provide flexibility so that planning decisions can be taken on the basis of what is appropriate for the areas in question i.e. multiple local authorities, within the area of the same Health Board, can plan together, where appropriate or they may choose to plan separately.

13. Subsection (5) sets out that when preparing an integration plan, whether between an individual local authority and Health Board, or multiple local authorities and a Health Board, a local authority must (a) take into account any other integration plan that is currently or has been prepared for the same Health Board area, and (b) the potential impact on the Health Board of any plans prepared in relation to that Health Board. This provision establishes the importance of different integration plans within a single Health Board area paying due regard to their combined effect, and inter-operability, in relation, in particular, to the effective running of the Health Board.

**Section 3 – Considerations in preparing integration plan**

14. Section 3 requires the local authority and Health Board to consider the integration principles and the national health and wellbeing outcomes when preparing their integration plan. This provides the link with the national outcomes for health and wellbeing from the outset and underpins the purpose of integrating services, to ensure integration arrangements which embed a preventative, anticipatory and person-centred approach to the planning and delivery of services. Section 4 provides further information on integration principles and section 5 provides further information on national health and wellbeing outcomes.

**Section 4 – Integration planning principles**

15. Section 4 establishes the integration planning principles that must be taken into account when preparing an integration plan.

16. The effect of subsection (1)(a) is to ensure that decisions about integration of functions take account of the principle that services, for the purposes of carrying out functions that must or may be delegated, are to improve the wellbeing of users of that service.

17. Subsection (1)(b) supplements this by setting out principles for delivery which must also be taken into account in taking decisions about how functions will be integrated. The effect is to ensure a focus on integrated delivery, consideration of the needs of different individuals and different areas, local planning and leadership, anticipation and prevention, and effective use of resources.

**Section 5 – Power to prescribe national outcomes**

18. This section provides for the Scottish Ministers to set out in regulations, national outcomes that relate to health and wellbeing. The national outcomes will provide for improved experience of services and outcomes that services achieve. The intention is for the national

outcomes on health and wellbeing to be reflected in the Single Outcome Agreements, which the national outcomes expressed within the National Performance Framework.

19. Before doing so, the Scottish Ministers are required to consult persons set out in subsections (3) and (4). The effect of the provision is to involve the groups identified in the development of the national outcomes on health and wellbeing.

**Section 6 – Consultation**

20. Section 6 sets out consultation requirements in relation to the preparation of integration plans.

21. The local authority and Health Board, before submitting the integration plan for approval, are required to consult (a) those persons or groups of person, set out by the Scottish Ministers, by regulations, and (b) any other persons as the local authority and Health Board think fit. The consultation must be carried out jointly by the local authority and the Health Board. The local authority and Health Board are required to take account of views expressed as part of the consultation, when finalising the integration plan.

**Section 7 - Approval of integration plan**

22. This section requires a local authority and Health Board to jointly submit the integration plan to the Scottish Ministers for approval, before a date that will be set by the Scottish Ministers by regulations.

23. Subsection (5) gives Ministers a discretionary power to grant an extension for submission of a plan for approval. The Scottish Ministers may grant an extension on their own initiative or on the request of the local authority and the Health Board. Where the request comes from the local authority and the Health Board it must be made jointly and reasons must be given. The effect is to enable a plan to be accepted after the statutory deadline for submission, where there is good reason.

24. The Scottish Ministers may decide either to approve an integration plan submitted to them, or to refuse to approve it. Although any information that may be included by virtue of section 1(3)(e) does not form part of the information to be approved, it may be taken into account by Ministers in coming to their decision.

25. If the Scottish Ministers refuse to approve the submitted integration plan, the local authority and Health Board must jointly amend the plan and resubmit it for approval.

**Section 8 – Publication of integration plan**

26. Section 8 requires the local authority and Health Board to publish the approved integration plan, as soon as practicable after it has been approved.

*Implementation of integration plan*

**Section 9 – Functions delegated to integration joint board**

27. This section provides that, where the Scottish Ministers approve an integration plan which sets out that functions will be delegated to an integration joint board under section 1(4)(a), Ministers may by order establish the integration joint boards, which will have the functions specified in the integration plan delegated to it.

28. Subsection (3) provides for the functions in the integration plan to be delegated before a date set, by the Scottish Ministers, by regulations.

**Section 10 – Chief officer of integration joint board**

29. Section 10 requires the integration joint board to appoint a member of staff to be its chief officer. The integration joint board will not necessarily be given powers to employ its own staff. Section 11 provides for the Scottish Ministers to give the ability to joint boards to appoint staff. In the absence of an order being made under section 11 to allow for the appointment of staff, subsections (2), (3) and (4) set out the default position that the chief officer is to be seconded to it from one of its constituent local authorities or Health Board. In the event that there is a wish in future for the chief officer to be employed directly by the joint integration board, Ministers have powers to make an order under subsection (5) to enable this.

30. Subsection (4) provides that where the person to be appointed is not an existing member of staff of a local authority or Health Board by which the integration joint board was established, the person is first to be appointed to the local authority or the Health Board and then seconded to the integration joint board.

31. Subsection (6) requires the integration joint board to consult the Health Board and local authority, before appointing the chief officer of the integration joint board.

32. Subsection (7) provides for the Scottish Ministers to approve the responsibilities of the chief officer.

**Section 11 – Other staff of integration joint board**

33. This section provides for the Scottish Ministers, by order, to give integration joint boards the ability to appoint staff other than a chief officer and to make further provision in relation to the staffing of integration joint boards (generally or making different provision in relation to different joint boards) as the Scottish Ministers think fit, including; (a) the appointment of staff, (b) the numbers of staff, (c) the terms and conditions of staff. The Scottish Ministers may make provision for these matters to be subject to the determination, direction or agreement of any person. This allows the Scottish Ministers to permit other persons, such as integration joint boards, to decide these matters.

**Section 12 – Integration joint boards: further provision**

34. This section enables the Scottish Ministers to make further provision about integration joint boards.

35. Subsection (1) gives the Scottish Ministers powers to make provision by order (either generally or making different provision about different joint boards) about the membership, proceedings and general powers of integration joint boards; the supply of services or facilities to integration joint boards by a local authority or Health Board; and any other matter as the Scottish Ministers think fit in relation to the establishment or operation of integration joint boards.

36. Subsection (3) provides for the Scottish Ministers to make schemes for the transfer to an integration joint board of staff, property, rights, liabilities, or obligations of a local authority or a Health Board. This power may be exercised to support the delivery of delegated functions by the integration joint board, where that is considered appropriate.

**Section 13 - Payments to integration joint boards in respect of delegated functions**

37. Section 13 provides for the allocation of resources by the local authority and Health Board in relation to functions delegated by them to an integration joint board, to support the effective carrying out of the functions.

38. The duty requires payments to be made of the amount calculated in accordance with the method set out in the integration plan as approved by the Scottish Ministers.

**Section 14 – Functions delegated to local authority or Health Board**

39. Section 14 applies where the Scottish Ministers approve an integration plan under section 7 and that plan contains provision about the delegation of functions by a local authority to a Health Board or functions delegated by a Health Board to a local authority, or both, as the case may be, under section 1(4)(b), (c) or (d).

40. Subsection (2) requires the local authority and Health Board to set up, before a date set by the Scottish Ministers by regulations, an integration joint monitoring committee to monitor the operational delivery of the functions set out in the integration plan. It also requires that the local authority and the Health Board must delegate the functions in accordance with the integration plan before that date.

**Section 15 – Transfer of staff where functions delegated to a local authority or Health Board**

41. Section 15 provides that the Scottish Ministers may make provision by scheme about the transfer or secondment of staff from the body responsible for delegating the functions in the integration plan as set out in 1(4)(b), (c) or (d), to the body the functions are delegated to. This provision therefore relates to transfers to local authorities or Health Boards, as opposed transfers to integration joint boards which are dealt with by section 12(3).

**Section 16– Integration joint monitoring committees: further provision**

42. Section 16 confers a power on the Scottish Ministers to make provision by order about the establishment, membership and proceedings of integration joint monitoring committees (either generally or making different provision about different committees), as well as any about any other matter relating to their operation as Ministers think fit.

**Section 17 – Payments to Health Boards in respect of delegated functions**

43. Section 17 requires that where a local authority delegates a function to the Health Board, in accordance with an approved integration plan, the local authority must make payment to the Health Board of an amount calculated in accordance with the method set out in the integration plan.

**Section 18 – Payments to local authorities in respect of delegated functions**

44. Section 18 requires that where a Health Board delegates a function to a local authority, in accordance with an approved integration plan, the Health Board must make payment to the local authority of an amount calculated in accordance with the method set out in the integration plan.

**Section 19 – Transfer of staff: effect on contract of employment**

45. Section 19 makes provision about the effect on an individual's contract of employment on the transfer (or proposed transfer in the case of subsection (2)) of that individual's employment by scheme under section 12 or 15.

46. Subsection (2) provides that where, before the day of transfer, a person who is to be transferred informs their original employer that they do not wish to transfer employment, the person's contract of employment is terminated on the day before the day of transfer. The effect of this is that a person who does not wish to transfer does not have to do so but instead his or her contract will end immediately before the transfer would have taken place.

47. Subsection (3) sets out the effects of a transfer on an employee's contract. In effect, the contract continues as it was before the transfer, except that the new employer takes the place of the previous employer. This means that the rights, powers, duties and liabilities of the original employer under or in connection with the contract of employment are transferred to the new employer and anything done by or in relation to the original employer in respect of the contract of employment is treated as having been done by or in relation to the new employer.

48. Subsection (4) makes provision to put beyond doubt that a person is not to be treated as being dismissed as a result of any provision of this section.

49. Subsection (5) protects any right that a person may have under general employment law to terminate their contract where there is a substantial detrimental change to his or her working conditions.

50. Subsection (6) makes clear that the change in employer as a result of the transfer of a person under this section does not constitute a substantial detrimental change to a person's working conditions. This has the effect that the transfer of a person by scheme under section 12 or 15 cannot be considered a substantial detrimental change such as to give rise to any right protected by subsection (5).

**Section 20 - Co-operation**

51. Section 20 operates where two or more local authorities have joined together to prepare an integration plan under section 2(4), or there is otherwise more than one integration plan in relation to a Health Board's area. It puts a duty on the local authorities involved and the Health Board to cooperate with each other in relation to the efficient and effective use of buildings, staff and equipment relevant to the plan or plans.

*Carrying out of delegated functions*

**Section 21 – Effect of delegation of functions**

52. Section 21 sets out the effect the delegation of functions, by one body to another, on the rights, powers, duties and liabilities of those bodies. Where a function is delegated from one body to another, the body to whom the function is delegated (referred to here as the "receiving" body) will be subject to the duties, rights and powers of the delegating body, that is the integration joint board, Health Board and/or the local authority as the case may be. This extends to duties imposed and rights and powers conferred after the function is delegated.

53. The receiving body is also entitled to enforce any rights acquired, and is liable in respect of any liabilities incurred, in the carrying out of the delegated functions. Any proceedings in relation to the enforcement of relevant rights and liabilities must be brought by or against the receiving body in its own name and not in the name of the body which has delegated the function.

54. This section, at subsection (6), also confers a power on the Scottish Ministers, by order, to require an integration joint board to exercise or not exercise a right or power, conferred by subsection (2)(b), in relation to a delegated function.

**Section 22 – Further powers of persons to whom functions are delegated**

55. This section (at subsection (1)(a)) enables integration joint boards to direct the local authorities or the Health Board that have delegated functions to it in accordance with an integration plan, to carry out a function on its behalf.

56. It also (at subsection (1)(b)) enables a local authority or Health Board which has had functions delegated to it in accordance with an integration plan to direct the local authority or Health Board which delegated the function to it to carry out the functions on its behalf.

57. Directions by local authorities, Health Boards and joint integration boards under subsection (1) must set out the payment or calculation method for payments to the person

directed to carry out the function. The person making the direction is required by subsection (3) to make payments accordingly.

58. A direction may also include further detail such as how the delegated functions are to be delivered operationally, or about the rights, powers, duties or liabilities of the body carrying out the function. By virtue of subsections (4) and (5), unless different provision is made in the direction about such rights, powers, duties and liabilities, section 21(2) to (5) will apply as though the person carrying out the function was the person to whom it was delegated under the integration plan.

59. Subsection (6) requires local authorities and Health Boards to comply with any direction given to them under this section.

60. Subsection (7) provides for directions made under this section to revoke or vary any earlier direction and that a direction made under subsection (1) must be made in writing.

61. Subsection (8) confers a power on the Scottish Ministers, by order, to require an integration joint board to give or not give a direction under subsection (1). This will enable the Scottish Ministers to determine whether the integration joint board carries out the delegated functions itself or to require the functions delegated to the integration joint board to be carried out on its behalf.

*Strategic planning etc.*

**Section 23 – Requirement to prepare strategic plans**

62. Section 23 requires the integration authority for the area of each local authority to prepare a strategic plan. This section sets out what a strategic plan is and the period the plan relates to. Section 39 sets out who is the integration authority for a local authority area, depending on the integration model adopted in the integration plan.

63. The integration authority can include such material as it thinks fit in the strategic plan, however there are two mandatory elements:

- A strategic plan must set out the arrangements for carrying out the integration functions (defined in section 40) in the local authority area over the period of the plan (subsection (2)(a)). The area must be divided into localities for this purpose, and the arrangements for each locality must be set out separately (subsection (3)).
- A strategic plan must also set out the way in which the arrangements for carrying out the functions are intended to achieve or contribute towards achieving the national health and wellbeing outcomes.

64. The first strategic plan of an integration authority must be prepared before a date set by the Scottish Ministers by regulations, and must cover the three year period starting with a date also to be set by the Scottish Ministers by regulations (subsection (4)).

65. Subsequent strategic plans must be prepared on an annual basis, before each anniversary of the start date of the first strategic plan, and cover a three year period beginning with the date of that anniversary (subsection (5)).

**Section 24 – Considerations in preparing strategic plan**

66. Section 24 requires the integration authority to take into account to the integration delivery principles (set out in section 25) and the national health and wellbeing outcomes (prescribed under section 5) in preparing a strategic plan. The effect of section 24 is to ensure the principles and national outcomes are at the heart of planning for the population and embeds a person centred approach, alongside anticipatory and preventative care planning.

**Section 25 – Integration delivery principles**

67. Section 25 sets out the integration delivery principles that must be taken into account in preparation of the strategic plan and in the actual carrying out of integration functions (as required by section 31).

68. The effect of subsection (1)(a) is to ensure that in making arrangements for the carrying out of integration functions, the integration authority takes account of the principle that the purpose of the services provided in pursuance of those functions is to improve the wellbeing of users of the service.

69. Subsection (1)(b) supplements this by setting out principles for delivery which must also be taken into account in making arrangements for delivery of integration functions. The effect is to ensure a focus on integrated delivery, consideration of the needs of different individuals and different areas, local planning and leadership, anticipation and prevention, and effective use of resources.

**Section 26 – Establishment of consultation group**

70. Section 26 puts an obligation on integration authorities to establish a consultation group for each local authority area, for the purposes of preparing the strategic plan for that area.

71. Depending on the model of integration chosen, the group must involve members nominated by the local authority or the Health Board, or both, as set out in subsection (1)(a), (b) and (c). In effect, this provides for the partners who prepared the integration plan and are party to the integrated arrangements to be involved in the development of the strategic plan. In addition, the integration authority will be required by subsection (1)(d) and (e) to involve a range of relevant stakeholders.

72. The group must also include representatives of groups prescribed by the Scottish Ministers by regulations under subsection (2) as having an interest, and other persons as the integration authority considers appropriate.

73. The integration authority is to determine the procedure of the group, and may pay members of the group expenses and allowances.

**Section 27 – Steps following establishment of consultation group**

74. Section 27 sets out the process for the involvement of the range of stakeholders on the consultation group in the development of the strategic plan, assuring their engagement in the process from the start.

75. The integration authority is required to prepare proposals about matters the strategic plan should contain, and consult the group on the proposals (subsection (1)) and then to prepare a first draft of the strategic plan, taking into account the views of the group expressed during the consultation. The integration authority must then consult the group on the draft (subsection (2)).

76. Taking account of the views in response to the consultation on the first draft, the integration authority is required to prepare a second draft of the strategic plan and send a copy of it for comment to persons mentioned in subsection (4), and any other persons the integration authority considers appropriate (subsection (3)).

77. The persons mentioned in subsection (4) include the local authority and the Health Board or both (depending on the model of integration chosen) as well as representatives of any groups prescribed by the Scottish Ministers under subsection (5). The effect of this is to ensure that any others with an interest will have an opportunity to comment on the draft plan.

78. Subsection (6) requires the integration authority to take into account the views obtained through consultation on the second draft of the strategic plan when finalising the strategic plan.

**Section 28 – Requirement for agreement to certain strategic plans**

79. Section 28 applies where a strategic plan is prepared by an integration authority that is a local authority or a Health Board.

80. It ensures that the body who has delegated functions to the integration authority is in agreement with the arrangements for delivery of those functions set out in the plan. This is achieved by duties on the integration authority to submit the finalised strategic plan for approval to the delegating Health Board, where the integration authority is a local authority; or the delegating local authority, where the integration authority is a Health Board.

81. Subsection (4) requires the integration authority to modify the plan where it is not approved and submit the modified plan for approval.

**Section 29 – Publication of strategic plans**

82. Section 29 places a duty on integration authorities to publish strategic plans.

83. Where the integration authority is an integration joint board or the strategic plan relates to an integration plan in which functions are delegated to both the local authority and the Health Board, the plan must be published as soon as it has been finalised. Where the integration

authority is a local authority or a Health Board and approval is required under section 28, the plan must be published as soon as it has been approved.

84. Subsection (3) requires an integration authority to publish a statement at the same time it publishes its strategic plan, which describes the consultation it undertook under section 27.

**Section 30 – Significant decisions outside strategic plan: public involvement**

85. Section 30 makes provision for where an integration authority plans on making a decision that would have a significant effect on the arrangements for provision of a service in pursuance of integrated functions outwith the context of the strategic planning cycle.

86. The integration authority is required to take appropriate action in order to involve and consult users or potential users of the service which is being or may be provided in relation to the decision.

*Carrying out of integration functions*

**Section 31 – Carrying out of integration functions: general**

87. Section 31 obliges integration joint boards, local authorities and Health Boards to have regard to the national health and wellbeing outcomes and the integration delivery principles set out in section 25, when carrying out an integration function. The effect is to embed the principles in delivery as well as in planning to ensure a shift towards preventative and anticipatory care and that the services delivered meet the different needs of different individuals and are ‘person centred’.

**Section 32 – Carrying out of integration functions: localities**

88. Section 32 requires person carrying out an integration function for the area of a local authority (which may be the local authority, the Health Board or the integration joint board depending on the integration model adopted and any directions made under section 22) to involve and consult interested persons prescribed by the Scottish Ministers by regulations where it proposes to take a decision that it considers might significantly affect the service provision in a locality of the area of the local authority.

**Section 33- Integration authority: performance report**

89. This section requires each integration authority to prepare and publish a performance report for each reporting year.

90. The report must set out an assessment of performance in carrying out the integrated functions during the reporting year.

91. Subsection (3) enables the Scottish Ministers to make regulations that set out the form and content of performance reports, and the period within which performance reports must be published.

92. In accordance with subsection (4) the "reporting year" is the period of one year starting on the start date set by the Scottish Ministers for the first strategic plan (under section 23(4)(b)) and each subsequent year.

*Change of integration plan*

**Section 34 – Revised integration plan**

93. This section sets out the process for varying the integration plan after it has been approved by the Scottish Ministers.

94. Any variation must be made jointly by the local authority and the Health Board and is to be achieved by the preparation of a revised integration plan.

95. Subsection (3) establishes the scope of variation that may apply to the integration plan. A revised integration plan may include further functions that are to be delegated, set out functions that are no longer to be delegated, amend the functions that are to be carried out in conjunction with the delegated functions when delegating to a Health Board only or a local authority only or to both, and make adjustments to the method of calculating payments.

96. A revised integration plan must be jointly submitted by the local authority and the Health Board to the Scottish Ministers for approval, who will set the date on which the revised integration plan will take effect.

**Section 35 – New integration plan**

97. Section 35 sets out that a local authority and Health Board must prepare a new integration plan under section 1 where they wish to change the local authorities that are party to the plan or the integration model. The new plan is subject to all the same requirements including as to consultation and the requirement for Ministerial approval as the originally prepared plan.

**Section 36 – Power to make provision in consequence of replacement of integration plan**

98. This section confers powers on the Scottish Ministers to take steps in consequence of a new integration plan approved under section 35. They are empowered to provide by order for the winding-up of any integration joint board that was established in pursuance of the original plan. They can also provide by scheme for the transfer of staff, property, rights, liabilities or obligations of an integration joint board, local authority or Health Board as may be necessary in light of the new plan.

*Supplementary*

**Section 37 – Information-sharing**

99. Section 37 allows for the disclosure of information between local authorities, Health Boards and integration joint boards for the purpose of preparing an integration plan, carrying out the functions that are delegated, the functions that are to be carried out in conjunction with delegated functions and the preparation of a strategic plan. The sharing of information for these

purposes can take place without breaching any duty of confidentiality that may be owed by a Health Board or local authority to any person.

**Section 38 – Grants to local authorities**

100. Section 38 provides for the Scottish Ministers to make grant payments to local authorities in respect of costs incurred by virtue of Part 1 of the Bill, and to set conditions in relation to grants made.

**Section 39 – Default power of Scottish Ministers**

101. Section 39 provides for the Scottish Ministers to take action where a local authority and Health Board have failed to submit an integration plan to them for approval by the deadline set under section 7.

102. In such circumstances the Scottish Ministers may require the local authority and Health Board to adopt the integration joint board model of integration and may decide the functions to be delegated to it. They may also establish the integration joint board by order, set a deadline by which the local authority and Health Board must delegate the specified functions to the integration joint board, specify payments to be made by the local authority and Health Board to the integration joint board and impose other requirements in relation to the delegated functions.

**Section 40 – Directions**

103. Section 40 confers a power on the Scottish Ministers to give directions to integration joint boards, Health Boards and local authorities.

104. Directions given to a local authority or Health Board under this section may relate to the functions conferred on them by this Bill, the carrying out of functions delegated to them in pursuance of an integration plan, and the functions to be carried out in conjunction with the delegated functions (subsections (1) and (2)).

105. Directions to an integration joint board may relate to the functions conferred on it by this Bill and the carrying out of functions delegated to it in pursuance of an integration plan (subsection (3)).

106. Integration joint boards, Health Boards and local authorities are required to comply with a direction given to them by the Scottish Ministers under this section.

107. Subsection (5) provides that directions made under this section may vary or revoke earlier directions made under this section and are to be made in writing.

**Section 41 – Guidance**

108. Section 41 requires every local authority, Health Board and integration joint board to take account of any guidance issued by the Scottish Ministers about their functions, under or in relation to the Bill.

**Section 42 –Meaning of "integration authority"**

109. Section 42 sets out who is the integration authority for a local authority area for the purposes of Part 1 of the Bill. This depends on the model of integration adopted, so that the integration authority is: the integration joint board, where the integration plan provides for functions to be delegated to an integration Joint Board; the Health Board, where in accordance with the integration plan functions are delegated to the Health Board only; the local authority where, in accordance with the integration plan, functions are delegated to the local authority only; or both the local authority and the Health Board acting jointly where, in accordance with the integration plan, functions are delegated to both the local authority and the Health Board.

**Section 43 – Meaning of "integration functions"**

110. Section 43 sets out what the integration functions for the area of a local authority are for the purposes of Part 1 of the Bill. Where the integration plan provides for functions to be delegated to an integration joint board, the integration functions are those delegated to the board in pursuance of the plan. Where the integration plan provides for functions to be delegated to either a local authority or to a Health Board or to both a local authority and a Health Board, the integration functions are those delegated in pursuance of the plan, as well as the functions specified in the plan as ones which are to be exercised in conjunction with the delegated functions.

**PART 2**

**SHARED SERVICES**

**Section 44 - Shared services**

111. Section 44(1) provides for the Common Services Agency for the Scottish Health Service to provide, or arrange the provision of, goods and services to the bodies listed in subsection (2). The Common Services Agency may only provide, or arrange the provision of, goods and services to those bodies with the consent of the Scottish Ministers.

112. Subsection (3) provides an illustrative list of the services which may be provided. The list comprises administrative, technical and legal services.

113. The Common Services Agency also has powers under the National Health Service (Scotland) Act 1978 ("the 1978 Act") to provide goods and services to certain persons. For example, under section 15, the Common Services Agency may provide goods to doctors, dentists and ophthalmologists who are providing primary medical services under a contract with a Health Board. Subsection (4) sets out that the power of the Common Services Agency to provide goods and services under subsection (1) of this section sits alongside and does not compromise any other power of the Common Services Agency to provide goods or services to other persons

**Section 45 – Extension of schemes for meeting losses and liabilities of health service bodies**

114. Section 45 amends section 85B of the National Health Service (Scotland) Act 1978 (the "1978 Act") to permit local authorities and integration joint boards to participate in the scheme established under that section for the purposes of meeting losses and liabilities incurred in the exercise of relevant functions.

115. Subsection (3) inserts references into the 1978 Act, which have the effect of restricting the functions of local authorities that can be covered by a scheme made under section 85B of the 1978 Act. It restricts the functions to integration functions and to functions that a local authority carries out in accordance with a direction from a integration joint board. The Scottish Ministers are given the power to specify by order other functions of local authorities that can be covered by a scheme under section 85B of the 1978 Act "Integration functions" are defined for the purposes of this section in relation to local authorities as functions which are: delegated to the authority under an integration plan; to be carried out in conjunction with delegated functions; or to be carried out by the local authority in pursuance of a direction by a Health Board or integration joint board under section 22.

116. Subsection (4) amends the existing power in the 1978 Act so that the Scottish Ministers are not able to direct local authorities to participate in a scheme made under section 85B of the 1978 Act.

**PART 3**

**HEALTH SERVICE: FUNCTIONS**

**Section 46 – Scottish Ministers: power to form companies etc.**

117. Section 46 provides for amendments to section 84B (Joint ventures) of the 1978 Act. Currently, the Scottish Ministers may only form or participate in companies as defined by section 1(1) of the Companies Act 2006. The amendment permits the Scottish Ministers to form and participate in any type of body corporate. This includes limited liability partnerships and Scottish Charitable Incorporated Organisations.

**Section 47 –Health Boards: carrying out of functions**

118. Section 47 amends the 1978 Act to permit Health Boards to exercise any function of another Health Board where the other Health Board and the Scottish Ministers give their consent.

**PART 4**

**GENERAL**

**Section 48 – Interpretation**

119. Section 48 provides various definitions that apply to this Act.

**Section 49 - Subordinate legislation**

120. The Bill contains various powers for the Scottish Ministers to make regulations and orders. This section makes further provision about regulations and orders under the Bill in particular enabling them to make different provision for different purposes, and to include supplementary, incidental, consequential, transitional or transitory provision. It also provides that regulations under section 5(1) and any order under section 50 which amends the text of another Act is subject to the affirmative procedure. Other regulations and orders under the Bill are subject to the negative procedure.

**Section 50 - Ancillary provision**

121. This section provides powers for the Scottish Ministers to make supplementary, incidental or consequential provision by order, as they consider appropriate for the purposes of, or in connection with, or for the purposes of giving full effect to, any provision made by, or by virtue of, this Act. Such an order may also make such transitional, transitory or savings provision as the Scottish Ministers consider appropriate for the purposes of, or in connection with, the coming into force of any provision.

**Section 51 – Repeals**

122. Subsection (1) and (3) repeal sections 4A and 4B of the National Health Service (Scotland)Act 1978 (c.29) and section 2 of the National Health Service Reform (Scotland) Act 2004 (asp 7), thereby removing Community Health Partnerships from statute.

123. Subsection (2) repeals sections 15 to 17 of the Community Care and Health (Scotland) Act 2002 (asp5) which provide the current mechanism for Health Boards and local authorities to delegate functions and make payments in relation to those functions, and for the transfer of staff in relation to the delegated functions.

124. Subsection (4) repeals section 20 of the Social Care (Self-directed Support) (Scotland) Act 2013 (asp1) which amends section 15 of the Community Care and Health (Scotland) Act 2002 (which is itself repealed by subsection (2)).

**Section 52 – Commencement**

125. Section 52 establishes that sections 49, 50, 52 and 53 of the Bill come into force on the day after Royal Assent. Powers are conferred on the Scottish Ministers to commence the other provisions of the Act on dates appointed by order and to make transitory, transitional or savings provisions in connection with commencement.

**Section 53 – Short title**

126. Section 53 states that the short title of this Act is the Public Bodies (Joint Working) (Scotland) Act 2014.

---

# FINANCIAL MEMORANDUM

## INTRODUCTION

1. This document relates to the Public Bodies (Joint Working) (Scotland) Bill introduced in the Scottish Parliament on 28 May 2013. It has been prepared by the Scottish Government to satisfy Rule 9.3.2 of the Parliament's Standing Orders. It does not form part of the Bill and has not been endorsed by the Parliament.

2. The purpose of this Financial Memorandum is to set out:

- the best estimates of the administrative, compliance and other costs to which the provisions of the Bill will give rise, as well as likely efficiency savings;
- the best estimates of the timescales over which the costs and savings are expected to arise; and
- an indication of the margins of uncertainty in these estimates.

3. The Bill sets out different models for Health Boards and local authorities to integrate health and social care services. The Financial Memorandum summarises the cost implications of each model.

4. The Bill provides the framework which will support improvement of the quality and consistency of health and social care services through the integration of health and social care in Scotland. This framework permits integration of other local authority services with health services. The Scottish Ministers intend to use the framework to integrate adult health and social care services as a minimum, and for statutory partners to decide locally whether to include other functions in their integrated arrangements. The Financial Memorandum, therefore, only gives consideration to costs in relation to integration of adult health and social care functions.

5. The Financial Memorandum draws upon a variety of evidence sources to present general modelling of the costs of the different models of integration for which the Bill provides. It does not provide a blueprint for how individual Health Boards and local authorities will integrate adult health and social care locally. Minimum functions that must be included in local integrated arrangements will be prescribed in regulations and statutory guidance.

6. The Financial Memorandum is structured as follows:

<u>Part One</u>
Cost implications to the Scottish Government from provisions in the Bill: Transitional costs

<u>Part Two</u>
2.1 Recurrent cost implications to Health Boards and local authorities from provisions in Part 1 of the Bill

2.2 Cost implications to Health Boards and local authorities from provisions in Part 2 of the Bill
2.3 Cost implications to Health Boards and local authorities from provisions in Part 3 of the Bill
2.4 Consequential cost implications to Health Boards and local authorities from provisions in Part 1 of the Bill

<u>Part Three</u>
Cost implications to other Public Bodies from provisions in the Bill

<u>Part Four</u>
Consequential cost implications to other bodies, individuals and businesses from provisions in the Bill.

7. The following terms are used in this Financial Memorandum:

- **Community Health Partnerships (CHPs)**, as constituted under the NHS Reform (Scotland) Act 2004 and The Community Health Partnership (Scotland) Regulations 2004. Two forms of CHP have evolved, as follows: a health only structure, and a health structure that incorporates aspects of social care alongside health. For the purposes of this Financial Memorandum, the term "Community Health Partnership" refers to both types of structure.
- **Section 33 bodies**, which are bodies identified by that section in the Value Added Tax Act 1994 that are funded by local taxation and are able to reclaim, except for minor exceptions, all of the VAT they incur in the purchasing of goods and services. Local authorities have section 33 VAT status.
- **Section 41 bodies**, which are bodies identified by that section in the Value Added Tax Act 1994 that are able to reclaim VAT on certain services. Health Boards have section 41 VAT status.

## BACKGROUND

### Summary of Health Board and local authority health and social care expenditure

8. The policy intention of the Scottish Ministers is to prescribe in regulations that adult health and social care functions must be integrated as a minimum. The following material provides information by way of context for expenditure in this area and with regard to the financial challenges that Health Boards and local authorities face in relation to health and social care services for adults.

9. In 2011/12, estimated total expenditure by Health Boards on the provision of services for adults was almost £9bn. Table 1 sets out the spend by category of care.

**Table 1: Health Board expenditure by sector, £m, 2011/12.**

| Sector | £m |
|---|---|
| Acute | 3,853 |
| Mental health and learning difficulty | 1,127 |
| Maternity and care of the elderly | 540 |
| Community | 1,054 |
| Family health sector | 2,248 |

(Source: ASD analysis of Scottish Health Service Costs R100[1])

10. The figures in Table 1 include £332m of resources transferred to local authorities in 2011-12 to fund jointly planned community care services, which have resulted in long-stay hospital closures and bed reductions over the last 20 years.

11. In 2011/12, net expenditure by local authorities on adult social care was £2.1bn, 43% of which was spent on residential care.

**Table 2: Net adult social care expenditure by care group, £m, 2011/12.**

| Care group | £m |
|---|---|
| Older persons | 1,264 |
| Adults with learning difficulties | 484 |
| Adults with physical or sensory disabilities | 183 |
| Adults with mental health needs | 94 |
| Adults with addictions/substance misuse | 39 |

(Source: Annex A Scottish Local Government Finance Statistics 2011/12[2]).

12. These are figures net of the resource transfer received from Health Boards noted above and also income received from charging, which was £43m for adults.

13. In 2010/11, nearly two thirds of health and social care expenditure on people aged 75+ was accounted for by spending on care delivered in institutional settings (care homes and hospitals). Emergency admissions to hospital accounted for nearly 70% of total hospital expenditure for people aged 75+, equating to one third of total health and social care expenditure on this age group – approximately £900m. The cost of all inpatient and day cases (planned and unplanned) for people aged 75+ was £1,200m, which represents 44% of total expenditure on occupied bed days in hospital.

14. The number of people whose discharge from hospital is delayed, once their clinical care is complete, and the length of time for which they are delayed, are symptoms of disjointed care pathways. In the nine months to December 2012, the number of occupied bed days accounted for by delayed discharge totalled 366,311, suggesting an annual total of 488,000 days. This is

[1] SG ASD analysis of information provided in Executive Summary 100, http://www.isdscotland.org/Health-Topics/Finance/Publications/2012-11-27/Costs_R100_2012.xls

[2] http://www.scotland.gov.uk/Publications/2013/02/4659 - Annex A

equivalent to 44 hospital wards, an estimated fully absorbed cost to the NHS of £120m, and a direct cost estimated at £88m. Most people affected by delayed discharge are older people.

15. As of 31 March 2012, there were 916 care homes in Scotland for older people. Despite increases in the numbers of older people in the population, the total care home population has been relatively stable for the past decade because of the Scottish Government's policies to enable more vulnerable people to be cared for at home.

16. Over the same period, a trend has emerged in the number of local authority funded elderly care home residents reducing annually by around 2%. This is due to an overall decrease in the number of placements in residential care, resulting from policy aims to provide more care at home, and is also a result of a growing proportion of self-funders in care homes. The current average contribution to care home fees from clients recently increased to £144 per week; based on the average national contract (2012/13 rate) of £527, the current average local authority contribution per resident is £383.

17. Expenditure on health and social care services is projected to increase, both because of demographic change – more people living for longer – and because more people are living with multiple co-morbidities. The Registrar General has projected that the number of people in Scotland aged over 75 will grow by around 10,000 every year, over the decade ahead. Changes in demography will vary in scale, depending on location. Around one quarter of Scotland's population will be aged 65 and over by 2033; for some of our more rural areas the proportion is predicted to rise to nearly one third.

18. The Finance Committee[3] noted that, taking current patterns of utilisation of health and social care services as a starting point, demand for health and social care could increase by between 18.4% and 28.7% between 2010 and 2030, depending on the trajectory of healthy life expectancy. These estimates do not take account of increased numbers of adults with learning or physical disabilities due to improvements in life expectancy at all ages[4].

*Integrated care*

19. Reform needs to deliver care that is better joined up and delivers better outcomes for patients, service users and carers, wherever they live. By improving the continuity and person-focus of care, some efficiencies may be achievable where it is possible to deliver care within the community setting rather than an institutional setting. Any such efficiencies must be taken within the context of the overall growing population of people with multiple support needs.

20. As noted above, the challenge and associated opportunities for improvement are particularly relevant to the provision of care and support for older people, a growing group within the population, who are frequently admitted to expensive institutional care – hospitals and

[3] Finance Committee. 2nd Report, 2013 (Session 4): Demographic change and an ageing population. Published by the Scottish Parliament on 11 February 2013; (Paragraph 42) http://www.scottish.parliament.uk/S4_FinanceCommittee/Reports/fiR13-02_rev.pdf

[4] NHS Health Scotland (2004): People with Learning Disabilities in Scotland, Health Needs Assessment Report. Available at: www.gla.ac.uk/media/media_63872_en.pdf)

care homes – for long periods, when a package of support in the community might have served their needs better, with better outcomes and at equal or lower cost per person.

21. Evidence from the UK[5] and further afield, shows that better outcomes for people, better use of resources (money and people's time) and better experience of care can all flow when services are planned and delivered in an effectively integrated way – between GPs, hospitals and community based health and social care teams. Integration of health and social care will enable partners to redesign services and use resources across sectors differently to shift the balance of care away from reactive institutional based care to preventive and community based care that better meets the needs of adults with complex needs[6].

22. Despite the presence of some confounding factors, an initial comparison of unplanned bed days for people aged 75+ between Torbay Care Trust, (one of the most successful examples of integration in England[7]) and Scottish partnerships shows that the levels achieved in Torbay are lower than those in Scotland[8].

23. It is possible to estimate some of the potential efficiencies that may be achieved through integration, as described below:

*Delayed discharge*

24. Delayed discharge occurs when patients are unnecessarily delayed in a hospital setting when their needs could more appropriately be met in the community. Reducing delayed discharge therefore provides both a better outcome for the individual and a reduced cost to the public purse.

25. Local authorities and Health Boards have worked hard over the last 10 years to reduce unnecessary delays in getting people out of hospital. However, progress has been more difficult in recent years, as can be seen in chart 1 below.

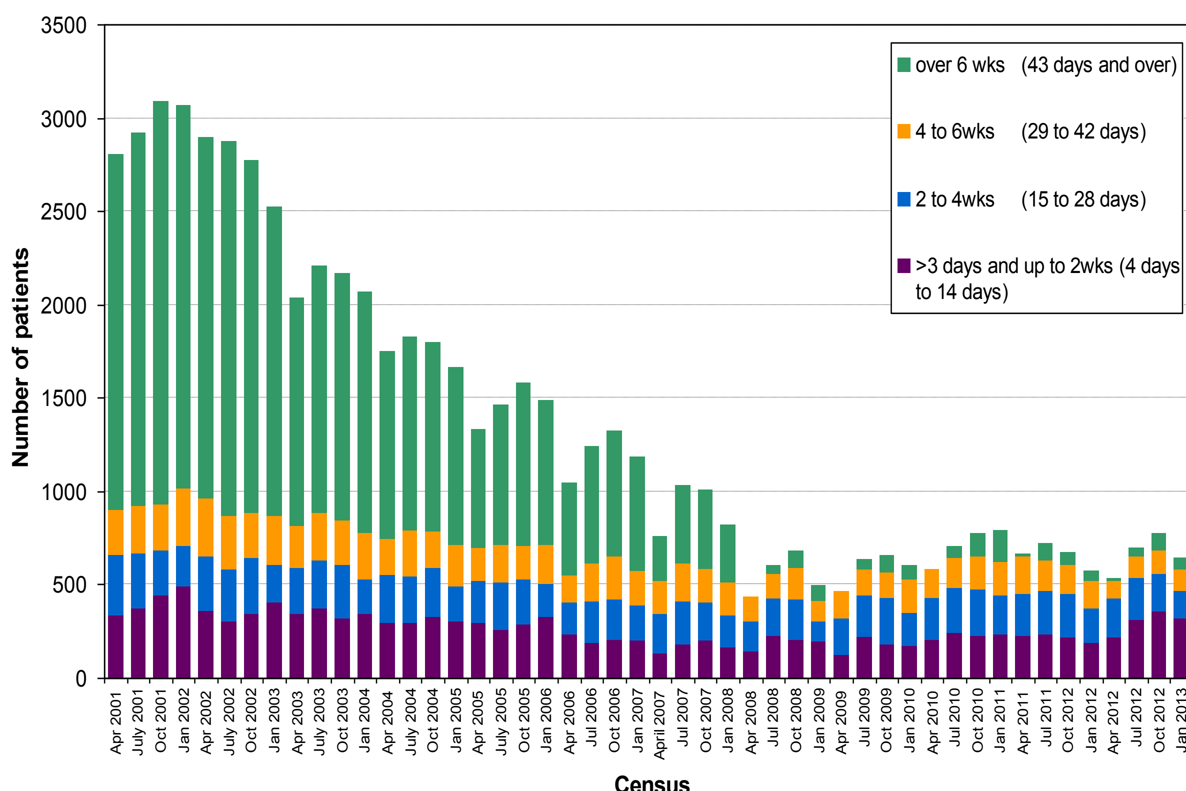
[5] Thistlethwaite P, (2011) *Integrating health and social care in Torbay*. London: The King's Fund. Available at http://www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay

[6] Ham C, Dixon A, Brooke B (2012) Transforming the Delivery of Health and Social Care: the case for fundamental change London: Kings Fund. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf

[7] Currie C, (2010) *Health and Social Care of Older People: Could Policy Generalise Good Practice?,* Journal of Integrated Care, Vol. **18** Iss: 6, pp.19 – 26. Available at http://dx.doi.org/10.5042/jic.2010.0648

[8] ISD Comparison of Occupied Bed Days for 65+, 75+ and 85+ between Scottish partnerships and Torbay Care Trust. Unpublished analysis. ISD can provide this information on request: http://www.isdscotland.org/

**Chart 1: NHS Delayed Discharges by length of delay (excluding code 9s (complex cases) and delays of 3 days or less): Scotland; Historical Trend April 2001 to January 2013**




26. It is projected that 488,000 bed days will be used in 2012/13 by patients awaiting discharge from hospital. Delayed discharge happens for a variety of reasons. ISD published data[9] shows that 96% of delayed patients were delayed for reasons of community care assessment or community care arrangements. Health Boards and local authorities will be required to ensure that the maximum delay is no longer than 14 days by April 2015; requirements on Health Boards and local authorities to put in place strategic planning arrangements will enable better allocation of resources to achieve this target. The public expenditure implications of moving to a 14 day limit on delays can be estimated by comparing the current cost of service provision with the costs of alternative (more appropriate) community based health and social care services.

27. For this estimate, the bed days used by delayed patients (excluding those who are complex cases) were converted into bed weeks. For the baseline expenditure the bed weeks used by delayed discharge patients were costed at an adjusted cost per bed day, and for the projected expenditure post integration, those bed weeks were costed at a weighted average rate of residential care, home care, and care at home. These estimates suggest that reducing delayed discharge by reallocating expenditure from hospital to community based health and social care to

[9] ISD (2012) *Delayed Discharges in NHS Scotland - Figures from July 2012 Census*. Available at https://isdscotland.scot.nhs.uk/Health-Topics/Health-and-Social-Community-Care/Publications/2012-08-28/DD_jul12_tables_charts.xls?16603816 - Table 2

facilitate timely departure from hospital and provide alternatives to admission to hospital, could generate potential efficiencies of around £22m per annum for a maximum 14 day delay. If partnerships wish to be more ambitious and move beyond the target, a further £41m of potential efficiencies may be generated for a 72 hour limit for delays.

*Anticipatory care plans*

28. Anticipatory care plans (ACP) are produced for an identified population, which has been assessed as at risk of admission to hospital, using a risk assessment tool. The benefit of the plan is that it allows individuals who are at risk of unplanned admission to have a plan for their care that will help to avoid unnecessary admission to hospital. Effective anticipatory care planning depends on two factors: accurate identification of people at risk of admission, and deployment of an integrated multi-disciplinary team working with the care group to plan their care[10]. Many unplanned admissions to hospital for older people would be avoidable if alternative care options were available to local care professionals, patients and carers. This is desirable because unnecessary time spent in hospital by older people can lead to rapidly diminishing life skills and further avoidable institutional care. It is expensive, both in terms of the human cost of accelerating dependence and diminishing independence, and in financial terms.

29. The potential implications of anticipatory care plans for the cost of health and social care in Scotland have been estimated based on the findings of the Nairn study. By extrapolating the results to a Scotland-wide level using an estimate of the potential number of patients with similar risk characteristics as were included in the Nairn study[11], it is estimated that potential efficiencies of approximately £12m may be generated.

*Reducing variation*

30. There is variation in per capita expenditure on health and social care across partnerships[12]. For healthcare, the variation cannot be explained by differences in need across partnership populations or in input costs and may be due to inefficiencies. For adult social care expenditure, the picture is less clear and we are unable to determine whether the variation is due to differences in local democratic decisions, input costs, prevalence of unpaid care, the relative size of the voluntary sector or inefficiencies. Furthermore, some of the variation in per capita expenditure by one partner may be required to compensate for variation in per capita expenditure by the other partner.

31. The requirement on Health Boards and local authorities to delegate resources to the integration joint board or the lead agency, will highlight the extent of variation and will enable them to understand more clearly the underlying causes. Over time, it is anticipated that Health Boards and local authorities may respond to greater clarity regarding variation in their allocations to the integration joint board or the lead agency by moving to a more equitable allocation of resources to partnerships thereby driving efficiencies in their use of integrated

---

[10] Purdy S (2010) Avoiding hospital Admissions: what does the evidence say?. London: King's Fund. Available at http://www.kingsfund.org.uk/publications/avoiding-hospital-admissions

[11] Baker A, Leak P, Ritchie LD et al (2012) Anticipatory care planning and integration: a primary care pilot study aimed at reducing unplanned hospitalisation. *BJGP* Vol **62**, No 595, pp. e113-e120(8) Available at http://dx.doi.org/10.3399/bjgp12X625175

[12] Scottish Government IRF mapping 2010-11. Unpublished analysis. Available on request from Christine.Mcgregor@scotland.gsi.gov.uk

resources. Such an effect would probably be most immediately apparent in those partnerships within the same Health Board area, where local comparisons will most readily be made. In the longer term such an effect could be observed across Scotland, particularly if there is an appetite for benchmarking and sharing good practice.

32. The potential for efficiencies from reducing variation in allocations to partnerships with the same Health Boards has been estimated by comparing the expenditure per person between partnerships. Due to the confounders for variation in per capita social care expenditure noted above, this estimate is limited to the variation in costs per head for healthcare expenditure.

33. The costs per head are adjusted for local population need, using the resource allocation formula weightings, to ensure that it does not include variation that is driven by differences in local population need. If costs per head in the higher cost partnerships are reduced to the average cost per head for the partnerships with the relevant Health Board, this could generate potential efficiencies of around £104m per annum.

34. The Bill will enable Health Boards and local authorities to plan and deliver holistic integrated health and social care services and to improve efficiency in allocation and utilisation of their joint resources. In summary, it is estimated that the potential efficiencies for partnerships from the combined effect of Anticipatory Care Plans, reducing Delayed Discharge and reducing variation, to be between £138m and £157m. These potential efficiencies should be considered in the context of the scale of the projected increase in expenditure attributable to demographic change, noted in paragraph 17, and will need to be reinvested within the partnerships in order to help meet demand.

35. It is important to note that there is considerable uncertainty around these estimates and the eventual outcome and phasing will be dependent on local decisions taken by partners on resource allocation and utilisation through their strategic plans. Nevertheless, these estimates provide a reasonable indication of the potential scale of efficiencies. Any actual realisation of efficiencies from reduced demand for care in institutional settings will be contingent on the scale of the planned change and on cost behaviour, i.e., how costs are affected by a change in an organisation's volume and pattern of activity.

36. All of these factors will need to be taken into account by integration authorities in developing their strategic plans and this level of understanding will be important if partnerships are to maximise the value of their integrated resources in addressing the demographic challenges over the longer term.

## PART ONE

## COST IMPLICATIONS TO THE SCOTTISH GOVERNMENT FROM PROVISIONS IN THE BILL: TRANSITIONAL COSTS

37. The Bill sets out a number of key provisions described further in the Explanatory Notes. Table 3 summarises transitional non-recurrent costs to the Scottish Government associated with Bill implementation:

| **Table 3 - Summary of Scottish Government investment (£m)** | | | | | | | **Non-recurrent** |
|---|---|---|---|---|---|---|---|
| | | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | |
| **Costs directly associated with Bill implementation** | | | | | | | **Overall Total (£m)** |
| **Transitional costs** | | | | | | | |
| Para 37 | Transition team | 0 | 0 | 7.4 | 2.4 | 0 | **9.8** |
| Para 44 | Displacement of CHP leadership staff | 0 | 0 | 1.8 | 0.7 | 0.7 | **3.2** |
| Para 50 | Strategic workforce and organisational development | 0.085 | 1.0 | 0.685 | 0 | 0 | **1.770** |
| Para 56 | Developing VAT guidance with HMRC | 0 | 0 | 0.035 | 0 | 0 | **0.035** |
| Para 59 | Support to develop strategic plans | 0 | 0.2 | 0.2 | 0 | 0 | **0.4** |
| Para 60 | Support to third sector – national partnership initiative | 0 | 0.18 | 0.18 | 0 | 0 | **0.36** |
| Para 63 | Financial governance (included in organisational development and transition team) | 0 | 0 | 0 | 0 | 0 | **0** |
| Para 64 | Capital and assets (included in transitional costs) | 0 | 0 | 0 | 0 | 0 | **0** |
| Para 65 | ISD data activity information sets | 0 | 0.25 | 0.5 | 0 | 0 | **0.75** |
| **Total** | | **0.085** | **1.63** | **10.8** | **3.1** | **0.7** | **16.315** |

38. The following sections provide further information on the costs listed above.

*Transition team*

39. In NHS Highland (and also in Torbay Care Trust and North East Lincolnshire Care Trust, which have established similar arrangements) a transition team was set up for the purpose of leading and overseeing the transition arrangement in moving to a delegation between partners model of integration. NHS Highland delegated functions in relation to children's community

health services to Highland Council and Highland Council delegated functions relating to adult social care services to NHS Highland.

40. The Highland Partnership, between NHS Highland and Highland Council, in taking forward the delegation between partners model of integration, received £450k from the Scottish Government, over the period 2010-2012 to support a programme of change management necessary to achieve the model of integration permissible within the current legislation and the specifications of their integration plan.

41. For the purpose of the estimates of the potential costs of transition, the costs of the Highland transition team have been used. These have been adjusted to exclude the sums that relate to the children's services aspect of the Highland arrangements. In addition, Highland were able to prioritise existing resources to carry out some of these tasks so that some of the costs were opportunity costs. There is uncertainty whether this could be replicated in other partnerships and this is reflected in the scenarios considered at paragraph 45.

42. There are also likely to be economies of scale in cases where Health Boards are developing partnerships with more than one local authority, and this has also been considered in the estimates.

43. The scale and volume of the transition tasks noted above is different for the two main models of integration permitted in the Bill, delegation to a body corporate and delegation between partners; the second model can operate in a number of ways, as described in the Bill. The volume of transition tasks required for delegation between partners, especially in the cases where provision of services is delegated and staff are transferred, being greater than for delegation to a body corporate or delegation between partners, with no staff transfers. The Bill sets out that partnership arrangements will be formed between one local authority and one Health Board and provides for flexibility for more than one local authority to join together to form partnership arrangements with the same Health Board.

44. Given that the costs of transition are contingent on whether partners choose delegation to a body corporate or delegation between partners and the extent that they are able to offset some of the costs through prioritising existing capacity and through economies of scale for multiple partner Boards, a range for the potential total transition cost is possible. In order to provide an overview of this potential, a number of scenarios are set out below, each of which have different assumptions regarding the main variables. Note that in considering scenarios, the likely case is based on the assumption that all partners, with the exception of Highland, will opt for delegation to a body corporate; this reflects feedback on the preference of partnerships between the two main models.

45. Three scenarios have been considered, each of which is based on the Bill receiving Royal Assent and commencement of provisions to establish partnership arrangements being enacted in the financial year 2014/15:

- A prudent likely case, where all partnerships (except Highland) opt for delegation to a body corporate and are able to realise economies of scale. Under this scenario the

non-recurrent cost of establishing transition arrangements will be £9.8m, with £7.4m incurred in 2014/15 and the balance in 2015/16;

- A lowest cost case where all partnerships opt for delegation to a body corporate and are able to realise opportunity costs and economies of scale. Under the second scenario the non-recurrent cost of establishing transition arrangements will be £6.4m with £4.8m incurred in 2014/15 and the balance in 2015/16;
- A highest cost case, where all partnerships opt for delegation between partners and do not achieve opportunity costs or economies of scale. This scenario would require £22.6m, with £16.9m in 2014/15 and the balance in 2015/16.

**Displacement of staff in Community Health Partnership roles**

46. There are a number of roles, as described above, which support the current arrangements in Community Health Partnerships. Some staff employed by Health Boards will be displaced with the removal of Community Health Partnerships. In addition, there are staff employed by local authorities who carry out similar roles in respect of adult social care services that are currently aligned with Community Health Partnerships. It is reasonable to assume that most of these will be transferred to posts in support of the new partnership arrangements. The possible exception to this may be staff currently occupying Community Health Partnership Director/ General Manager posts, who may or may not be in competition for the new chief officer post in those partnerships which choose the body corporate model of integration.

47. It is acknowledged that local authorities have committees established to provide governance, with responsibility for delivery arrangements for social care services, including adult social care functions. The Bill does not prescribe the removal of such committees; however, it is reasonable to expect that some of these arrangements may no longer be necessary given the proposed responsibilities of the partnership arrangements (integration joint board or lead agency). In any case, it would be for individual local authorities to determine, and therefore no costs have been included.

48. There are currently 25.6 WTE Community Health Partnerships leadership posts in Scotland (and 28 post holders) at a recurrent annual cost of £2.6m. Health Boards will offer a range of options to displaced staff in leadership posts including voluntary redundancy terms. If such options are not accepted by the individuals involved, they will be enrolled in Health Board re-deployment registers on protected salaries. It should be noted that in the event of the latter, the non-recurrent cost of the protected salary of these staff may be incurred for several years until the individual gives notice or a suitable vacancy arises.

49. The specific criteria and guidance for the recruitment and appointment of chief officer posts is being developed jointly by the Scottish Government and relevant stakeholders. The cost of displaced staff will vary depending on the proportion that are successful in applications for chief officer posts and also on whether displaced staff accept voluntary redundancy or move to the redeployment register; and so a potential range exists for the cost of displacement. To illustrate this potential range three scenarios are set out below. Two are at the extremes in which either all the displaced Community Health Partnership leadership staff are appointed to the new chief officer posts or none are appointed; and one in which half of the staff are appointed to the posts.

50. No estimates are made for any displaced local authority staff as the Bill does not prescribe the removal of any local authority post and, in any case, it will be for individual local authorities to determine such matters. The Bill will not remove the requirement for existing local authority or Health Board statutory posts with the exception of Community Health Partnerships director posts.

51. For the purposes of this estimate, it has been assumed that half of the displaced staff accept voluntary redundancy, and half move on to redeployment registers for a period of three years:

- If all of the 28 displaced Community Health Partnership leadership staff that move to redeployment are successful in securing the post of chief officer, then there will be no non-recurrent cost incurred.
- If none of the 28 displaced Community Health Partnership leadership staff that move to redeployment are successful in securing the post of chief officer, the non-recurrent cost would be £3.5m incurred in 2014/15 and £1.3m incurred in each year thereafter until 2016/17.
- If half of the 28 displaced Community Health Partnership leadership staff that move to redeployment are successful in securing the post of chief officer, the non-recurrent cost would be £1.8m incurred in 2014/15 and £0.7m incurred in each year until 2016/17.

**Strategic workforce and organisational development**

52. The duties placed on statutory partners by the proposals will require a sustained and integrated approach by partners to organisational and professional/management development, in addition to effective, on-going education and training for a wide range of staff groups.

53. Support will be necessary at all levels in the new partnerships, including the establishment of new integration joint boards, or integration joint monitoring committees, through to education and training for frontline practitioners, working in new ways to support service users. Supporting partnerships to understand and build the conditions for change and improvement will be necessary for sustained success in delivering better outcomes for people and communities. Statutory partners will need to ensure that their organisational development plans reflect the integration agenda and offer a comprehensive, systematic and practical approach to improving individual and organisational effectiveness. This shared endeavour will be necessary to support the culture change that will be required to underpin greater multi-disciplinary and multi-agency joint working and to reflect the move towards a greater community focus for service planning and delivery.

54. Significant support for professionals and staff is already available locally and via a range of innovative national programmes of work delivered by NHS Education Scotland and Scottish Social Services Council, as part of the Scottish Government's Reshaping Care of Older People Programme, e.g. dementia and palliative care training. Locally, Community Health Partnerships are continuing to develop their workforce to enable delivery of local Change Fund Plans for Older People, supported by a range of improvement bodies to support care pathway development and joint working with third and independent sector partners.

55. Support for leadership development will also be important; for Health Board and local authority Chief Executives, the new arrangements will change their relationship and they will be jointly and equally accountable for the delivery of agreed national outcomes; the role of the chief officers will require a high level of skill, expertise and experience and the ability to lead change and system wide improvement in a highly complex working environment. More widely, professional leadership will be essential to create the right conditions for the development of a flexible and adaptive workforce, particularly in the context of locality planning.

56. An organisational development programme that integrates the existing partnership organisational development capacity with national support will be required to provide:

- Integration joint board and integration joint monitoring committees development sessions, including work locally on the development of a shared set of values, purpose and vision for the Board and its members;
- Development sessions for Health Board non–executive directors and local authority elected members;
- Supporting the development of skills and behaviours needed for the chief officer posts;
- Targeted programme of support for Health Board and local authority chief executives and chief officers;
- The Scottish Government will work with national partners via public sector leaders forum to support development for key groups of staff and professional;
- Development support for senior professional teams, including GPs and Chief Social Work Officers to lead change within localities and as part of the strategic commissioning process locally;
- Support for staff working in non-statutory organisations.

57. The Scottish Government is working with stakeholders through the Workforce Development Strategic Group[13] to support developments in workforce and organisation development and model approaches to collaborative working, which will support the effective integration of health and social care and locality planning arrangements. The Scottish Government has provided £85k in 2012-13 to support this work and anticipates providing further funding of £1m in 2013-14 and £0.685m in 2014-15 to support implementation of the Bill.

**VAT**

58. Health Boards and/or local authorities will be required to delegate resources and functions, under delegation between partners arrangements, to the host organisation, that is the partner that will be responsible for the delivery and management of functions on behalf of the other partner, or to the body corporate. Health Boards and local authorities will incur a number of non-recurrent and recurrent costs associated with financial governance of the delegated functions and resources.

[13] http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/WorkforceDevelopmentGroup

59. Different VAT arrangements pertain in Health Boards and local authorities. Health Boards are section 41 bodies (VAT Act 1994) for VAT purposes, such that they can only reclaim VAT on certain specified services. In contrast, local authorities are section 33 bodies (VAT Act 1994) and, with a few minor exceptions, have full VAT recovery. The different VAT status of the partners complicates the recovery of VAT on goods and services purchased through the resources in an integrated budget and this introduces risks for recurrent resources. This is considered in detail in the recurrent costs section below. There is existing HM Revenue and Customs (HMRC) guidance for the delegation between partners model, and the Scottish Government will work with HMRC to tailor this to the Scottish context and to develop new guidance for the delegation to a body corporate model. Professional advisors have been appointed by Scottish Government at a non-recurrent cost of £35k.

60. In addition, each partnership will have to obtain agreement from HM Revenue and Customs on a case-by-case basis, which will involve preparation of financial statements. Based on experience in Highland, this will be marginal and is covered by the non-recurrent transitional costs outlined above. There will be a cost to HM Revenue and Customs for the process of application and approval of the integrated VAT arrangements for each partnership. Scottish Government officials are working with HM Revenue and Customs on these matters.

**Strategic planning**

61. Investment is required in Health Boards and local authorities to ensure that strategic planning is taken forward with maximum effectiveness. This issue has been recognised for some time and a programme of development has been established. A Local Learning Development Framework has been produced by the Institute of Public Care (IPC). Building on that, the Scottish Government is working with IPC and the Joint Improvement Team (JIT) to develop an accredited course on strategic commissioning, aimed at the statutory, independent and third sectors. This will cost £100k over two years. In addition, the JIT is undertaking a two year national improvement and support programme, working directly with local partnerships at a cost of £150k a year for two years from 2013/14.

**Support to the third sector**

62. It is intended, through secondary legislation, that integration authorities will be required to fully involve the third sector as key partners in strategic commissioning, locality planning and service delivery activity. The Scottish Government recognise the key role non-statutory, not-for profit providers of health and social care services play in the provision of care, working in partnership with statutory partners. It is expected that there will be a degree of overlap between these activities and those currently required for third sector participation in community planning and in developing change fund commissioning plans.

63. However, initial scoping work with third sector partners has identified a number of levels at which additional resources might be required to ensure sufficient knowledge and capacity to enable third sector partners to fully participate. These include:

- Strategic involvement at integration joint board and integration joint monitoring committee level;

- Bringing together and contributing on a co-production basis, the full extent of the third sector's knowledge, expertise, and information, both in relation to communities and the sector itself, to strategic commissioning and locality planning; and
- Development of local capacity, including workforce development, partnership working and facilitation, to ensure a focus on prevention and upstream interventions, essential to delivering the full benefits of health and social care integration.

64. Scottish Government officials, with third sector partners, are scoping out a range of these estimated costs, which will be attributable to statutory partners. However, it is also anticipated that, in addition, some initial transitional cost for this function will be provided by the Scottish Government as part of the transitional costs to third sector partners in the partnership. Transitional costs of £360k will be made available to the third sector over 2013/14 and 2014/15 to support a national partnership initiative which will aid local change work. This will be alongside and complement local discussions between the third sector and statutory partners about how other transitional support available locally is utilised, including support to the sector locally. Third sector partners will also be expected to consider efficient and effective use of current resources and funding streams to enhance their capability and capacity.

**Other financial governance**

65. Delegating resources in a delegation between partners model to create the integrated budget in the host partner will require changes to financial recording and reporting in both partners, as well as preparation of the statements in support of the integrated budget and development of the finance sections of the integration plan. In addition, in the delegation to a body corporate model, Financial Procedure Notes and Standing Orders will need to be developed in the new bodies. The non-recurrent costs associated with this are based on the Highland experience and are included in the transition costs to the Scottish Government noted above.

**Capital and assets**

66. There are likely to be non-recurrent costs associated with carrying out due diligence reviews on assets and liabilities transferred to the host partner in the delegation between partners model. The estimate for these, based on the Highland experience, is included in the transition costs noted above. Under delegation to a body corporate, it is not intended that the new bodies will own capital assets, so there is no need to provide for costs associated with carrying out due diligence reviews on transferred assets and liabilities as is the case for delegation between partners model. This will result in a small reduction in the cost required for the transition team, but this will be offset by the small additional cost required for developing the Standing Orders etc. for the new body.

**Health and social care activity information**

67. To provide partnerships with information for developing their strategic plans and to inform performance management, a linked patient/client level health and social care dataset and information system will be required. It is likely to be more efficient that this be developed as a national solution by Information Services Division and for partnerships to access their data

remotely. Non-recurrent estimates for the development of this, based on a preliminary assessment by ISD, are £250k in 2013/14 and £500k in 2014/15.

**Summary - overall transitional costs to the Scottish Government**

68. The Scottish Government will provide approximately £16.7m, which will be available to Health Boards and local authorities as partners in integration joint boards or lead agency arrangements, on a proportional basis for transitional costs, to implement the organisational development and other change management functions necessary, as set out above, to meet the requirements set out in the Bill. In moving to these arrangements, it is reasonable to assume that Health Boards and local authorities will realise opportunity costs, which will be expected to be used to support transitional arrangements.

## PART TWO

### 2.1 – RECURRENT COST IMPLICATIONS TO HEALTH BOARDS AND LOCAL AUTHORITIES FROM PROVISIONS IN PART 1 OF THE BILL

Table 4 provides a summary of the recurrent costs to Health Boards and local authorities associated with delegation between partner model of integration set out in the Bill.

| **Table 4 - Summary of costs to Health Boards and local authorities – Delegation between partner model (£m)** | | | |
|---|---|---|---|
| | | 2014/15 (£m) | 2015/16 – (£m) **recurrent** |
| **Costs directly associated with Bill Implementation Recurrent costs** | | | |
| Para 85 | Financial costs teams | 0.8 | 0.8 |
| Para 87 | Clinicians' involvement in locality planning | 3 | 3 |
| Para 92 | Health and social care dataset and information system | 0 | 0.25 |
| Para 93 | Economist and analytical support for health and social care activity information | 0.5 | 0.5 |
| **Total** | | **4.3** | **4.55** |

Table 5 provides a summary of the recurrent costs to Health Boards and local authorities associated with delegation to a body corporate model of integration set out in the Bill.

| **Table 5 - Summary of costs to Health Boards and local authorities – Delegation to a body corporate (£m)** | | | |
|---|---|---|---|
| | | 2014/15 (£m) | 2015/16 - (£m) **recurrent** |
| **Costs directly associated with Bill Implementation Recurrent costs** | | | |
| Para 68 | Appointment of chief officer | 0.9 | 0.9 |
| Para 83 | Financial recording and reporting | 0.15 | 0.15 |
| Para 85 | Financial costs teams | 0.8 | 0.8 |
| Para 87 | Clinicians' involvement in locality planning | 3 | 3 |
| Para 92 | Health and social care dataset and information system | 0 | 0.25 |
| Para 93 | Economist and analytical support for health and social care activity information | 0.5 | 0.5 |
| **Total** | | **5.35** | **5.6** |

**Establishment of an integration joint board or integration joint monitoring committee**

69. The partnership will be required to establish a joint board or joint committee, depending on the model of integration used, and its membership will be determined by the Health Board and local authority that are partners in the partnership arrangements within the requirements of the legislation. The cost implications to establish and maintain the joint boards or joint committees are immaterial as they will be mitigated by the removal of Community Health Partnership committees.

**Appointment of a chief officer in a body corporate model**

70. The Bill requires the appointment of a chief officer, where partners delegate functions and resources to the integration joint board within the body corporate model of integration. The chief officer will be responsible for the effective management of the integrated budget to deliver the services set out in the integration plan in order to achieve the nationally agreed outcomes via the strategic plan.

71. It is anticipated that the recurrent cost of a chief officer in each partnership that chooses to integrate via the delegation to a body corporate model of integration will be a maximum of £3.5m p.a. if all partnerships adopt this model; this estimate is based on 30 Whole Time

Equivalent (WTE) posts. This cost will be offset by the existing resource incurred by Health Board and local authority partners used to fund CHP general managers of £2.6m p.a., giving a maximum net additional cost of £900k p.a.. Approximately half of this cost is attributable to increasing the number of WTEs from 23.6 to 30 and the balance is attributable to the likely increased grading of the chief officer posts compared to Community Health Partnership general managers. The Scottish Government will provide guidance to support Partners on the appointment of the chief officer.

**Other roles in the partnership**

72. There are other recurrent costs associated with Community Health Partnerships, such as clinical leadership, financial management, HR support and administration functions, which will be required by the new partnerships and, therefore, the changes under the Bill are assumed to be cost neutral.

**VAT**

73. The different VAT status of the statutory partners complicates the recovery of VAT on goods and services under integrated arrangements, which introduces a risk that VAT currently recovered may not be possible post integration. The extent of potential exposure for this risk is a recurrent cost of £32m p.a. based on the estimated total VAT recovered by local authorities for adult social care services.

74. The VAT implications for integration are contingent on whether partners opt for delegation between partners or delegation to a body corporate.

*VAT: delegation between partners*

75. The VAT regime of the host partner in the delegation between partners model will apply to the integrated budget and this introduces a risk of additional recurrent costs in cases where local authority functions are delegated to Health Boards and VAT previously recovered by local authorities is no longer able to be recovered under NHS arrangements.

76. This risk is mitigated by establishing arrangements under existing HMRC guidance for delegation between partners, which allows a solution for partnerships that is VAT neutral compared to the pre-partnership position. The experience of the Care Trusts in Torbay and North East Lincolnshire, both of which took advantage of the solution in the guidance, was a VAT neutral outcome. Highland Partnership are also following this approach and, although its position is not yet finalised with HMRC, it expects a VAT neutral outcome also. The likely position, therefore, is that there will be no additional cost under the new arrangements for VAT.

*VAT: delegation to a body corporate*

77. Unlike with the delegation between partners model, where HMRC guidance allows a VAT neutral solution, there is no guidance available for this model. Consequently, there is a risk that VAT currently reclaimed by local authorities is no longer able to be recovered under the VAT arrangements in the body corporate. However, Scottish Government appointed VAT advisors have indicated that the key factor in determining recovery of VAT in this model will be

the extent to which the body corporate delivers services, and that the proposed arrangements are likely to be interpreted by HMRC as the body corporate re-allocating the integrated budget and for delivery by Boards and local authorities; consequently, it is likely that a VAT neutral position is attainable.

78. Note that should the Scottish Ministers extend, at a future juncture, the remit of the body corporate to be allowed to take advantage of employment and contracting powers, then there is a risk that HMRC will revise their view and conclude that the body corporate is in fact providing services. Under this contingency, the VAT status of the body corporate is less clear and the recovery of VAT is at risk. The full extent of potential exposure for this risk is a recurrent cost of £32m p.a. based on the estimated total VAT recovered by local authorities for adult social care services.

79. The Scottish Government is working with its advisors and HMRC to develop new guidance for the delegation to a body corporate model, based on the same principal of VAT neutrality that informs the guidance for delegation between partners. The likely position, therefore, is that there will be no additional cost under the new arrangements for VAT.

**Other financial governance**

80. In cases where staff and functions are transferred between partners, there is a transfer of risk to the host partner with an associated cost of indemnity to the host partner. Under the body corporate model, it is not intended for the integration joint board to employ staff or provide services, so that there will be no staff transferred to the new body and no associated transfer of risk and need for indemnity.

81. Nevertheless, staff transfers between partners may result from the subsequent commissioning decisions of the partnership, in which case the issues noted above for delegation between partners would apply. Under current arrangements, host partners would be required to obtain cover for risks arising from delegated staff and functions from the market and this may be material, particularly in cases of local authorities hosting health functions.

82. Part two of the Bill makes provision to extend the scope of the CNORIS clinical and other risks self-assurance scheme to allow cover for local authority social care functions and membership of local authorities, such that risks associated with social care services hosted by Health Boards and/or health services hosted by local authorities can be covered under the scheme. Under this arrangement, indemnity is estimated to be cost neutral. In cases where there is no transfer of staff between partners, but where integration results in innovation in the roles of care staff, there may be an increase in indemnity premiums for local authorities; however, given the likely nature of these innovations, this is not considered to be material.

*Other financial governance: delegation between partners*

83. Internal and external audit of the integrated budget and associated systems will be provided by the host partner auditors and, based on the Highland Partnership experience, is expected to be cost neutral from a partnership (delegation between partners) perspective.

84. Integration will act as a catalyst for consideration of the opportunities for rationalisation of support services. These are likely to be most apparent in Finance and HR due to the delegation of resources and potential of transfer of staff, but can potentially extend to all support services. Highland Partnership are in the early stages of discussions on shared services. Notwithstanding this, the national opportunities for this will depend on the circumstances in each partnership arrangement. As a result, it is difficult to estimate the potential saving and any associated re-organisation costs, and so none are included for this.

*Other financial governance: delegation to a body corporate*

85. Financial recording and reporting for the body corporate will be provided through a separate domain within the systems of either parent body at marginal on-going cost. The body corporate will require its own audit arrangements, and, whereas these are likely to be provided by the auditors of either of the parent bodies, this will require new work and is estimated at £150k p.a.

86. The potential benefits from rationalisation of support services and the cost of additional capacity in costing teams noted above for recurrent costs of delegation between partners equally apply under this model.

*Other financial governance: for both models*

87. The inclusion of hospital services in the integrated budget will necessitate a greater emphasis on hospital activity and cost in Health Board financial management and financial planning systems, which will require investment in costing teams. The estimate for this is £800k p.a. based on increasing the capacity of Health Boards costing teams to a proportionately consistent level.

**Strategic planning**

88. Integration joint boards and the lead agency will be under a duty to produce a strategic plan. The plan will be developed in collaboration with the third and independent sector providers, outlining how the objectives of the integration plan will be delivered using the integrated budget. Partners will be expected to adequately support involvement and consultation of a range of stakeholders in the planning process.

**Locality planning**

89. The Bill will place a requirement on partnerships to establish effective locality planning arrangements at a level of planning and commissioning for services for an identified population. Local clinicians and care professionals, in particular, will play a greater role in locality planning, which will inform the partnerships' strategic plans. Carers, patients, service users and their families will also inform locality planning arrangements. Locality planning arrangements currently exist in many Community Health Partnerships and local authorities, though it is expected that these will need to be re-configured and developed to cover the scope of the new proposals. In some areas there will be a need for additional resources to fund clinical involvement. The recurrent costs to fund clinical involvement are estimated as £3m p.a. from 2015/16 and are based on existing good practice in a number of partnerships.

**Capital and assets**

*Capital and assets: delegation between partners*

90. Integration of health and social care offers the potential for some rationalisation of Health Board and local authority estate, which may result in non-recurrent receipts from asset disposals and will accrue to the owner of the asset. In the case of the Highland Partnership, property rationalisation is at the heart of the redesign of adult services and has the potential to affect team bases and properties used for in-house care home and day-care services.

91. In addition, rationalisation may result in recurrent savings on revenue property costs. Consideration of this is at an early stage in Highland and figures for potential savings are not available. Moreover, extrapolating from Highland to a national estimate would be difficult given the different asset configurations in each partnership. Accordingly, there is insufficient evidence to estimate the potential benefits from asset rationalisation and no figures are included.

*Capital and assets: delegation to body corporate*

92. Notwithstanding that the new bodies will not own capital assets; integration under this model still offers the potential for rationalisation of Health Board and local authority estate as that under delegation between partners; this will be through the strategic commissioning process and of recurrent savings on revenue property costs. The same difficulties in estimating the potential benefit of this noted above apply for this model and no figure is included for this.

**Health and social care activity information**

93. To provide partnerships with information for developing their strategic plans and to inform performance management, a linked patient/client level health and social care dataset and information system will be required.

94. The recurrent running costs and depreciation for the linked patient/client level health and social care information system (outlined above) are estimated as £250k p.a. from 2015/16, based on a preliminary assessment by Information Services Division.

95. In addition, care economists and analyst capacity will be required by partnerships in developing their strategic plans, to analyse and model existing and future needs and activity. Some partnerships have used change fund resource to fund this on a non-recurrent basis and there are also three WTE posts at £150k p.a funded by the Scottish Government currently supporting this work. To provide this capacity across all partnership on a recurrent basis would require an additional £500k p.a.

## 2.2 – COST IMPLICATIONS TO HEALTH BOARDS AND LOCAL AUTHORITIES FROM PROVISIONS IN PART 2 OF THE BILL

### Broadening the remit of the Common Services Agency

96. Current legislation provides that whilst the Common Services Agency (CSA), commonly known as NHS National Services Scotland, may provide goods and services to NHS bodies in Scotland generally, it may only provide a limited range of goods and services to other public bodies, and then only to a limited range of public bodies. It is considered that this acts as a block to the Common Services Agency being as efficient and productive as it might otherwise be, and also prevents a range of public bodies in Scotland working as efficiently and productively as they might.

97. In January 2013, the Scottish Ministers approved laying a Public Services Reform Act Order to enable the Common Services Agency to move from a provider of shared services to NHS bodies only, to a provider of shared services to Scottish public bodies (including local authorities). It is envisaged that there are opportunities for the Common Services Agency to offer services such as legal, procurement, counter fraud and IT support to the wider public sector, which have the potential to produce operating and cost efficiencies.

98. Scottish Ministers agreed that the changes to the remit of the Common Services Agency made through the Public Services Reform Act Order would then be reviewed and restated through an updated approach to provisions in the Bill.

99. It is difficult to accurately gauge the level of uptake off the Common Services Agency's shared services across the wider public sector as this is not a mandatory measure - rather it is for public bodies themselves to determine the benefits of using the services provided by the Common Services Agency. However, what is apparent is that the costs to the public sector will be cost neutral. There will be no increase in the level of the Common Services Agency budget as a result of it delivering services to the wider public sector.

### Extending the scope of CNORIS indemnity scheme

100. Current legislation (Section 85(B) of The National Health Service (Scotland) Act 1978) enables that a scheme may be created by regulation whereby any of the bodies listed in section 85(B) may make provision to meet:

(i) expenses arising from any loss of or damage to their property; and

(ii) liabilities to third parties for loss, damage or injury arising out of the carrying out of the functions of such members.

101. The Clinical Negligence and Other Risks Insurance Scheme (CNORIS) was created on 1 April 2000 pursuant to The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000; the regulations limit membership to all the NHS entities plus the Mental Welfare Commission for Scotland and also define the scope of the functions covered by the scheme. Under these arrangements, local authorities are not permitted to participate in the scheme nor are social work functions permitted to be covered.

102. Consequently, under the lead agency model, cases where local authorities host delegated health functions or where Health Boards host local authority functions, would not be covered by the scheme. In these cases, indemnity cover would need to be obtained from the market and this may be prohibitive.

103. The Bill amends s85(B) of the National Health Service (Scotland) Act 1978 to allow membership by local authorities and to extend cover to social care functions. This provision will allow local authorities and Health Boards to obtain indemnity cover under CNORIS and avoid the potentially material costs of market indemnity.

## 2.3 – COST IMPLICATIONS TO HEALTH BOARDS AND LOCAL AUTHORITIES FROM PROVISIONS IN PART 3 OF THE BILL

### Joint venture structures

104. The Bill also 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.

105. In respect of collaborative procurement, there are two elements of cost reduction to Health Boards – development costs/ fees for projects and on-going Special Purpose Vehicle costs. By way of an example, several Health Boards who are members of the hub North Territory are proposing to enter into one Design, Build, Finance and Maintain (DBFM) contract with a Special Purpose Vehicle (SPV) formed for this purpose by their hubco. Under this contract, each Health Board will be provided with individual facilities. Bundling the various facilities into one DBFM contract will maximise financial efficiency through economies of scale and avoiding the additional costs of setting up and running SPVs for each facility, and will facilitate funding by aggregating the otherwise individual borrowing requirements. Not having additional powers means that there will be two financial close processes (one for NHS Grampian and one for NHS Highland) required rather than one, and two special purpose vehicles created rather than one.

106. The financial implications of this example would be additional fees of up to £250,000 to get to financial close and additional costs of £75,000 to £100,000 per annum over the life of the agreement (25 years) in respect of the management of the additional Special Purpose Vehicle. These costs are in effect recovered from Health Boards via the unitary payments made in respect of premises developed.

107. In this example alone, having these powers would save NHS Scotland a minimum of £2.125m in revenue costs over 25 years or an average of £85,000 per annum. We can reasonably expect that the requirement for such bundles that cross Health Board boundaries would occur every 2 to 3 years. Financial modelling (using lower end cost estimates) shows in cash terms, over a 25 year period, savings in the order of £15.9m could be made when compared to the existing position of requiring separate financial close and SPV arrangements for such bundled projects.

108. Proposals for flexibility in company structures have no direct financial implications in themselves. These proposals will allow collaboration on an equal basis between partners and,

whilst structures such as LLP's offer some tax efficiencies, these cannot be quantified at this time, and will be dependent on the application of such structures, which cannot be quantified at this time.

*Implications for business*

109. The bodies/stakeholders affected by the proposals are Health Boards, local authorities and private sector suppliers contracted to provide community based facilities. The proposals will streamline procurement of facilities and improve efficiency for those bodies developing such facilities.

110. There are no additional regulations or requirements being placed on private sector stakeholders. In respect of collaborative procurement, the powers sought will be used in the context of existing contractual arrangements and documentation. The proposals will not impact on access to public sector markets.

111. For Health Boards, there will be increased flexibility in the procurement of facilities and a consequent reduction in both development and on-going costs. Private Sector Development Partners have already been selected via open procurement in accordance with EU procurement law.

## 2.4 - CONSEQUENTIAL COST IMPLICATIONS TO HEALTH BOARDS AND LOCAL AUTHORITIES FROM PROVISIONS IN PART 1 OF THE BILL

### Harmonisation of terms and conditions

112. The Bill will not require the transfer of staff between Health Boards and local authorities or to the integration joint board. Nevertheless, partners may choose to transfer some staff between them in order to better integrate delivery teams. Where staff transfer, they will do so under TUPE arrangements but there is a risk of a potential cost to partners in terms of harmonisation of terms and conditions, including equality of pay; the risk is different depending on which model of financial integration is chosen.

*Harmonisation of terms and conditions: delegation between partners*

113. Experience in Highland, Torbay and North East Lincolnshire indicates that transfer of staff is likely under this model; if staff transfer, the risk of harmonisation of terms and conditions depends on which organisation is the host partner:

114. Where staff transfer to the Health Board, the initiative for harmonisation would be with the Board; experience from Torbay and North East Lincolnshire, where staff transferred to the Care Trusts, was that the Trusts encouraged transferred staff to migrate onto the same terms and conditions as their new colleagues and that this helped to establish multi-disciplinary co-located teams and deliver truly integrated services. Although staff would be free to remain on TUPE terms and conditions, it is unlikely because migration of staff onto NHS terms and conditions would be to their individual advantage.

115. Where staff transfer to the local authority, the initiative for harmonisation would be with the local authority in the same way as in the case above, but there would also be a risk of an equal pay claim from the existing local authority staff.

116. In cases where staff transfer from a local authority to a Health Board but remain in the local government pension scheme, the Health Board will be required to recognise in its accounts the proportion of any surplus or deficit on the local authority pension fund that relates to the transferred staff; this may be a charge (in the case of a deficit) or a credit (in the case of a surplus) to the Board Accounts. Statutory mitigation enables local authorities to manage the fluctuations that relate to its employees through its reserves, but this facility is not available to Health Boards and so has the potential for instability in Health Board accounts and, in the case of deficits, creates a potential cost. The Scottish Government is considering options for a solution to this issue and no estimate has been included in the scenarios at paragraph 121.

*Harmonisation of terms and conditions: delegation to a body corporate*

117. Discussions with stakeholders lead us to think that most partners will use the body corporate model. Under this model, it is not intended that staff will transfer to the body corporate, but partners may nonetheless choose in time to transfer some staff between each other in the same way as under delegation between partners, in order to integrate delivery teams. The risk of cost of harmonisation is therefore contingent on a future decision to transfer staff between partners.

118. In the event of such transfers, the situation would be similar to those under delegation between partners outlined above. Note that there may be an additional theoretical risk that, under this model of integration, future claims may be brought by staff, or groups of staff, on the grounds that they undertake similar duties but work for separate employers on different pay, terms and conditions, within an integrated system. Such situations exist now, but may increase and be more obvious to staff as integration takes effect and is more widely acknowledged. The risk, and scale of any such potential cost pressures, is very difficult to estimate in advance.

119. Given the contingent nature of staff transfers under delegation to a body corporate, in the scenarios for potential costs described below, we have assumed that no staff will transfer under this model and have therefore assumed no harmonisation costs.

120. Costs associated with staff transfer have been scoped on the basis of three scenarios and are dependent on the model of integration agreed by the Health Board and local authority; the estimates are based on the synthesis of a number of analyses: the experience in NE Lincolnshire and Torbay Care Trusts; analysis by Health and Social Care Directorates Analytical Services Division for transfer of adult social care service staff to Agenda for Change; and detailed analysis for a sample of adult NHS Highland adult social care staff. The scenarios assume that transferred staff remain in their original pension schemes, and it includes an estimate of additional employers' pension contributions due.

121. The following material provides the three estimates for costs associated with staff transfer under the two main models of integration (delegation to a body corporate or delegation between partners).

- A likely case, where all partnerships opt for delegation to a body corporate model (except Highland); this is also the lowest cost scenario. The cost under the first scenario is £nil p.a.;
- A mid cost case where half of partnerships opt for delegation to a body corporate model and half opt for delegation between partners model; the cost in this case would be £13.5m.
- A highest cost case, where all partnerships opt for delegation between partners model with functions delegated to Health Boards and adult social care staff transferring to Boards. The cost under the highest cost case is £27m p.a.

## PART THREE

## COST IMPLICATIONS TO OTHER PUBLIC BODIES FROM PROVISIONS IN THE BILL

### Scrutiny of strategic plans and service delivery

122. The Bill places a duty on the Health Board and local authority to achieve the nationally agreed outcomes for health and social care. The outcomes and the performance indictors will be prescribed by the Scottish Ministers. Where other functions beyond adult health and social have been delegated, the Health Board and/or local authority will be required to take account of other relevant outcome measures. The performance of partnerships in achieving the nationally agreed outcomes and other relevant outcomes in relation to the delegated functions will be assessed jointly by Healthcare Improvement Scotland and the Care Inspectorate. Healthcare Improvement Scotland and the Care Inspectorate undertook ‘pilot’ joint inspection of integrated services in early 2013. Estimates based on the pilots from Care Inspectorate and Healthcare Improvement Scotland suggest a cost of £173,362 per joint inspection. It is anticipated that these bodies will undertake six inspections per year.

123. Additional resource, longer term, will also be required to fund the Care Inspectorate and Healthcare Improvement Scotland for scrutiny of strategic commissioning. The scrutiny bodies will review strategic plans as part of joint inspections, assessing whether the plan meets all statutory requirements and has been created within the statutory duties laid out in the Bill. It is anticipated the scrutiny bodies will carry out six joint inspections per year, with a recurrent cost estimated at **£670k p.a**., some of this work is already underway. This is based on an assessment by Care Inspectorate and Healthcare Improvement Scotland of the additional requirements being placed upon them. It will be incurred from 2015/16.

## PART FOUR

## CONSEQUENTIAL COST IMPLICATIONS TO OTHER BODIES, INDIVIDUALS AND BUSINESSES FROM PROVISIONS IN THE BILL

124. As discussed above, the Bill will place duties on Health Boards and local authorities, therefore, costs will mainly fall to these statutory bodies. However, providers of social care services, in particular, but also other community services, are provided by third or independent organisations. The Business Regulatory Impact Assessment also explores the potential

consequential impacts of the provisions in the Bill on businesses, though the provisions in the Bill only directly impact on Health Boards and local authorities. The Business Regulatory Impact Assessment is published separately. It is reasonable to anticipate that as a result of the requirement for Health Boards and local authorities to jointly plan and deliver adult health and social care services through the effective use of the integrated budget and resources, that businesses may incur costs in order to support the delivery of services that will shift in the balance of care to community provision.

125. The costs to businesses are anticipated to be the following;

- Costs for delivery of training; to diversify the business to take into account the demand for community provision, increase capacity and support delivery of more community based services and skills to participate in the commissioning and planning process;
- Costs arising from diversification, rationalisation or expansion of business model in response to commissioning of health and social care services;
- Increased costs to business to support and train unpaid carers;
- Costs associated with participation in partnership planning arrangements; and
- Costs associated with compliance with Information Technology, data sharing and data protection protocols.

126. However, given that these will be dependent on the commissioning decisions of the partnerships, no costs are included.

**Direct costs resulting from the Bill**

127. Table 6 provides a summary of direct costs resulting from the Bill.

| Table 6 – Summary of direct costs resulting from the Bill | | | | | | |
|---|---|---|---|---|---|---|
| | **2012/13 £m** | **2013/14 £m** | **2014/15 £m** | **2015/16 £m** | **2016/17 £m** | **2017/18 Recurrent £m** |
| **Transitional costs to the Scottish Government** | | | | | | |
| Transition team | 0 | 0 | 7.4 | 2.4 | 0 | 0 |
| Displacement of CHP leadership staff | 0 | 0 | 1.8 | 0.7 | 0.7 | 0 |
| Strategic workforce and organisational development | 0.085 | 1 | 0.685 | 0 | 0 | 0 |
| Developing VAT guidance with HMRC | 0 | 0 | 0.035 | 0 | 0 | 0 |
| Support to develop strategic plans | 0 | 0.2 | 0.2 | 0 | 0 | 0 |
| Support to third sector – national partnership initiative | 0 | 0.18 | 0.18 | 0 | 0 | 0 |
| Financial governance (included in organisational development and transition team) | 0 | 0 | 0 | 0 | 0 | 0 |
| Capital and assets (included in transitional costs) | 0 | 0 | 0 | 0 | 0 | 0 |
| ISD data activity information sets | 0 | 0.25 | 0.5 | 0 | 0 | 0 |
| **Subtotal costs to Scottish Government** | **0.085** | **1.63** | **10.8** | **3.1** | **0.7** | **0** |
| **Costs to Health Boards and local authorities** | | | | | | |
| Appointment of chief officer | 0 | 0 | 0.9 | 0.9 | 0.9 | 0.9 |
| Financial costs teams | 0 | 0 | 0.8 | 0.8 | 0.8 | 0.8 |

**Table 6 – Summary of direct costs resulting from the Bill (continued)**

| | **2012/13**<br><br>**£m** | **2013/14**<br><br>**£m** | **2014/15**<br><br>**£m** | **2015/16**<br><br>**£m** | **2016/17**<br><br>**£m** | **2017/18 Recurrent**<br><br>**£m** |
|---|---|---|---|---|---|---|
| Financial recording and reporting | 0 | 0 | 0.15 | 0.15 | 0.15 | 0.15 |
| Economist and analytical support for health and social care activity information | 0 | 0 | 0.5 | 0.5 | 0.5 | 0.5 |
| Health and social care dataset and information system | 0 | 0 | 0 | 0.25 | 0.25 | 0.25 |
| Clinicians' involvement in locality planning | 0 | 0 | 3 | 3 | 3 | 3 |
| **Subtotal costs to Health Boards and local authorities** | **0** | **0** | **5.35** | **5.6** | **5.6** | **5.6** |
| **Costs to other public bodies** | | | | | | |
| Scrutiny of strategic plans and service delivery | 0 | 0 | 0 | 0.67 | 0.67 | 0.67 |
| **Costs to other bodies, individuals and businesses** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **0.085** | **1.63** | **16.15** | **9.37** | **6.97** | **6.27** |

**ANNEX**

**Current areas of Scottish Government investment relevant to the scope of the Bill**

128. Improved joint working between Health Boards and local authorities, to improve outcomes and the experience of those most in need and their carers, has been a longstanding policy objective of the Scottish Government. This is evident in a range of current and future initiatives. Table 7 provides a summary of the wider financial commitments of the Scottish Government to support the integration agenda. Future funding will be subject to the spending review.

| **Table 7 - Wider Scottish Government financial context (£m)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | **Overall Total (£m)** |
| Para 130 | Reshaping Care for Older People Change Fund | 70 | 80 | 80 | 70 | 0 | **300** |
| Para 131 | Support to Third Sector Interface | 0 | 8.2 | 8.2 | 8.2 | 0 | **24.6** |
| Para 134 | Change Fund: Enhancing the Role of the Third Sector | 0 | 0.18 | 0.18 | 0.18 | 0 | **0.540** |
| Para 135 | A Stitch in Time | 0 | 0.078 | 0.12 | 0.12 | 0 | **0.318** |
| Para 136 | Support to Independent providers in relation to Reshaping Care for Older People | 0.06 | 0.09 | 0 | 0 | 0 | **0.15** |
| Para 137 | Data Sharing and Information technology integration support | 2 | 2 | 2 | 2 | 2 | **10** |
| Para 139 | Support for partnerships to develop Health and Social Care Activity data (3xWTE) | 0 | 0.15 | 0.15 | 0 | 0 | **0.3** |
| **Total** | | **72** | **90.33** | **90.33** | **73.8** | **2** | **328.24** |

129. The following sections provide further information on the investments listed above.

**Reshaping Care for Older People Change Fund**

130. The Reshaping Care for Older People Change Fund[14] represents one of the Scottish Government's key preventative spend funds (£300 million of the overall £500 million preventative spend budget: £70m/£80m/£80m/£70m across the four financial years from 2011-12 to 2014-15 respectively). Statutory, voluntary and independent sector partners responsible for delivering health and social care across Scotland are using the Fund as bridging finance to make better use of their total combined resources for older people's services. The Fund is already helping to redesign care services for Scotland's growing older population - helping to prevent delays, provide more proactive community-based services and better care and support at home. In line with the Scottish Government's proposals for the integration of adult health and social care, the future Change Fund to 2015 will be explicitly linked to delivery of joint commissioning strategies.

**Support to the third sector**

131. The Scottish Government is providing £8.2 million for three years from 2012/13 to support the network of 32 third sector interfaces in Scotland. There is a single third sector interface within each local authority area in Scotland. The third sector interface has four key functions:

- Volunteering development;
- Social enterprise development;
- Supporting and developing a strong third sector;
- Building the relationship with community planning.

132. A set of common service standards was developed which ensures a consistent level of service expectation across the interface network in each of the 32 local authorities in Scotland.

133. The Joint Improvement Team (JIT) has a specific remit to support health and social care partnerships to operate more effectively *as partnerships*, across all their services and any other areas of activity. This has traditionally involved Health Boards and local authorities. More recently, the arrangements required by the Reshaping Care for Older People Programme (RCOP) and its attendant Change Fund have brought the third and independent sectors firmly and formally into the partnership relationship.

134. The JIT and the Third Sector Unit of Scottish Government have jointly funded a three year project delivered by the Health and Social Care Alliance (the Alliance) in partnership with other third sector partners, and designed to build the capacity of the third sector to engage with RCOP. The project's full title is 'Change Fund: Enhancing the Role of the Third Sector[15] and has a budget of £180,000 p.a. The project has a focus on supporting Third Sector Interfaces and

[14] http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Older-People/ReshapingCare
[15] http://www.alliance-scotland.org.uk/what-we-do/projects/change-fund-enhancing-the-role-of-the-third-sector-programme/

national third sector organisations but it also has sufficient locus to work with other third sector organisations as appropriate.

135. A Stitch in Time?[16] is a partnership based National Demonstration Project, facilitated by Evaluation Support Scotland (ESS) in partnership with other third sector partners, and supported by the Scottish Government Third Sector Unit and the JIT providing £0.318m over 3 years from 2012/13. It aims to fully understand the contribution of third sector-delivered interventions to the outcomes of the Reshaping Care for Older People programme in a defined geographical area.

**Independent sector**

136. The Joint Improvement Team have funded Scottish Care with grant payments of £60,000 in 2011-12 and £90,000 in 2012-13. These grants are to enable support for capacity development in the independent sector in relation to Reshaping Care for Older People and related work. This includes developing and sustaining the independent sector's capacity to contribute to the Reshaping Care objectives and development and implementation of the Reshaping Care for Older People's Change Fund plans, along with contributing towards the developing work on health and social care integration and other related government policies.

**Data sharing and information technology**

137. The Scottish Government eHealth budget currently includes a dedicated budget of £2m p.a. to support Health and Social Care IT integration. The NHS and local authorities have invested significant amounts in previous years to put in place modern IT systems. The focus of future work will be on exploiting the capabilities of these systems to improve information sharing.

138. The eHealth Strategy[17] published in Autumn 2011 included a commitment to produce a Health and Social Care IT strategy (by early 2014) in partnership with local authorities. In addition, a Data Sharing Technology Board (DSTB) has been established under local authority chairmanship and is meeting regularly. This Board is responsible for decisions on the existing infrastructure and the development of consensus on the way forward. The Board undertakes this role in a broader context of co-operation between stakeholders through their role in the development of the Health and Social Care IT Strategy.

**Health and social care activity information**

139. Analysis of existing population needs and resource allocation and utilisation is a critical stage in the joint commissioning cycle. A number of partnerships have used the Change Fund for Older People's Services to pay for analyst posts to support the development of their strategic plans. In addition, the Scottish Government has provided £150k p.a. funding to Information Services Division for a further 3 WTE economists and analysts to provide support to other partnerships. These posts have used mapping data from the Integrated Resource Framework to analyse current health and social care expenditure in those partnerships and have carried out

[16] http://www.evaluationsupportscotland.org.uk/how-can-we-help/shared-learning-programmes/stitch-time/

[17] NHS Scotland, eHealth Strategy 2011 -2017 http://www.scotland.gov.uk/Resource/Doc/357616/0120849.pdf

cohort analyses on specific care groups, for example, dementia, substance misuse and delayed discharges.

---

## SCOTTISH GOVERNMENT STATEMENT ON LEGISLATIVE COMPETENCE

On 28 May 2013, the Cabinet Secretary for Health and Wellbeing (Alex Neil MSP) made the following statement:

> "In my view, the provisions of the Public Bodies (Joint Working) (Scotland) Bill would be within the legislative competence of the Scottish Parliament."

---

## PRESIDING OFFICER'S STATEMENT ON LEGISLATIVE COMPETENCE

On 28 May 2013, the Presiding Officer (Rt Hon Tricia Marwick MSP) made the following statement:

> "In my view, the provisions of the Public Bodies (Joint Working) (Scotland) Bill would be within the legislative competence of the Scottish Parliament."

# PUBLIC BODIES (JOINT WORKING) (SCOTLAND) BILL

## EXPLANATORY NOTES

## (AND OTHER ACCOMPANYING DOCUMENTS)

© Parliamentary copyright. Scottish Parliamentary Corporate Body

Information on the Scottish Parliament's copyright policy can be found on the website - www.scottish.parliament.uk

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by APS Group Scotland.

ISBN 978-1-78351-195-2