Inverclyde council

AGENDA ITEM NO: 4

Report To:	**Health & Social Care Committee**	**Date:**	**28th August 2014**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No:**	**SW/05/2014/HW**
Contact Officer:	**Helen Watson Head of Planning, Health Improvement and Commissioning**	**Contact No:**	**01475 715369**
Subject:	**Consultation on Draft Regulations to Public Bodies (Joint Working) (Scotland) Act 2014**		

1.0 PURPOSE

1.1 To outline the implications of the Draft Regulations for the Committee and present a summary report of consultation responses.

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Scotland) Act received Royal Assent on 1st April 2014. Since then the Scottish Government has issued two sets of draft regulations for consultation, the first set running from 12th May to 1st August, and the second from 27th May to 18th August.

2.2 The draft regulations clarify some of the detail of the legislation, and responses were submitted on behalf of Inverclyde Council and Inverclyde CHCP Sub Committee.

2.3 It should be noted that the requirements of the legislation are largely in line with our current CHCP arrangements, however there are some points of detail that should be considered and these are noted in the draft summary report.

2.4 Some key timeline milestones that should be noted are as follows:

Action	**Completed by**
Submit Inverclyde CHCP response to set 1 of regulations	1st August 2014
Submit CHCP response to set 2 of the regulations and present summary report on regulations to the CHCP Sub Committee.	18th August 2014
Develop draft Integration Scheme	31st December 2014
Consult on draft Integration Scheme	January-March 2015
Agree Integration Scheme at CHCP Sub Committee	23rd April 2015
Agree membership (both voting and non-voting) of IJB	23rd April 2015
Develop draft proposals for membership and workplan for HSCP strategic planning group	1st January – 28th February 2015
Agree membership of and set up HSCP strategic planning group	23rd April 2015

3.0 RECOMMENDATIONS

3.1 It is recommended that the Committee note and comment on issues raised by both consultation responses.

3.2 The Committee is asked to review and agree the key actions and timescales outlined at 2.4 above.

Brian Moore
Corporate Director
Inverclyde Community Health & Care
Partnership

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Scotland) Act received Royal Assent on 1st April 2014. Since then the Scottish Government has issued two sets of draft regulations for consultation, the first set running from12th May to 1st August, and the second from 27th May to 18th August.

4.2 It should be noted that the requirements of the legislation are largely in line with our current CHCP arrangements, however there are some points of detail that should be considered and these are noted in the report.

4.3 After the consultation period the finalised regulations will inform the content and detail of our HSCP Integration Scheme which will also include the detail of the new governance arrangements.

4.4 This report considers the implications of both sets of draft regulations, for consideration.

5.0 DRAFT REGULATIONS SET 1

5.1 The Draft Regulations relating to the Public Bodies (Joint Working) (Scotland) Act 2014 – Set 1 cover the areas described at 5.2 through to 5.7.

5.2 Prescribed information to be included in our Integration Scheme. We have not identified any problems with the requirements as they align closely with our current Scheme of Establishment. The legislation requires that we include:

- Local governance arrangements for the Integration Joint Board (IJB), including the number of members that will be appointed by the Local Authority and Health Board, and whether the first Chair will be from the Local Authority or Health Board.
- Local operational delivery arrangements for the functions delegated to the IJB.
- Performance targets, improvement measures and reporting arrangements.
- Clinical and care governance of services.
- The operational role of the Chief Officer.
- The line management arrangements for the Chief Officer.
- Plans for workforce development.
- Financial management and reporting arrangements.
- The use of capital assets.
- Participation and engagement arrangements.
- Information sharing and data handling.
- Complaints procedures.
- Risk management.
- Dispute resolution.

5.3 Prescribed functions that must be delegated by the Local Authority.

These are listed thus:

- Social work services for adults and older people;
- Services and support for adults with physical disabilities;
- Services and support for adults with learning disabilities;
- Mental health services;
- Drug and alcohol services;
- Adult protection and domestic abuse;
- Carers support services;
- Community care assessment teams;
- Support services;
- Care home services;
- Adult placement services;
- Health improvement services;

- Housing support services, aids and adaptations;
- Day services;
- Local area co-ordination;
- Respite provision;
- Occupational therapy services;
- Re-ablement services, equipment and telecare.

Most of the functions prescribed are already included within our CHCP arrangements. We note however that Domestic Abuse is included under the prescribed functions and this currently sits with the Council's Community Safety Partnership. We stated in the draft response that there should be an option to include this in HSCPs, but that we would prefer locally that it remains within the Community Safety Partnership because it is best addressed as a cultural issue rather than a service provision issue. We also suggested that sensory impairment services should be considered within the prescribed functions as there are clear potential advantages to linking social work and clinical services in terms of improving referral pathways.

5.4 Prescribed functions that may or must be delegated by the Health Board.

The consultation asked for views on functions that may be delegated, and on services that must be delegated. Given that the *functions* described within the schedule are optional at this stage, these would be subject to further discussion between the Council and the Health Board, as we would need clarity about the potential implications for the HSCP if it was to accept responsibility for some of these functions, and in what context. With regard to the *services* that must be delegated (see appendix 1), we request further clarity in certain areas. For example, with regard to unscheduled care, we would want to be clear that there would be no expectation that the new Inverclyde HSCP will have operational responsibility for Inverclyde Royal Hospital services. Over the past six months we have been piloting work with acute colleagues and local GPs to identify the detail of how our population uses the local hospital. This activity has also highlighted variation in referral patterns and rates from local GPs to hospital departments, and this sets a firm basis for developing an understanding of how we can improve referral and care pathways at the interface between acute and community services. We believe that this considered approach will provide a better means of improving patient outcomes rather than a straight shift in responsibilities that does not take account of the things that might need to change, such as patterns of usage or modes of delivery. With regard to unscheduled care, we also suggested that the reference to "emergency conditions" needs to be clarified. We have assumed that this relates to illnesses but suggest that it would be helpful to make distinction regarding cases of trauma such as serious RTAs or other accidents. Given the level of specialism needed, it may not be possible to resource the required expertise at HSCP level. If this is not explicit, the regulations might raise unrealistic expectations.

We have also suggested a challenge to the inclusion of "Women's Health Services". Modern health services have moved away from "Women's Health Services" thinking and organising of services, in a focused attempt to shift the emphasis on sexual health responsibility away from just women and towards both partners. In Inverclyde we have been particularly successful in this regard with the highest rate of male partner engagement with sexual health services across the whole NHSGGC area. We are also concerned that by placing the emphasis on women, this could create a perception of excluding the MSM population from accessing services. Sexual Health services are currently delivered on a Board-wide basis with local hubs, and this works well. Fragmenting existing arrangements runs a risk of services not having the necessary critical mass of patients to make them clinically sustainable at HSCP level.

5.5 Proposals for national health and wellbeing outcomes.

The consultation sought views on whether the outcomes cover the right areas or if additional areas needed to be covered and whether the outcomes will be understood by users of services as well as by those planning and delivering them. The proposed outcomes are:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of service users.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.
7. People who use health and social care services are safe from harm.
8. People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.
9. Resources are used effectively in the provision of health and social care services, without waste.

These proposed outcomes are reflective of earlier iterations and officers are satisfied that they cover the right areas. The outcomes focus on improved experience and person-centred outcomes for service users, while many of our existing performance requirements, targets and returns focus on systems, outputs and processes. This means that the two will potentially be at odds with each other. We therefore proposed that national return requirements need to be fully reviewed and revised to reflect delivery on the outcomes and not the systems.

6.0 DRAFT REGULATIONS SET 2

6.1 The Draft Regulations relating to the Public Bodies (Joint Working) (Scotland) Act 2014 – Set 2 cover the areas described at 6.2 through to 6.5.

6.2 Prescribed groups which must be consulted when preparing or revising our Integration Scheme; preparing our Strategic Plan, and when making decisions affecting localities.

The regulations specify a list of standard consultees as follows:

- Health Professionals
- Users of health care
- Carers of users of health care
- Commercial providers of health care
- Non-commercial providers of health care
- Social care professionals
- Users of social care
- Carers of users of social care
- Commercial providers of social care
- Non-commercial providers of social care
- Non-commercial providers of social housing
- Third sector bodies carrying out activities related to health or social care

We have not identified any omissions from this list.

6.3 Prescribed membership, powers and proceedings of IJBs.

The regulations largely follow what was set out in the earlier policy statement. The powers of IJBs are prescribed, as well as their membership and how their proceedings are to be conducted.

The membership arrangements set out in the draft Order are intended to ensure parity in both membership and decision making for the Health Board and Local Authority.

Therefore it is proposed that:

- The Local Authority and the Health Board must nominate the same number of representatives to sit on the Integration Joint Board
- The Health Board and the Local Authority must agree on the number of representatives that they will each nominate
- The Health Board and Local Authority must put forward a minimum of three nominees each, however Local Authorities can require that the number of nominees is to be a maximum of 10% of their full council members
- The Local Authority will nominate councillors to sit on the Integration Joint Board
- The Health Board will primarily nominate non-executive directors to sit on the Integration Joint Board

Discussions are ongoing between Inverclyde Council and Greater Glasgow & Clyde Health Board regarding the number of representatives that each will nominate.

N.B. – The Chair and Vice Chair will be appointed with one being an Elected Member and the other being a Health Board appointee. The term of office of Voting Members is to be agreed between the Council and the Health Board but must not exceed 3 years, although Members can be reappointed. The Council and the Health Board must agree who is to appoint the first Chair and the term of office, and where the Council appoints the Chair, the Health Board will appoint the Vice Chair and vice versa. In the case of a tied vote, the Chair will have a casting vote, or where the Chair is absent, the Vice Chair will have a casting vote.

Non-voting Members

- The Chief Social Work Officer.
- A registered health professional employed and chosen by the Health Board.
- The Chief Officer of the IJB.
- One staff-side representative.
- One Third Sector representative.
- One service user representative.
- One carer representative.

With regard to voting members parity of representation has been a central expectation from the outset, and the regulations make allowance that Health Boards might have difficulty in nominating three non-executive directors. On that basis there is provision to reduce the number of non-executive directors to two, and have the third place filled by another “appropriate person”.

While the voting members are prescribed and limited by the regulations, the specified non-voting representatives are set as a minimum and our IJBs will be able to include whatever non-voting representation it regards as appropriate. On that basis officers have not identified any issues with the list of prescribed non-voting members.

The draft regulations also require the IJB to adopt procedural standing orders. In the main, it is for the IJB to decide what should be included in these but certain minimum requirements are included in the regulations relating to:

- Calling of Meetings
- Notice of Meetings
- Quorum (at least two thirds of each party’s Voting Members must be present)
- Conduct of Meetings
- Deputies (can be sent in place of a Voting Member and can vote but, if the depute is there in place of the Chair (or Vice Chair) they may not preside over the meeting and may not have a casting vote)
- Conflict of Interest
- Records

What is not clear from the draft regulations is a description of how the IJB will relate to the Council and the Health Board in terms of governance and accountability.

6.4 Prescribed membership of strategic planning groups.

The Act requires IJB to establish a strategic planning group comprising membership from the following list, as a minimum requirement.

- Health professionals
- Users of health care
- Carers of users of health care
- Commercial providers of health care
- Non-commercial providers of health care
- Social care professionals
- Users of social care
- Carers of users of social care
- Commercial providers of social care
- Non-commercial providers of social care
- Non-commercial providers of social housing
- Third sector bodies carrying out activities related to health or social care

While we recognise the importance of taking an inclusive approach and note that the list is set as a minimum, our experience as a CHCP has highlighted that it is not always helpful to focus on the need to have separate "health" and "social work" representation, as this can foster an ethos of emphasising differences rather than working to integrate not only in practice, but in thinking and culture. On that basis we propose that the prescribed list should be modified, and suggest the following:

- 2 x Health/Social Care professionals who operate within the local authority area
- 2 x Users of Health/Social Care who reside within the local authority area
- 2 x Carers of users of Health/Social Care who reside within the local authority area
- Commercial providers of health/social care who operate within the local authority area
- Non-commercial providers of health/social care who operate within the local authority area
- Non-commercial providers of social housing within the local authority area
- Third sector bodies within the local authority carrying out activities related to health or social care

We also note that in common with many other local authorities, we do not have commercial providers of (only) health care. Such providers will offer care under a social model of health which makes them difficult to distinguish from commercial providers of social care.

6.5 Prescribed form and content of performance reports.

The regulations prescribe what needs to be included in the annual performance report, specifically:

- Progress to deliver the national health and wellbeing outcomes.
- Information on performance against key indicators or measures.
- How our strategic planning and locality arrangements have contributed to delivering services that reflect the integration principles.
- Details of any review of the strategic plan within the reporting year.
- Any major decisions taken outwith the normal strategic planning mechanisms.
- An overview of the financial performance of the HSCP.
- The extent to which the HSCP has moved resources from institutional to community-based care and support, by reference to changes in the proportion of the budget spent on each type of care and support.

Officers have considered this list and believe that the draft prescribed content should enable robust scrutiny by the IJB as well as support a shift in focus away from service activity and outputs, and towards a focus on service user experience and outcomes.

7.0 IMPLICATIONS

Finance

7.1 Inverclyde Council has received a one-off sum of £135,000 to support the transitional arrangements needed to meet the requirements of the Act.

Financial Implications:

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
N/A					

Legal

7.2 There will be a requirement to develop revised Standing Orders for the emerging IJB and revisit the existing Standing Orders in respect of the Health and Social Care Committee. We will require legal guidance on ensuring clarity on constitutional issues around how the Council will oversee the IJB and its performance.

Human Resources

7.3 No human resources implications identified at this time.

Equalities

7.4 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO - This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

Repopulation

7.5 No repopulation implications identified at this time

8.0 BACKGROUND PAPERS

8.1 Consultation documents

Appendix 1

Table: Health services that must be included within integration

This table lists services that **must** be included within the scope of integrated strategic planning, as part of whole system redesign in favour of preventative and anticipatory care in communities.

In each case, integration must include all **adult** provision; inclusion of children's services in integrated arrangements is left to the discretion of local partners. Additional services covered by the list of functions that **may** be included in integration can, of course, also be delegated locally.

Note that, where "patient's home" is referred to as a place where a service is delivered, this includes care homes.

Service	What does the service involve?	Who provides the service?	Why is the service provided?	Where is the service delivered?
Unplanned inpatients	Medical care for urgent or emergency conditions in relevant specialities, to be described in statutory guidance	Doctors, nurses, AHPs	To provide assessment, investigation, diagnosis, care planning and treatment of patients who have had an unplanned admission to hospital	In hospital and on occasion part of that care may be provided in the community in 'step-up' and step-down' beds
Outpatients - Accident & Emergency	Medical care for urgent or emergency conditions, not requiring hospital admission	Doctors, nurses, AHPs, dentists and dental care professionals	To review patients seen in A&E with minor problems who do not require admission but do require review	In hospital
Care of Older People (previously known as geriatric medicine)	Medical care for older people, to the extent not covered by unplanned admissions	Doctors, nurses, AHPs, dentists and dental care professionals	To provide assessment, investigation, diagnosis, care planning and treatment of older people	In hospital, surgeries and community clinics

Service	What does the service involve?	Who provides the service?	Why is the service provided?	Where is the service delivered?
District Nursing	Full range of nursing services	Nurses	To provide assessment, investigation, diagnosis, care planning and treatment of patients	In surgeries, community clinics and patients' homes
Health Visiting	Full range of health visiting services, as they apply to adults	Health visitors	To provide assessment, care and protection of children (where relevant) and older people	In surgeries, community clinics, and patients' homes
Clinical Psychology	Full range of clinical psychology services	Clinical psychologists, clinical psychology assistants	To provide assessment, investigation, diagnosis, care planning and treatment of patients with psychological problems and distress	In hospital, community clinics, surgeries and patients' homes
Community Mental Health Teams	Full range of services for those with mental health problems **Note**: Integration Authorities should have a coordination and governance role in relation to more specialist mental health services that the population may require	Doctors, nurses, pharmacists, AHPs	To provide assessment, investigation, diagnosis, care planning and treatment of patients with mental health problems and psychological distress	In community clinics, surgeries and patients' homes
Community Learning Difficulties Team	Full range of services for those with a learning difficulty	Doctors, nurses, pharmacists, AHPs	To provide assessment, investigation, diagnosis, care planning and treatment of patients with learning difficulties	In community clinics, surgeries and patients' homes

Service	What does the service involve?	Who provides the service?	Why is the service provided?	Where is the service delivered?
Addiction Services	Full range of services, inpatient and outpatient, for those with addictions	Doctors, nurses, pharmacists, AHPs	To provide assessment, investigation, diagnosis, care planning and treatment of patients with addictions	In hospital, community clinics, surgeries and patients' homes
Women's Health Services (includes family planning services)	Full range of well woman and family planning services	Doctors, nurses	To provide assessment, investigation, diagnosis, care planning and treatment of women's health, sexual health and contraception (family planning) services	In hospital, community clinics, surgeries and patients' homes
Allied Health Profession Services	Full range of services delivered by all the allied health professionals	Allied Health Professionals	To provide assessment, investigation, diagnosis, care planning and treatment of patients	In hospital, community clinics, surgeries and patients' homes
GP Out-of-Hours	Assessment, treatment and sometimes referral on to specialist care, of those who present with urgent or emergency care needs in the out of hours period	Doctors, nurses	To provide assessment, investigation, diagnosis, care planning and treatment of patients	In out-of-hours centres (hospitals and community clinics) and patients' homes
Public Health Dental Service (previously known as community dental services)	Dental services	Dentists, dental care professionals	To provide assessment, investigation, diagnosis, care planning and treatment of patients	In hospitals, surgeries, community clinics, and patients' homes

Service	What does the service involve?	Who provides the service?	Why is the service provided?	Where is the service delivered?
Continence Services	Assessment, investigation, diagnosis and treatment of those with continence problems	Nurses, technicians	To provide assessment, investigation, diagnosis, care planning and treatment of patients	In community clinics, surgeries and patients' homes
Home Dialysis	Usually patients manage this themselves but some may need nursing assistance to carry out their own renal dialysis	Patients, nurses	To support those who self-manage dialysis in their own homes	In patients' homes
Health Promotion	All aspects of health promotion activity for lifestyle advice, screening for early disease	Doctors, nurses, AHPs, pharmacists, dentists, dental care professionals	To provide all aspects of health promotion, lifestyle and health improvement services	In surgeries, community clinics, and patients' homes
General Medical Services (GMS)	Full range of services provided by general medical practitioners and their teams	Doctors, nurses, Health care assistants, phlebotomists	To provide the full range of general medical services as set out in legislation and guidance, including to the assessment, investigation, diagnosis, anticipatory care, care planning and treatment of patients	In surgeries, community clinics, and patients' homes
Pharmaceutical services - GP prescribing	Prescribing and dispensing of all medication and therapeutic agents	GPs, nurse prescribers, prescribing pharmacists working in GP practices	To provide the full range of prescribing services set out in legislation and guidance	In surgeries, community clinics, and patients' homes