Corporate Policy & Strategy Committee

10am, Tuesday, 6 August 2013

Executive Summary of Public Bodies (Joint Working) (Scotland) Bill

Item number	7.8(a)
Report number	
Wards	All

Links

Coalition pledges	P12 and P43
Council outcomes	CO10, CO11, CO12, CO13, CO14, CO15
Single Outcome Agreement	SO2

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Executive Summary of Public Bodies (Joint Working) (Scotland) Bill

Summary

This report presents an executive summary of the Public Bodies (Joint Working) (Scotland) Bill and outlines Edinburgh's 'readiness' with regard to its provisions.

Recommendations

It is recommended that Corporate Strategy and Policy Committee:

- notes the introduction of the Public Bodies (Joint Working) (Scotland) Bill to the Scottish Parliament on 28 May 2013;
- note the main provisions, issues and risks associated with the Bill;
- notes that further regulations and statutory guidance will accompany the provisions of the Bill in future; and
- notes the current position in Edinburgh with respect to the provisions and that a joint submission of written evidence will be submitted to the Scottish Parliament Health and Sports Committee.

Measures of success

The Scottish Government will be issuing revised National Outcomes for the delivery of integrated Health and Social Care during 2013/14. In addition, the Programme Sub Group on Performance and Quality has begun to develop a local outcome framework for measuring the success of the new Health and Social Care Partnership. A baseline is now being developed.

Financial impact

The number and scale of services within the scope of integration from April 1 2013 will encompass significant revenue budget from both the Council and NHS Lothian. The details of this are currently being worked on and may change as discussions continue during 2013/14. The aim of the integration proposals, in the longer term, is to support the development of integrated budgets to deliver jointly agreed outcomes for the people of Edinburgh.

Equalities impact

The proposals for integration will impact, in particular, on older people and on adults with multiple and / or complex needs. The aims of the proposal are to improve outcomes for patients and service users and are therefore expected to have a positive impact on such equalities groups.

The Scottish Government undertook a partial Equalities Impact Assessment of the proposals included in the Consultation. It will be necessary to undertake joint equalities impact assessments of any proposed service changes as a result of integration.

Sustainability impact

The proposals within this report will have a positive impact on social sustainability in particular because major aims of the Scottish Government intentions are to:

- keep people independent in their homes with appropriate support for as long as is possible and safe,
- support carers to help people in this; and
- build capacity in the community for improving, reducing health and to help people to remain independent for as long as possible.

Consultation and engagement

The Bill places a duty upon Integration Authorities to involve a range of stakeholders in the integration of health and social care services and specific requirements in relation to the integration plan and strategic plan.

A range of consultation and engagement events and mechanisms is being built into the integration programme and the new Health and Social Care Partnership arrangements.

Background reading / external references

Finance and Budget Policy Development and Review Sub-Committee – 22 May 2013 Health and Social Care Integration: Update

Corporate Policy and Strategy Committee - 16 April 2013 – Integration of Adult Health and Social Care Consultation: Scottish Government Response.

Policy and Strategy Committee - 2 October 2012 - City of Edinburgh Council Item 13 – Integration of Health and Social Care: Proposals for Interim Governance Arrangements.

Policy and Strategy Committee - 4 September 2012 – Scottish Government Consultation on the Integration of Health and Social Care Services – Joint Response.

Executive Summary of Public Bodies (Joint Working) (Scotland) Bill

1. Background

1.1 The Scottish Government indicated its intention to legislate for the integration of health and social care services some time ago and held a public consultation on its proposals during summer 2012. The responses to the consultation were analysed and the Government released its response to these views in February 2013 with an indication that a Bill would follow.

1.2 On 28 May 2013 the Scottish Government introduced to the Scottish Parliament the Public Bodies (Joint Working) (Scotland) Bill along with associated documentation such as Policy and Finance Memoranda. A high level overview of the Bill is provided below and an executive summary is detailed in Appendix 1. Full details can be obtained from http://www.scottish.parliament.uk/parliamentarybusiness/Bills/63845.aspx

1.3 This report was presented to the Health and Social Care Partnership on 14 June 2013.

2. Main report

2.1 The Bill provides the framework which will support the improvement of the quality and consistency of health and social care services in Scotland. The framework:

a. permits the integration of local authority services with health services;
b. provides for the Common Services Agency (commonly known as NHS National Services Scotland) to provide goods and services to public bodies, including local authorities;
c. provides for Scottish Ministers to form wider joint venture structures than at present in order to make the most effective use of resources; and
d. extends the Clinical Negligence and other Risks Scheme (CNORIS) indemnity scheme run by Scottish Ministers.

2.2 The main provisions for integration are provided below and in more detail in Appendix 1.

The Bill:

a. requires health boards and local authorities to integrate their health and social care services via one of four models ('body corporate' model or 3 options for a 'delegated authority' model);
b. establishes the arrangement as an 'Integration Authority';
c. requires the delegation of functions and associated budgets/resources by the relevant health board and local authority to the Integration Authority in line with an agreed financial model;

d. establishes the policy principles for integration within the legislative framework (the spirit of the law);
e. depending on the model, requires either an Integration Joint Board (body corporate) or an Integration Monitoring Committee (delegated authority) for governance and scrutiny of arrangements;
f. requires the Integration Joint Board to appoint a chief officer. In the delegated model the chief executive of the 'lead' agency will be the jointly accountable officer. Each will be responsible to both the local authority and the health board;
g. requires the submission of a jointly agreed Integration Plan which will describe the integration authority arrangements;
h. requires the Integration Authority to prepare a Strategic Plan which will set out the planning, financing and operational elements of the delegated functions in order to deliver the national outcomes;
i. establishes a duty on the integration authority to work with local professionals, the third and independent sectors to determine how best to put local service planning arrangements into place and take account of their input in the Strategic Plan.

2.3 The significant items to note regarding the Joint Integration Board are that it:

a. will be an executive board;
b. will be required to appoint a chief officer;
c. will oversee the development of the Strategic Plan;
d. will allocate resources at a high level between the health board and the local authority in accordance with the Strategic Plan and within the parameters set by the Integration Plan; and
e. will ensure delivery of the national and local outcomes.

2.4 The Bill clearly states that, whatever the model chosen, the health board and the local authority remain statutorily responsible for discharging their responsibilities with regard to the provision of their services. In addition, it also specifies that for the 'body corporate' model, the Joint Integration Board is conferred the same duties, rights and powers, in relation to them as the health board and local authority would have.

2.5 Regulations and statutory guidance will be provided on a range of further details including:

a. minimum functions to be delegated and those not to be delegated;
b. membership and proceedings of Integration Joint Boards and Joint Monitoring Committees for accountability and professional advice, staff, third sector, users carers and the public representation;
c. national outcomes;
d. content of the Integration Plan; and
e. involvement of third sector in strategic commissioning/planning etc.

Edinburgh 'Readiness'

2.6 The City of Edinburgh Council and NHS Lothian have a long history of working together, including having a Joint Director of Health and Social Care for the past seven years, provision of a number of joint services and a significant amount of

joint planning and commissioning. This legislation allows the organisations to take a positive step forward.

2.7 A significant amount of work has been undertaken recently in preparation for the legislation, in particular the establishment the Edinburgh Health and Social Care Partnership and its associated interim governance arrangements based on the 'body corporate' model described above.

2.8 The work started on the Partnership Agreement and Strategic Work Plan place Edinburgh well for preparing the Integration Plan and Strategic Plan. Furthermore, sub groups have been established to consider approaches to finance and resources, performance reporting and organisational development. The work of these groups will be critical to meeting the requirements of the Bill in time for the date of establishment.

2.9 Other areas of work which will be required to be taken forward centrally by parent bodies will include preparing new financial procedures and standing orders to enable the partnerships to be established.

Parliamentary Process

2.10 The Scottish Parliament's Health and Sports Committee has been designated as the lead committee to debate and gather evidence on the Bill. They recently issued a call for written evidence on the Bill to run over the summer recess with a closing date of 2 August. Stage 1 for oral evidence will commence in September.

2.11 The timescale is short for written evidence but it is intended that a joint submission be made on behalf of the Council and NHS Lothian. Members of the Shadow Health and Social Care Partnership, Council Members, NHS Lothian Board members and officers in both the Council and NSH Lothian have been invited to contribute to the joint submission.

Key risks

2.10 There are a number of significant health, care and financial risks associated with the **current** system which have triggered the provision of new legislation. In particular these are:

a. it does not align with the resource models required by the Christie Commission;
b. local clinicians, elected members, users, carers and other stakeholders are unlikely to engage in locality planning if budgets associated with unplanned hospital capacity are not included;
c. the demand pressures from demographic change are biased to reactive care in institutional settings and, without the Bill, this would continue leading to a vicious cycle of spending more and more money on services that do not support people to best effect;
d. it does not explicitly recognise the reality of the integrated nature of health and social care services, particularly for frail elderly people and those with complex needs such that it is not possible to plan overall expenditure for defined populations and user groups or to use budgets flexibly to best effect.

2.11 There are many risks associated with a programme of change of this scale. The Bill specifically mentions the following financial risks:

a. Health board and local authority flexibility to allocate their resources across the full range of their budgets may be constrained by ‘ring-fencing’ of their previous allocations to the integration authority. The risk will be proportional to the extent of the minimum scope of services to be included;
b. there is a risk that health boards may be left to manage any overspends in hospital based budgets whilst being unable to direct under-spends in community health budgets to offset these; and
c. parent bodies may be limited in their options for managing compensating in-year under-spends to those from within and out of scope budget.

2.12 The Bill envisages that these risks will be mitigated through the joint nature of the governance of the integration authority and the provisions of the Integration Plan and Strategic Plan and through the direct accountabilities and responsibilities of the chief officer.

Financial implications

2.13 The Financial Memorandum details the financial implications of integration across a number of elements.

2.14 The Bill references the potential for national efficiencies, mostly across health care expenditure. The combined effect of reducing delayed discharge, improving anticipatory care (avoiding unnecessary admission to hospital) and reducing variation on per capita expenditure is estimated to be between £138m and £157m from health care expenditure nationally. This needs to be considered in the context of 2011/12 spend on health care of c£9bn and on adult social care of c£2.1bn. It is expected that these efficiencies will be reinvested within the partnerships in order to help meet demand.

2.15 The key costs are:

a) transitional costs – with an estimate of £16.315m nationally, the majority of which will be required in 2014/15; The **Scottish Government will provide £16.7m which will be available to Health boards and local authorities** as partners in integration joint boards or integration arrangements **on a proportional basis** for transition costs to implement organisational development and other change management functions necessary to meet the requirements of the Bill.
b) recurrent costs for each model - with an estimate of £4.55m for the delegated model and £5.6m for the ‘body corporate’ model nationally. Some of the running costs are expected to be mitigated by such matters as removal of CHP and by the expected removal of the CHP general managers which accrue to the health board;

2.16 Significant further work will be required to establish the local efficiency and cost impact for Edinburgh.

Impact on inequalities, including health inequalities

2.17 The proposals for integration will impact, in particular, on older people and on adults with multiple and / or complex needs. The aims of the proposal are to improve outcomes for patients and service users and are therefore expected to have a positive impact on such equalities groups.

2.18 The Scottish Government undertook a partial Equalities Impact Assessment of the proposals included in the consultation. It will be necessary to undertake joint equalities impact assessments of any proposed service changes as a result of integration.

3. Recommendations

3.1 It is recommended that Corporate Policy and Strategy Committee:

- notes the introduction of the Public Bodies (Joint Working) (Scotland) Bill to the Scottish Parliament on 28 May 2013;
- notes the main provisions, issues and risks associated with the Bill;
- notes that further regulations and statutory guidance will need to accompany the provisions of the Bill in future; and
- notes the current position in Edinburgh with respect to the provisions and that a joint submission of written evidence will be submitted to the Scottish Parliament Health and Sports Committee.

Peter Gabbitas

Director of Health and Social Care

Links

Coalition pledges	Ensuring Edinburgh, and its residents, are well cared for.
Council outcomes	Health and Wellbeing are improved in Edinburgh and there is a high quality of care and protection for those who need it.
Single Outcome Agreement	Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health
Appendices	Appendix 1 – Executive Summary of the Public Bodies (Joint Working) (Scotland) Bill

Appendix 1 Executive Summary of Public Bodies (Joint Working) (Scotland) Bill

Introduction

This note is an Executive Summary of the contents of the Public Bodies (Joint Working) (Scotland) Bill, introduced to the Scottish Parliament on 28 May 2013, and in particular the Policy and Financial Memoranda associated with the Bill.

Further details can be obtained by clicking the link below:

http://www.scottish.parliament.uk/parliamentarybusiness/Bills/63845.aspx

Executive Summary

Policy Context

1. Integration is not an end in itself – it will only improve the experience of people using services when partner organisations work together to ensure that services are being integrated as an effective means for achieving better outcomes.

2. Integrated health and social care means that services should be planned and delivered seamlessly from the perspective of the patient, service user or carer, and that systems for managing services should actively support such seamlessness.

3. From the perspective of people who use the system – patients, service users, carers and families – the problems to be addressed can be summarised as follows:
    a. There is inconsistency in the quality of care for people, and the support provided to carers, across Scotland, particularly in terms of older people's services;
    b. People are too often unnecessarily delayed in hospital when they are clinically ready for discharge; and
    c. The services required to enable people to stay safely at home are not always available quickly enough, which can lead to avoidable and undesirable admissions to hospital.

4. Clinicians and other professionals who provide health and social care support also indicate that, as far as possible, it is better for people's wellbeing if they are supported in their own homes or another homely setting in the community, rather than being admitted unnecessarily to hospital.

5. In terms of older people's services specifically, it is also known that:
    a. Almost one third of total spend on older people's services annually is on unplanned admissions to hospital;
    b. More is spent annually on unplanned admissions for older people than is on social care for the same group of people; and
    c. Even allowing for the possibility that people may live longer and in better health in future, and taking into account the Scottish Government's current emphasis on improving anticipatory and preventative care, Scotland will in future experience a material increase in the number of people who require care. The resources required to provide support will rise in the years ahead.

6. The policy ambition for integrating health and social care services is therefore to:
    a. improve the quality and consistency of services for patients, carers, service users and their families;

   b. provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and
   c. ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.

7. There is a great deal to be proud of in terms of health and social care provision in Scotland. Nevertheless, there is widespread recognition across Scotland that reform needs to go further. Addressing these challenges will demand commitment, innovation, stamina and collaboration from all of us who are involved, in different ways, in planning, managing, delivering, using and supporting health and social care services.

8. The principle enshrined in the legislation is that
   'effective services must be designed with and for people and communities'.
   Christie Commission on the future delivery of public services.
   http://www.scotland.gov.uk/About/Review/publicservicescommission

9. Public bodies are therefore being required to cooperate not simply for their own administrative convenience but with a view to the changing needs of the population, whose health and social care needs are not experienced in isolation or in relation to the professionals/organisational boundaries that currently exist.

10. The status quo is not an option as it does not fit with the Christie Commission views, does not encourage engagement by local clinicians and professionals due to the current exclusion of budgets for unplanned hospital capacity, does not allow a 'whole-system' view of care or resources and is biased to reactive care in institutional settings which would simply have to continue to expand as a result of the vicious cycle of patients having insufficient care in the community to prevent unplanned/unscheduled care.

Scope

11. The Bill encompasses all adult social care services. Regulations and statutory guidance will specify a minimum of what may be delegated and also what may not be delegated.

12. It enables other services to be included in the scope, such as Children's Services and specifically mentions the importance of Housing Services being included in the integrated approach to service planning and provision.

13. Secondary legislation will also enable partnership working with non-statutory providers such as third and independent sectors, patients, service users and carers.

Outline of the Bill

14. The Bill
    a) Permits ministers to ***require integration*** of, as a minimum, adult health and social care services.
    b) Describes the partnership arrangements as '***integration authorities'***. Each health board and local authority will be required to establish an integration authority and to delegate functions and resources to them.

    Model of Integration and Governance

    c) Will ***require*** local authorities and health boards to choose one of four options for the establishment of the integration authority as follows
       a. The 'body corporate' model - The health board and local authority choose to deliver integrated services through delegation to ***an Integration Joint Board***

established as a body corporate. This will require the appointment of a Chief Officer as the jointly accountable officer.

b. The delegated authority model which has three permutations and will be accountable through the 'lead' agency Chief Executive.
    i. the health board and local authority choose to deliver services through delegation to the health board in a delegation between partners arrangement and establish a ***Joint Monitoring Committee***;
    ii. the health board and local authority choose to deliver integrated services through delegation to the local authority in a delegation between partners arrangement and establish a Joint Monitoring Committee; or
    iii. the health board and local authority choose to deliver integrated services through delegation to the health board and the local authority in a delegation between partners arrangement and establish a Joint Monitoring Committee.

d) Establishes ***Integration Joint Boards*** and ***Integration Joint Monitoring Committees*** as the partnership arrangements for the governance and oversight of health and social care services depending on the integration authority model chosen from the four options above.

e) ***Requires*** health board and local authority partners to enter into arrangements ***to delegate functions and appropriate resources*** to ensure the effective delivery of services through;
    i. the body corporate model - 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; and
    ii. delegated model –a ***Joint Integration Committee***. In this case the health board and/or local authority delegates functions and the corresponding amount of resource, to the other partner.

f) Will ***remove Community Health Partnerships*** from statute.

Integration Plan

g) ***Requires*** local authorities and health boards to set out the terms of establishing their chosen model in ***an Integration Plan*** for joint approval by Council and Health Board and Ministers.

h) Will require the Integration Plan to include;
    i. the model of integration to be used and associated governance arrangements;
    ii. the functions and budgets/resources to be delegated to the integration authority and the method of calculating money to be delegated to support delivery of the functions/ financial model of integration;
    iii. outcomes to be achieved; and
    iv. a number of other aspects which will be specified in regulations, e.g. dispute resolution, clinical and care governance etc.

i) Health boards and local authorities will be required to consult widely on the Integration Plan and the Plan will be agreed by full Council and the Health Board and approved by Ministers. It will also be made publicly available.

National Outcomes

j) Provides for ***the Scottish Ministers to specify 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. These will be set out in Regulations such that they can be amended in future to keep pace with the needs

and aspirations of health and social care in Scotland. Scottish Ministers must consult appropriately.

k) National outcomes will be reflected in Single Outcome Agreements;

l) 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:
    a. improving the wellbeing of recipients,
    b. the requirement to balance the needs of individuals with the overall needs of the population;
    c. anticipation and prevention of need; and
    d. effective use of resources.

Chief Officer

m) ***Requires integration joint boards to appoint a chief officer***, who will be jointly accountable, through the board, to the constituent health board and local authorities, and responsible for the management of the integrated budget and the delivery of services for the area of the integration plan. The appointment will be made in consultation with the health board and the local authority. The responsibilities of the Chief Officer will be subject to agreement by Scottish Ministers;

n) Minister may, in future and by regulation, enable integration joint boards to appoint staff other than a Chief Officer;

o) The Chief Executive of the 'lead' agency will be the jointly accountable officer in the delegated model;

Strategic Plan and Performance Report

p) ***Requires the integration authority***, i.e. joint boards, and health boards or local authorities to whom functions are delegated ***to prepare a Strategic Plan for the area***, which sets out arrangements for delivery of integrated functions and how it will meet the national health and wellbeing outcomes. This will be led by either the Chief Officer of the 'lead' agency Chief Executive.

q) ***The Strategic Plan will also be a financial plan*** as it will define in-year operational budgets across the Integration Authority for services in scope which will, as a minimum include community health care, adult social care, and in-scope hospital services. It will be scrutinised jointly by the Care Inspectorate and Health Care Improvement Scotland.

r) The first plan will be a three year plan published before the prescribed day of establishment and will be publicly available;

s) 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.

t) Places a duty on integration authorities to work with local professionals the third and independent sectors to determine how best to put in place arrangements for planning local service provision, to put these arrangements in place and to support, review and maintain them.

u) Each Joint Integration Board must prepare ***an annual performance report***. The first will be from the date of establishment and the year thereafter to ensure a full year report.

Other Provisions

v) 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 of joint ventures structures to collaborate effectively with local authorities and enable a joint approach to asset management and disposal.

w) Provides for the extension of the Common Services Agency's ability to deliver shared services to public bodies including local authorities in such areas as
   a. Legal Services
   b. Counter Fraud services
   c. Procurement
   d. IT Services
   e. Information

x) 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.

Further Points

15. In both models services will continue to be delivered by the health board, local authority, third and independent sectors. Staff will continue to be employed by the health board and local authority. The Bill does however contain the power for Ministers to permit (by Regulation) the Integration Joint Board to employ staff itself should, in the future, if it were considered appropriate.

16. For the body corporate model, further guidance will be provided to describe the relationship between the Chief Officer of the Integration Authority and the Chief Executives of the health board and local authorities.

17. The Integration Joint Boards and Integration Monitoring Committees will be established as the joint and equal responsibility of health boards and local authorities to oversee planning and delivery of integrated services.
    a. The Joint Monitoring Committee will scrutinise the operation of the lead agency arrangement and ensure appropriate governance arrangements are in place to discharge statutory responsibilities.
    b. The Integration Joint Board will be accountable to the Health Board and the full Council for the delivery of delegated functions and outcomes in the strategic plan.

18. Regulations will set out the details of these arrangements. However it is important to note that ***the Joint Board will be conferred the same duties, rights and powers in relation to them as the health board and local authority have****, including the ability to enforce rights in connection with the carrying out of functions as well as liability in respect of any liabilities incurred.*

19. The Scottish Government will continue its work on the Integrated Resource Framework to ensure that the allocation of resources can meet needs in the most appropriate and cost effective way.

20. The minimum scope of budgets/resources to be included in scope will be defined in regulations and statutory guidance and the Bill permits Ministers to make directions on this matter. It is noted that the minimum scope will target specialities that are predominantly for unplanned care.

21. Information sharing is enabled as part of the function of the Joint Integration Board and Chief Officer for the purposes of integration and strategic planning as well as delegated functions without breaching the duty of confidentiality.

Key Risks

22. There are some significant financial, health and care risks associated with the current system. These include;
    a. it does not align with the resource models required by the Christie Commission;
    b. local clinicians, elected members, users, carers and other stakeholders are unlikely to engage in locality planning if budgets associated with unplanned hospital capacity are not included;
    c. the demand pressures from demographic change are biased to reactive care in institutional settings and, without the Bill, this would continue leading to a vicious cycle of spending more and more money on services that do not support people to best effect;
    d. it does not explicitly recognise the reality of the integrated nature of health and social care services, particularly for frail elderly people and those with complex needs such that it is not possible to plan overall expenditure for defined populations and user groups or to use budgets flexibly to best effect.

23. There are many risks associated with a programme of change of this scale. The Bill specifically mentions the following financial risks:
    a. Health board and local authority flexibility to allocate their resources across the full range of their budgets may be constrained by 'ring-fencing' of their previous allocations to the integration authority. The risk will be proportional to the extent of the minimum scope of services to be included;
    b. there is a risk that health boards may be left to manage any overspends in hospital based budgets whilst being unable to direct under-spends in community health budgets to offset these; and
    c. parent bodies may be limited in their options for managing compensating in-year under-spends to those from within and out of scope budget.

24. The Bill envisages that these risks will be mitigated through the joint nature of the governance of the integration authority and the provisions of the integration plan and strategic plan and through the direct accountabilities and responsibilities of the chief officer.

Financial Memorandum

25. The financial memorandum outlines the following:
    a. that adult health and social care functions must be integrated as a minimum;
    b. identifies that as a result of integration some efficiencies should be possible and specific areas such as delayed discharge, anticipatory care planning (avoiding unnecessary admission to hospital) and reducing expenditure variation;
    c. the best estimate of the administrative, compliance and other costs to which the provisions of the Bill give rise at a national level,
    d. the best estimate of the timescale over which the costs and savings are expected to arise, and
    e. an indication of the margins of uncertainty in these estimates.

26. The estimated efficiencies described in the Bill relate mostly to health care expenditure for a number of reasons. The estimated potential efficiencies for partnerships across Scotland from the combined effect of reducing delayed discharge, improving anticipatory care planning (avoiding unnecessary admission to hospital) and reducing per head expenditure to the national average is expected to be between £138m and £157m. This needs to be considered against the current health care spend of c£9bn for health care spend and c£2.1bn for adult social care (2011/12). ***It is expected that the efficiencies will be reinvested within partnerships in order to help meet demand.***

27. The estimated costs of integration are split into a number of categories, including:

a. transitional costs, estimated at £16.315 m nationally, the majority of which will be required in 2014/15; ***The Scottish Government will provide approximately £16.7 m which will be available to health boards and local authorities as partners in integration joint boards or integration arrangements on a proportional basis*** for transition costs to implement organisational development and other change management functions necessary to meet the requirements of the Bill. In moving to these arrangements, it is expected that opportunity costs realised by health boards and local authorities will be used to support transitional arrangements;
b. recurrent costs for each model- with an estimate of £4.55m for the delegated model and £5.6m for the 'body corporate' model nationally. Some of the running costs are expected to be mitigated by such matters as removal of CHP and by the expected removal of the CHP General Managers which accrue to the Health Board;
c. cost implications of CSA and CNORIS elements of the Bill; and
d. consequential cost implications – e.g. harmonisation of terms of conditions of staff where relevant (i.e. delegated model);

28. Organisational development plans will be required to support the integration agenda across health boards and local authorities and to support joint boards and join monitoring committees in terms of developing shared values, skills and behaviours. Leadership development will also be needed to support the new relationships and roles of the chief executives of health boards and local authorities and new chief officers.

29. There is a risk under the 'body corporate' model that VAT currently reclaimed by local authorities is no longer able to be recovered under the VAT arrangements in the body corporate. The 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 model delivers services. They indicate that the proposed arrangements are likely to be interpreted by HMRC as the body corporate re-allocating the integrated budget for the delivery by health boards and local authorities; consequently it is likely that a VAT neutral position is attainable. Guidance will be developed on this matter.

30. The Bill also references current areas of Scottish Government investment which are relevant to the scope of the Bill. These include:
    a. Re-shaping care for Older people- Change Fund,
    b. Support to Third Sector interface,
    c. Change Fund- enhancing the Role of the Third Sector,
    d. A Stitch in Time,
    e. Support to Independent Providers in relation to Reshaping Care,
    f. Data Sharing and IT integration support, and
    g. Support for partnerships to develop H&SC Activity data.

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