AGENDA ITEM NO: 5

Report To:	**Shadow Integration Joint Board**	**Date:**	**28th May 2015**
Report By:	**Brian Moore Chief Officer Designate, Inverclyde Health & Social Care Partnership**	**Report No:**	**SIJB/02/2015/HW**
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Subject:	**Health and Social Care Partnership Integration Update**		

1.0 PURPOSE

1.1 The purpose of this report is to update members on the preparation and submission of the Inverclyde HSCP Integration Scheme to the Scottish Government for approval, to set out the intentions and preparations for local implementation of the Public Bodies (Joint Working) (Scotland) Act 2014, and to present a draft outline for our Strategic Plan for approval.

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires that Health Boards and local authorities jointly prepare, consult and submit for approval an Integration Scheme to Scottish Ministers. The required content of the scheme is set out in Section 1(3) (a-f) of the Act and within the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014.

2.2 The version of the Scheme that was submitted is not substantially different to the version approved by the Council on 29th January 2015. However some minor adjustments had been made to some of the wording where legal compliance with the detail of the legislation was questioned as part of informal feedback. The Integration Scheme is designed to cover the requirements of the Act and demonstrate legislative compliance, while any further detail needed can be written into the operating instructions and Standing Orders, to be agreed and approved by the Integration Joint Board (IJB). The Scheme was submitted for approval on 31st March 2015, and has since been returned to officers with some further modifications required before Ministerial approval can be granted.

2.3 The Health and Social Care Partnership is also required to develop a Strategic Plan during the first year of its establishment, and a draft outline of what this plan might include is offered to members for consideration and approval (annex 2).

3.0 RECOMMENDATIONS

3.1 It is recommended that Members note that the Integration Scheme, which was submitted to the Scottish Government on 31st March for approval, has been returned for further work. This is currently being undertaken by officers with the understanding that any changes should not alter the substantive content or meaning of the Scheme approved by the Council and the NHS Board.

3.2 It is recommended that members approve the draft outline for the Inverclyde Strategic Plan.

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 was passed on April 1st 2014. Secondary legislation is being continuously developed to underpin the Act.

4.2 The Regulations and Orders were laid in the Scottish Parliament in October and November 2014 and the Affirmative Regulations came into force on 28th November 2014.

4.3 Guidance was issued to support integrated budgets in April 2014, along with a finance implementation checklist to help Health Boards and Local Authorities and shadow Integration Joint Boards to prepare for financial and governance arrangements under integration. Guidance for Integration Financial Assurance to support robust identification of integrated budget by Health Boards and Local Authorities has also been issued, as has guidance on Clinical and Care Governance and strategic commissioning.

4.4 The latest guidance, issued on 23rd March 2015, relates to the requirement for each IJB area to have at least two localities, and describes to some extent how these localities should inform strategic planning.

5.0 OVERVIEW OF THE DRAFT SCHEME

5.1 The preamble to the Scheme (sections 1 and 2) is designed to set the context and purpose of integration from an Inverclyde perspective. This is not formally part of the scheme.

5.2 Section 1 sets the general context in terms of the legislative requirements and the future status of the HSCP and IJB, and section 2 describes the aims and outcomes, and in particular specifies the national outcomes as prescribed by the Scottish Government. These have been included in the preamble to safeguard against any future changes or additions to the outcomes. As part of the preamble, adjustments would be minimal and would then not bring about the need to re-submit an amended Scheme to Scottish Ministers.

5.3 Section 3 marks the start of the proposed Scheme as a legal document, and from that point onwards must be fully compliant with the guidance.

5.4 The Scheme highlights that Inverclyde will be a body corporate integrated authority with delegated legal authority from both the Council and Health Board to plan, manage and deliver services on behalf of the two contributing partners.

5.5 Throughout the Scheme we have focused on including the minimum required to meet compliance standards. It should be noted that keeping our narrative to the minimum is not indicative of any wish to minimise our level of integration, but rather, to future-proof the Scheme so that it can accommodate any future improvements without having to re-submit to the Scottish Government for re-approval. Governance will remain tight through our Standing Orders and Financial Instruments. Although the Scheme has been returned for further work, this is generally in terms of the wording rather than the content.

5.6 <u>Integration Joint Board Membership</u>
Our Scheme specifies that voting membership will comprise four Councillors and four NHS non-executive director members, and that the first IJB Chair will be an Inverclyde Councillor, with the Vice Chair being an NHS non-executive director. After a two year term, this will switch to the Chair being an NHS non-executive director and the Vice Chair being a Councillor. There will be no casting vote, but rather, in cases where agreement cannot be reached, the Chief Officer will be required to re-draft the proposal to one that is acceptable to both Parties.

5.7 The minimum requirements for non-voting membership are outlined in the Guidance, but Partnerships are free to have additional members over and above the minimum, at their own

discretion. In Inverclyde, we anticipate that non-voting membership will comprise the following:-

- Chief Officer/Chief Social Work Officer
- Clinical Director
- Nurse Advisor
- Medical Lead from IRH
- Joint Finance Officer
- Carer Representative
- Service User Representative
- Third Sector Representative
- Two staff-side representatives (one from NHS and one from local authority)

We also anticipate that any other non-voting members deemed to have a locus within the business of the IJB will be invited to attend as and when required.

5.8 Strategic Plan

We are required by the legislation to have an overarching Strategic Plan, developed and implemented by a Strategic Planning Group. Minimum membership of the Strategic Planning Group is prescribed by the Regulations, and annex 1 highlights a proposal for how the Group should be populated, and how it should be governed by and inform the business of the IJB. This is important because the IJB will be required to approve the plan and to oversee and scrutinise its implementation. We also need to demonstrate how we will ensure the active engagement of the IJB with the business of the HSCP. The chart at annex 1 attempts to do this, and the outline plan at annex 2 proposes the suggested structure and content of the plan.

5.9 The Inverclyde HSCP will not have managerial responsibility for hospital services, however it will be involved in their planning, particularly with regard to the pathways between hospital and community services, and ensuring a person-centred and outcome-focused approach to the patient or service-user experience. NHS GGC hospital services span the whole NHS Board area, albeit the Inverclyde Royal Hospital is predominantly used by Inverclyde people. However it should also be noted that Inverclyde people also use other hospitals, and the IRH is used to a substantial degree by people from Argyll & Bute. We cannot therefore consider the IRH as a standalone resource. The interface between hospital and community, and the planning role of HSCPs will therefore need to be considered across all six IJBs within the NHSGGC catchment. On that basis, this dimension should be coordinated and held by the Health Board hospital sector and guided by the outputs of the Clinical Services Review. Work is ongoing locally to build on the successes of recent interface planning between primary and secondary care and community services to develop a shared understanding of need, demand and delivery. It is intended that this work will be further developed within the Strategic Plan. The outline for the plan structure builds on the existing array of plans and strategies which can be drawn on to provide the level of detail required by the IJB to take the Strategic Plan forward.

Members should note that the Strategic Plan outline will be populated using existing agreed plans as its foundation. This will ensure continuity between the current CHCP arrangements and the new HSCP arrangements. Members should also note that the Strategic Planning Group needs to include membership from the list prescribed by Regulations as a minimum, and that it needs to have explicit oversight by the IJB (see annex 1).

5.10 Performance Management

The legislation requires that the Health Board and the local authority set out the process by which the list of targets and measures that relate to the delegated functions will be developed and the extent to which responsibility will lie with the IJB. The CHCP has an integrated performance management framework in place which works well and has been developed to reflect the SHANARRI outcomes. This will need to be refined and take account of the national health and wellbeing outcomes (noted at 2.1 in the Scheme) and integration principles, but we are in a strong position to take this forward due to our existing outcomes-

focused approach. Work is also required at locality level to determine what performance reporting will be needed to the Integration Joint Board, and how this is derived from operational management intelligence.

Members should note that there is a potential mismatch between the indicators that we currently have and the intelligence required to demonstrate progress in achieving the national outcomes. The Information and Statistics Division of the NHS National Services (ISDScotland) is currently working on a new dataset, definitions, recording guidance and file specifications to support the requirements of the legislation. NHSGGC still requires data in respect of HEAT targets and standards, and the Scottish Government Social Work Performance Indicators are still extant. This means that we could be working in an extremely onerous reporting framework, with indicators that report on contradictory objectives (patient/ client/ carer outcomes versus systems outputs and throughputs), and that are not necessarily aligned to the Strategic Plan.

5.11 Clinical and Care Governance

In respect of effective Clinical and Care Governance, it is recognised that as well as ensuring appropriate arrangements for directly provided health and social care services, we need to co-ordinate action across a range of services and providers, including the third and independent sector. The Inverclyde Integration Scheme sets out our approach to Clinical and Care Governance, building on the foundations that we have established over four years as a fully integrated CHCP, and noting the intention to strengthen the approaches we have for the oversight of both internal services and those commissioned from the third and independent sector, including the monitoring of care standards and professional obligations via practice and staff governance.

The Regulations require the appointment of professional staff to the non-voting membership of the Integration Joint Board (as noted at 5.7), and these members will support the Clinical Director and Chief Social Work Officer in governance matters regarding practice, registration and development of professional staff as well as advising on clinical and care governance aspects of the Strategic Plan.

5.12 Localities

Members should note that it is a requirement of the Act that each HSCP area is split into a minimum of two localities. The latest draft guidance issued by the Scottish Government in March 2015 stipulates that "*Locality areas should be based on clusters of GP practices and should relate to natural communities in ways that make sense to the people living and working in them*." Whilst officers have noted a contradiction in this requirement (inasmuch as our clusters of GP practices do not always relate geographically to the communities in which their premises are located), the most pragmatic approach seems to be that we identify two localities within Inverclyde. It is proposed that these should be:

- Inverclyde East
- Inverclyde West.

By nominating these localities we can then get on with the business of working out how we ensure locality level participation but retain an Inverclyde-wide strategic overview. Within the two formal localities it is likely that we will have sub-localities or neighbourhoods based on the localities identified through the Inverclyde Alliance Programme Board structures. Whatever mechanisms are developed to achieve this, there will be a need to support local communities to influence the services they receive without fragmenting current structures and thereby bringing a need for additional capacity for management, reporting and recording etc.

5.13 Workforce Planning

It is recognised that successful delivery of integrated services will be dependent on an engaged workforce and this will be achieved through effective leadership, management, support, learning and development. To deliver this we intend to build on the successes we have had in relation to integrated staff and practice development as a CHCP.

Members should note that the Scheme commits to the development of an integrated Workforce Development Plan, building on the rolling joint training plan we have had in place for four years.

5.14 Information Sharing

The sharing of information between Health Boards and the Council will be essential to planning and delivering improved care based on the patient or client journey through services. Inverclyde Council and NHSGGC already have an agreed information sharing protocol that has served us well over the past four years. Any future development will be undertaken in tandem with the Council's Records Management Plan arrangements.

5.15 Complaints

The legislation also requires that we outline our approach to complaints handling. We have therefore taken the opportunity to set out a picture of how complaints will be managed and integrated from the perspective of service users. Our Integration Scheme sets out the intended process for handling of complaints, based on the recent review and revision of procedures that were undertaken under the guidance of the Council's Chief Internal Auditor.

5.16 Risk Management

The guidance requires that the Parties describe the process they will follow in order to develop a shared risk management strategy. The Scheme sets out the approach we will take to develop a shared risk management strategy. Members should note that the Scheme commits to six-monthly reviews of the risk register by the IJB.

6.0 IMPLICATIONS

Finance

6.1 None at this time.

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					

6.2 **Legal**

6.3 To be completed by colleagues in Legal Services, but will include drafting of Standing Orders.

Human Resources

6.4 It is not intended that in a body corporate integration arrangement there is any change to employment and/ or terms and conditions of HSCP staff, therefore no HR implications identified at this stage.

Equalities

6.5 None at this time, although recognition will be given to the wider and associate equalities agenda.

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

6.6 N/A.

7.0 CONSULTATIONS

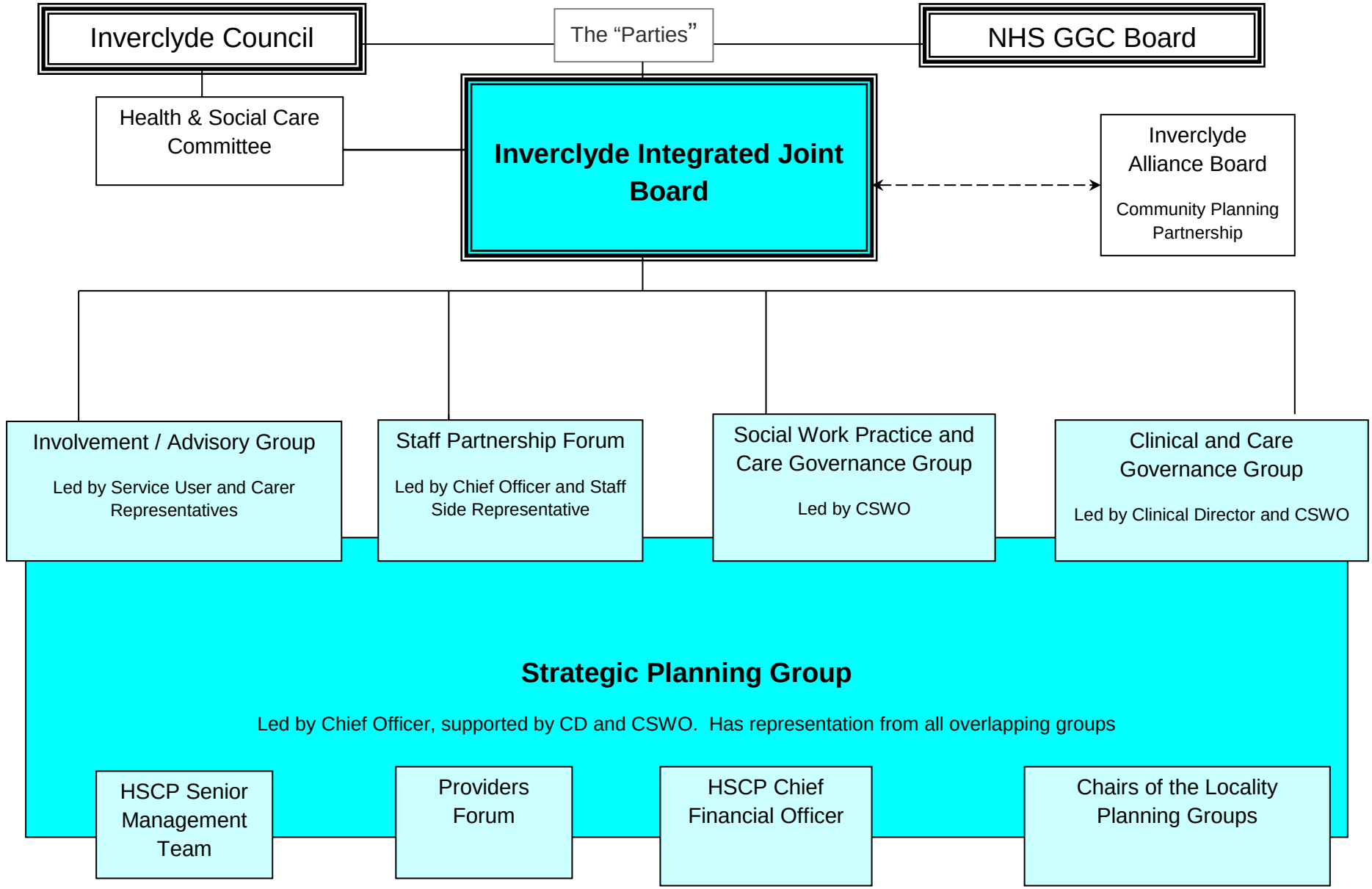
7.1 Consultation is ongoing with the statutory consultees and with officers in each Party.

8.0 LIST OF BACKGROUND PAPERS

8.1 Inverclyde draft Integration Scheme.

8.2 Public Bodies (Joint Working) (Scotland) Act 2014 and its associated Regulations.

Annex 1: Integration Structure



Inverclyde Health & Social Care Partnership

Draft Outline for the Strategic Plan

2015 – 2018

Version 1 – 7th May 2015

Chief Officer Statement

Very brief précis of why we are changing - legislative requirements, but that it fits with our journey so far; the motivation for change (key drivers of health & social inequalities; building on what has been achieved so far etc.). Highlight the success of the CHCP and the improvements that it has brought, and how it is a robust foundation for our HSCP arrangements and our aspirations for the future.

Vision

CHCP vision - "Improving Lives", underpinned the values that:

- We put people first;
- We work better together;
- We strive to do better;
- We are accountable.

To realise our vision we need to take a strategic approach to how we look at our services, alongside the needs and aspirations of Inverclyde people, and look to a future that focuses on better outcomes – improving lives – and ensuring that we have the best possible arrangements and choices in place to achieve that, and all within the limited public purse that funds us.

Structure of the HSCP

- IJB make-up and purpose. Voting and non-voting membership.
- Outline map of the IJB and the key groups that sit below it, and line of sight to parent organisations (Council and NHS Board).
- Brief comment about the function of each group, and how it all comes together to give us clear accountability back to communities and localities.
- High level summary of HSCP responsibilities.

Functions Delegated to the Integration Joint Board

This section will include the final list of functions that are delegated to the IJB from both the Health Board and the Council. This section will have to be approved by the IJB at its first meeting in order that the formal delegation can proceed and the IJB can assume responsibility for service delivery and performance against the national outcomes.

Inverclyde Strategic Plan (this would be the "what")

The main purpose of our Plan is to provide strategic direction and keep us focused on the big changes we aim to deliver. [Scope of the plan - adults, children, criminal justice]. We want to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from

health and social care at the same time. This is a natural progression building on the aspirations and achievements of the Inverclyde Community Health and Care Partnership (CHCP) which existed from 2010 until 2015, when our HSCP arrangements replaced the CHCP. Our Plan brings together a number of plans that have already been developed in partnership with our communities and other stakeholders (see appendix 1), and is structured around the National Health and Wellbeing Outcomes, namely:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or 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.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively in the provision of health and social care services.

Link to National Outcomes for Children and Criminal Justice:

- Our children have the best start in life and are ready to succeed;
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens; and
- We have improved the life chances for children, young people and families at risk

Link to National Outcomes and Standards for Social Work Services in the Criminal Justice System:

- Community safety and public protection;
- The reduction of re-offending; and
- Social inclusion to support desistance from offending.

Engagement - How and who?

Inverclyde CHCP has an established record of engaging with communities, through mature and well-connected networks. We want to build on that and shift the emphasis by:

- getting communities engaged at an even earlier stage;
- finding ways to include the views of groups who have traditionally been less likely to participate;
- building on the assets that are already inherent in our communities.

Challenges (this would be the "why")

Outline of key challenges around inequalities, demographics etc. – take from the most recent CSWO Annual report. A balance though between the challenges and the progress that has been made so far. Stress the importance of the positive dimensions of Inverclyde.

Key Workstreams and Actions (this would be the "how")

(Actions framed in the context of the strategic priorities)
Our strategic priorities are based on the national outcomes and will provide a framework to improve services and describe how we will achieve our vision. ***Where we can, link back to existing strategies and plans that have already been agreed through robust engagement processes***

1. People are able to look after and improve their own health and wellbeing and live in good health for longer - ***What we plan to do to shift the balance of care. Core commissioning work and building on other workstreams e.g. RCOP***
2. People, including those with disabilities or 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. ***Redesign work referencing back to extant plans and/or strategies***
3. People who use health and social care services have positive experiences of those services, and have their dignity respected. ***Involving People work, plus continued work with the Advisory Network. Emphasis on building on existing foundations.***
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. ***Shifting to a stronger outcomes focus, SDS work***
5. Health and social care services contribute to reducing health inequalities. ***All our plans and strategies as a CHCP had a clear focus on reducing health inequalities – a commitment to continue this, and link back to our vision and values. Financial inclusion and employability work***
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing. ***Co-produced Carer Strategies***
7. People using health and social care services are safe from harm. ***Patient safety programme; clinical and care governance; quality assurance***
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. ***Staff Governance Standard; QA linked closely to training and practice development***
9. Resources are used effectively in the provision of health and social care services. ***All savings proposals are subject to impact assessments***

Where our strategic priorities will take us (includes measuring performance)

Targets; milestones etc. but clearly linked back to the national outcomes.

- Performance and Improvement
- Clinical and care governance, including the providers that we commission from
- Financial governance
- Managing risk

Making the most of our resources

Financial and workforce planning.

- Getting the most from the resources we have – both cash and people.
- How we streamline. How we remove duplication.
- Wider resources, e.g. carers; volunteers etc.
- Early intervention and prevention – anticipating need and planning
- What we will do with our resources, why is this different and what will it achieve?

How the elements of the plan come together to deliver the vision – shifting from top-down to bottom-up.

Traditionally our planning has been based on achieving the high level targets, measured through service outputs (top-down approach). Real change can come about if we move away from these high level targets towards focusing on outcomes and what makes a real difference to the lives of individuals, families and communities. Strategic needs assessment, taken from the wealth of information we already have, will help us to understand the health and social care needs of the people of Inverclyde, and consider how resources can be organised to meet those needs in the best possible way, with the explicit aim of improving lives.

Outcome focused assessment (bottom-up approach) informs commissioning at the individual level (includes SDS). Aggregating individual commissioning will in turn inform strategic commissioning, and the Strategic Planning Group will:

- Oversee service/client group commissioning.
- Identify commissioning commonalities across services/client groups.
- Identify opportunities for collaboration across services or across providers.
- Identify priorities for investment and disinvestment.

How will we stay on track?

The Strategic Planning Group will develop the key actions that need to be included in this plan, including timescales and how we will measure if we are achieving our ambitions.

- Initial discussions indicate the need for a **Strategic Needs Assessment**, drawing on the information held by the CHCP and the Community Planning Partnership. We need to scope what we currently deliver and consider the drivers for that delivery. Which arrangements have been put in place to deliver targets, and are these still valid? Do they deliver or contribute to the outcomes? Is there a better way? What do our communities really need?

- Change will be delivered through the right commissioning choices, based on outcome-focused assessment. We already have a **Commissioning Strategy,** but does this need to be reviewed?

- The overarching **Commissioning Strategy** provides strategic direction and is underpinned by a number of service or client group Commissioning Plans that have been developed in collaboration with service users, families and communities. We need to consider if there are any gaps in our commissioning plans, but this will be informed by the Strategic Needs Assessment and outcome-focused assessment.

- We will need to develop a **Performance Reporting Framework** that lets us know if what we are commissioning is delivering what has been indicated through the Strategic Needs Assessment. Our performance reporting through the former CHCP has started the shift towards outcomes by mapping what we report to the SHANARRI outcomes rather than simply focusing on targets, so we have a good foundation to build on.

- The **Strategic Plan** will be developed by the Strategic Planning Group but will be approved, overseen and scrutinised by the Integration Joint Board. This will ensure that there is strong governance around delivering the commitments of the plan, and a mechanism to inform future plans.