INVERCLYDE
HSCP
Health and Social Care Partnership

Agenda 2015

Inverclyde Integration Joint Board

For meeting on:

10	November	2015

INVERCLYDE HSCP Health and Social Care Partnership

Municipal Buildings, Greenock PA15 1LY

Ref: SL/AI

Date: 29 October 2015

A meeting of the Inverclyde Integration Joint Board will be held on Tuesday 10 November 2015 at 3pm within the Municipal Buildings, Greenock.

Gerard Malone
Head of Legal and Property Services

BUSINESS

1.	**Apologies, Substitutions and Declarations of Interest**	**Page**
2.	**Minute of Meeting of Inverclyde Integration Joint Board of 10 August 2015**	**p**
3.	**Membership of the Inverclyde Integration Joint Board** Report by Chief Officer, Inverclyde Health & Social Care Partnership	**p**
4.	**IJB Audit Arrangements** Report by Chief Officer, Inverclyde Health & Social Care Partnership	**p**
5.	**Schedule of Reports** Report by Chief Officer, Inverclyde Health & Social Care Partnership	**p**
6.	**Health & Social Care Partnership – Financial Report 2015/16 as at Period 5 to 31 August 2015** Report by Chief Officer, Inverclyde Health & Social Care Partnership	**p**
7.	**Business Update** Report by Chief Officer, Inverclyde Health & Social Care Partnership	**p**
8.	**Update on Plans for Replacement Greenock Health Centre** Report by Chief Officer, Inverclyde Health & Social Care Partnership	**p**
9.	**Communication Framework** Report by Chief Officer, Inverclyde Health & Social Care Partnership	**p**
10.	**Delayed Discharge Performance and Winter Planning 2015/16** Report by Chief Officer, Inverclyde Health & Social Care Partnership	**p**

11.	**NHS Greater Glasgow & Clyde Clinical Services Strategy 2015** Report by Chief Officer, Inverclyde Health & Social Care Partnership **NB There will also be a presentation on this item**	**p**
The documentation relative to the following item has been treated as exempt information in terms of the Local Government (Scotland) Act 1973 as amended, the nature of the exempt information being that set out in paragraph 6 of Part I of Schedule 7(A) of the Act.		
12.	**Governance of HSCP Commissioned External Organisations** Report by Chief Officer, Inverclyde Health & Social Care Partnership on the performance of progress relating to the HSCP Governance process for externally commissioned social care services	**p**

Enquiries to - **Sharon Lang** - Tel 01475 712112

Inverclyde Integration Joint Board

Monday 10 August 2015 at 3 pm

Present: Councillors V Jones, S McCabe, J McIlwee and L Rebecchi, Dr D Lyons, Mr A MacLeod, Mr R Finnie, Ms C Roarty, Dr C Jones, Mr B Moore, Ms L Bairden, Ms R Gacha (for Mr R Taggart), Ms D McCrone, Mr I Bruce and Ms S MacLeod.

Chair: Councillor McIlwee presided.

In attendance: Ms H Watson, Head of Planning, Health Improvement & Commissioning, Ms B Culshaw, Head of Health & Community Care, Ms V Pollock (for Head of Legal & Property Services), Ms S Lang, Legal & Property Services, Ms K Haldane, Executive Officer, Your Voice, Inverclyde Community Care Forum and Ms M Maskrey, Lead Clinical Pharmacist, Inverclyde HSCP.

Prior to the commencement of business, Councillor McIlwee, on behalf of the Board, expressed appreciation for the contribution made by the current Vice-Chair, Mr Ken Winter, whose term of office as a Non-Executive Director of Greater Glasgow & Clyde Health Board ends on 31 August 2015 and he extended his best wishes to Mr Winter for the future.

1 Apologies, Substitutions and Declarations of Interest 1

Apologies for absence were intimated on behalf of Mr R Taggart (with Ms R Gacha acting as proxy), Ms M Telfer, Mr A Black and Dr H MacDonald.

2 Minute of Meeting of Inverclyde Shadow Integration Joint Board of 28 May 2015 2

There was submitted minute of the Inverclyde Shadow Integration Joint Board of 28 May 2015.
Decided: that the minute be noted.

3 Membership of the Inverclyde Integration Joint Board 3

There was submitted a report by the Head of Legal & Property Services on the proposed membership arrangements for the Inverclyde Integration Joint Board.
Decided:
(1) that the Board note its prescribed members being (a) the voting members at Section A of appendix 1 of the report and (b) minimum non-voting members at Section B of appendix 1;
(2) that the Board agree the stakeholder members at sections C and D of appendix 1;
(3) that the Chief Officer contact NHS Greater Glasgow & Clyde to clarify the position in respect of proxies for its voting members and to report thereon to the Board; and
(4) that the Board's appreciation of the contribution of Councillor Jim MacLeod to the work of the former CHCP Sub-Committee be recorded.

4 Inverclyde Joint Board – Integration Scheme, Standing Orders and Code of Conduct **4**

There was submitted a report by the Head of Legal & Property Services requesting the Board to consider its governance arrangements.
Decided:
(1) that the Board note the contents of the Integration Scheme as detailed in appendix 1 of the report;
(2) that the Board approve the Standing Orders detailed in appendix 3 as the Standing Orders to govern the conduct of meetings of the Inverclyde Integration Joint Board; and
(3) that the Board note the terms of the model Code of Conduct for Members of Devolved Public Bodies as detailed in appendix 4.

5 Appointment of Chief Officer **5**

There was submitted a report by the Chief Executive, NHS Greater Glasgow & Clyde and the Chief Executive, Inverclyde Council requesting the Board to consider the appointment of its Chief Officer.
Decided: that the Board formally appoint Mr Brian Moore as its Chief Officer.

6 Appointment of Chief Finance Officer **6**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership requesting the Board to consider the appointment of its Chief Finance Officer.
Decided:
(1) that the Board formally appoint Ms Lesley Bairden as its Chief Finance Officer and note that this is a short term appointment as Ms Bairden is shortly due to take up a post in another local authority; and
(2) that the Board's appreciation of Ms Bairden's contribution to the development of the Health & Social Care Partnership and the Community Health & Care Partnership be recorded.

7 Financial Regulations **7**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership providing the Board with draft Financial Regulations for information.. It was noted that the final Financial Regulations, supported by a detailed Finance Manual, will be approved by the IJB Audit Committee once established, following conclusion of outstanding issues.
Decided:
(1) that the Board note the contents of the report and agree the draft Financial Regulations as set out in the appendix to the report; and
(2) that it be agreed to remit the approval of the final Financial Regulations and Finance Manual to the IJB Audit Committee once established, following conclusion of outstanding issues.

8 Audit and Risk Management Strategy - Update 8

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership providing a position statement on the internal and external audit function for the Board, along with an associated risk management strategy.

Decided:

(1) that the Board note the contents of the report;

(2) that it be agreed to receive detailed proposals on the function, membership and frequency of the Audit Committee at the next meeting; and

(3) that it be agreed that updates be reported to each meeting of the Board as outstanding issues are clarified.

9 Inverclyde Health & Social Care Partnership – Due Diligence Process 9

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership providing the Board with the partnership starting budget for 2015/16 (excluding set aside budgets for large hospital and hosted services) and explaining the associated due diligence process undertaken to arrive at this budget.

Decided:

(1) that the Board note the due diligence work undertaken;

(2) that the Board note the 2015/16 original revenue budget; and

(3) that it be agreed to receive aligned revenue reporting for the remainder of the financial year 2015/16, with full budget delegation operating from 1 April 2016/19 supported by a 2016/19 financial strategy.

10 Establishment Plan 2015/2016 10

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership appending the draft Establishment Plan 2015/16 for approval by the Board.

Decided:

(1) that the Board approve the Establishment Plan 2015/16 and direct the Strategic Planning Group to develop the Strategic Plan covering the time frame 2016/19; and

(2) that the Strategic Plan be submitted to the first meeting of the Board in financial year 2016/17.

11 Update on Delayed Discharge Performance 11

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership on performance towards achieving the target for delayed discharge.

Decided: that the Board note the progress towards achieving the target for delayed discharge and the ongoing work to maintain performance.

12 Update on Prescribing and Medicines Management 2015 12

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership on prescribing and medicines management within Inverclyde Health & Social Care Partnership.

The Board heard a presentation on this subject by Ms Margaret Maskrey, Lead Clinical Pharmacist, who thereafter answered a number of questions from members.

Decided:

(1) that the Board note and endorse the report on the current situation in respect of prescribing within the HSCP, with particular regard to (a) current issues in prescribing and medicines management, (b) prescribing and medicines management support and (c) the prescribing expenditure position; and

(2) that a report be submitted to a future meeting of the Board on the integration arrangements in place with local pharmacies in the HSCP area.

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 3

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10 November 2015**
Report By:	**Brian Moore, Chief Officer, Inverclyde Health & Social Care Partnership**	**Report No:**	**VP/LP/149/15**
Contact Officer:	**Vicky Pollock**	**Contact No:**	**01475 712180**
Subject:	**Membership of the Inverclyde Integration Joint Board**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Inverclyde Integration Joint Board ("IJB") of a change in its voting membership arrangements.

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 sets out the arrangements for the membership of all Integration Joint Boards.

2.2 Membership of the IJB was approved at its first meeting on 10 August 2015. Since then, the Vice-Chair of the IJB, Mr Ken Winter has intimated his resignation from the IJB. Greater Glasgow & Clyde NHS Board has taken steps to fill this vacancy by appointing a new voting member and Vice-Chair.

2.3 This report sets out the revised voting membership arrangements for the IJB.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Inverclyde Integration Joint Board:-

(1) notes the resignation of Mr Ken Winter as Vice-Chair of the Inverclyde Integration Joint Board;
(2) notes the appointment by Greater Glasgow & Clyde NHS Board of Mr Simon Carr as a voting member of the Inverclyde Integration Joint Board; and
(3) notes the appointment by Greater Glasgow & Clyde NHS Board of Mr Ross Finnie as Vice-Chair of the Inverclyde Integration Joint Board.

Vicky Pollock
Legal & Property Services

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 ("the Order") sets out the arrangements for the membership of all Integration Joint Boards.

4.2 Membership of the IJB was approved at its first meeting on 10 August 2015. Since then, the Vice-Chair of the IJB, Mr Ken Winter, intimated his resignation from the IJB with effect from 31 August 2015.

4.3 The Order states that the Council or the NHS Board may change the person appointed by them as Chair or Vice-Chair during an appointing period. Paragraph 2.3 of the Integration Scheme between the Council and the NHS Board sets out the local arrangements for the appointment of the Chair and Vice-Chair of the IJB.

4.4 As a result, Greater Glasgow & Clyde NHS Board has nominated a new voting member, Mr Simon Carr and has appointed Mr Ross Finnie as the new Vice-Chair of the IJB.

5.0 PROPOSALS

5.1 It is proposed that the IJB note the revised IJB voting membership arrangements as set out in Appendix 1 Section A.

6.0 IMPLICATIONS

Finance

6.1 None.

Financial Implications:

One Off Costs

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

Annually Recurring Costs/ (Savings)

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

Legal

6.2 The membership of the IJB is set out in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

Human Resources

6.3 None.

Equalities

6.4 None.

Repopulation

6.5 There are no direct implications in respect of repopulation.

7.0 CONSULTATIONS

7.1 The Chief Officer of the Inverclyde Health & Social Care Partnership has been consulted in the preparation of this report.

7.2 The report has also been subject to consultation with representatives from Greater Glasgow & Clyde NHS Board.

8.0 BACKGROUND PAPERS

8.1 N/A

Inverclyde Integration Joint Board Membership

SECTION A. VOTING MEMBERS		
		Proxies (Voting Members)
Inverclyde Council	Councillor Joe McIlwee (Chair) Councillor Stephen McCabe Councillor Ciano Rebecchi Councillor Vaughan Jones	Councillor Gerry Dorrian Councillor Jim Clocherty Councillor Kenny Shepherd Councillor Ronnie Ahlfeld
Greater Glasgow and Clyde NHS Board	Mr Ross Finnie (Vice Chair) Dr Donald Lyons Mr Allan MacLeod Mr Simon Carr	To be advised
SECTION B. NON-VOTING PROFESSIONAL ADVISORY MEMBERS		
Chief Officer of the IJB	Brian Moore	
Chief Social Worker of Inverclyde Council	Brian Moore	
Chief Finance Officer	Vacant	
Registered Medical Practitioner who is a registered GP	Inverclyde Health & Social Care Partnership Clinical Director Dr Hector MacDonald	
Registered Nurse	Professional Nurse Advisor Ms Cathy Roarty	
Registered Medical Practitioner who is not a registered GP	Chief Medical Officer Dr Chris Jones	
SECTION C. NON-VOTING STAKEHOLDER REPRESENTATIVE MEMBERS		
A staff representative (Council)	Mr Robin Taggart (UNISON Branch Secretary)	
A staff representative (NHS Board)	Ms Diana McCrone	
A third sector representative	Mr Ian Bruce Manager CVS and Chief Executive Inverclyde Third Sector Interface	
A service user	Ms Margaret Telfer Chair Inverclyde Health and	

	Social Care Partnership Advisory Group	
A carer representative	Mr Alistair Black	
SECTION D. ADDITIONAL NON-VOTING MEMBERS		
Representative of Inverclyde Housing Association Forum	Ms Sandra McLeod, Director of Housing & Customer Services, River Clyde Homes	

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 4

Report To:	**Inverclyde Integration Joint Board**	**Date: 10 November 2015**
Report By:	**Brian Moore** **Chief Officer** **Inverclyde Health & Social Care Partnership (HSCP)**	**Report No: IJB/22/2015/HW**
Contact Officer:	**Helen Watson** **Head of Service** **Planning, Health Improvement & Commissioning**	**Contact No: 01475 715285**
Subject:	**IJB – AUDIT ARRANGEMENTS**	

1.0 PURPOSE

1.1 The purpose of this report is to present proposals for the audit arrangements of the Inverclyde Integration Joint Board (IJB), including the establishment of a Financial and Audit Committee.

2.0 SUMMARY

2.1 This paper proposes that the IJB establishes a Financial Performance and Audit Committee. It sets out the proposed composition and draft remit for discussion. The paper also proposes internal and external audit arrangements.

3.0 RECOMMENDATION

It is recommended that:

3.1 the Integration Joint Board considers the terms of this report;

3.2 the Integration Joint Board establishes a Financial Performance and Audit Committee as a standing committee of the Integration Joint Board, the remit and powers of which are set out in Part 5 of this report;

3.3 the Integration Joint Board appoints 6 Members to serve on the Financial Performance and Audit Committee, having due regard to the requirements set out in Paragraph 5.3 of this report;

3.4 the Integration Joint Board appoints a Chair and Vice-Chair to the Financial Performance and Audit Committee, having due regard to the requirements set out in Paragraph 5.3 of this report;

3.5 in the first year of operation, the Financial Performance and Audit Committee will meet on dates within the agreed cycle of meetings commencing in 2016 as follows: 26 January and 10 May, subject to there being business to consider; and

3.6 the Integration Joint Board directs the Chief Officer to develop and implement a Service Level Agreement with Inverclyde Council's Chief Internal Auditor in relation to the internal audit arrangement for the Integration Joint Board.

Brian Moore
Chief Officer
Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

4.1 Audit Scotland has emphasised that health and social care integration requires effective governance arrangements for the new Integration Joint Boards, and that a crucial element of governance is the IJB audit arrangements.

4.2 Under our former CHCP enhanced partnership arrangements, audit was undertaken as part of the existing NHS GGC and Inverclyde Council audit arrangements. Given that the IJB is a separate legal entity (rather than an enhanced partnership), we are required to establish defined audit arrangements. The IJB needs assurance that governance, including financial performance is sound, therefore it is proposed that a Financial Performance and Audit Committee is established to:

- Ensure effective performance management systems are in place to evidence delivery of the organisation's key objectives, including the Strategic Plan.
- Act as a focus for best value and service improvement.
- Establish and review information governance and risk management arrangements.
- Review the annual work programme of internal and external audit.
- Ensure appropriate action is taken in response to audit findings.

4.3 Given the IJB's responsibilities for budget expenditure, best practice within the Scottish Public Finance Manual dictates that an Audit Committee should be established to advise the IJB on internal control (including corporate governance) and audit matters. Such an Audit Committee should:

- Be a formal subcommittee of the IJB.
- Be under the chair of a voting member other than the Chair of the IJB.
- Determine who will provide the internal audit service for the IJB and appoint a Chief Internal Auditor.
- Confirm an external auditor to be met at least once a year.
- Require the Chief Officer, Chief Financial Officer and appointed Chief Internal Auditor to attend meetings (though not as members of the Financial Performance and Audit Committee).
- Have written terms of reference.
- Have a clear programme of work (i.e. an internal audit plan) and arrange its meetings to ensure effective delivery of that programme.

5.0 REMIT, MEMBERSHIP AND MEETINGS

5.1 Remit

The proposed remit of the committee is to review the overall internal control arrangements of the IJB and make recommendations to the IJB regarding signing of the Governance Statement.

5.2 Specifically the committee will be responsible for the following:

- Ensuring that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising financial performance against set objectives, levels and standards of service and the performance indicators.
- Acting as a focus for value for money and service quality initiatives.
- Reviewing and approving the annual Audit Plan on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and reporting to the Board.
- Monitoring the annual work programme of internal audit.

- Considering matters arising from internal and external audit reports.
- Reviewing on a regular basis action planned by management to remedy weaknesses or other criticisms made by internal or external audit.
- Reviewing risk management arrangements, receiving annual risk management updates and reports.
- Ensuring existence of and compliance with an appropriate risk management strategy.
- Reporting to the IJB on the resources required to carry out performance reviews and related processes.
- Considering annual financial accounts and related matters before submission to and approval by the IJB.
- Ensuring that the senior management team, including heads of service, professional leads and service managers maintain effective controls within their services which comply with financial procedures and regulations.
- Setting its own work programme which will include the right to undertake reviews following input from the IJB and any other committees established by the IJB.
- At its discretion setting up short term working groups for review work, membership of which will be open to anyone whom the committee considers will assist in the task assigned. The working groups will not be decision making bodies or formal committees but will make recommendations to the Financial Performance and Audit Committee.
- Promoting the highest standards of conduct by board members.
- Monitoring and keeping under review the Codes of Conduct maintained by the IJB.
- Having oversight of information governance arrangements as part of the performance and audit process.

5.3 Membership

Membership of any committee established by the IJB must comprise an equal number of voting members from both the Health Board and the Council. It is proposed that the membership comprise 4 IJB voting members (2 from the Health Board and 2 from the Council) with an additional 2 members drawn from the wider non-voting membership of the Integration Joint Board (i.e. a minimum of six members). Once established, it will be open to the committee to appoint additional co-opted members as it considers appropriate.

It is important that the Financial Performance and Audit Committee be able to demonstrate the appropriate level of scrutiny. Recognising that the chair of the IJB cannot be the chair of the Financial Performance and Audit Committee, it is further proposed that if the chair of the IJB is an NHSGGC Non Executive Member then the chair of the Financial Performance and Audit Committee be an Inverclyde Council Elected Member and vice versa.

Three members of the Financial Performance and Audit Committee will constitute a quorum.

5.4 Attendance at meetings

In addition to the members of the committee, those persons in attendance at meetings will vary but in general will include the Chief Officer, the Chief Financial Officer, the Chief Internal Auditor and other professional advisors and senior officers as required. External audit or other persons shall attend meetings at the invitation of the Committee.

5.5 Meeting Frequency

The Financial Performance and Audit Committee will meet at least three times each financial year. There should be at least one meeting a year, or part thereof, where the committee meets the external and Chief Internal Auditor without other senior officers present.

6.0 AUDIT ARRANGEMENTS

6.1 The national Integrated Resources Advisory Group Guidance recommends that:

- The internal audit service should be provided by one of the internal audit teams from the Health Board or Local Authority (para 2.4.7).
- The Chief Internal Auditor from the Health Board or Local Authority undertake this role for the Integration Joint Board in addition to their role as Chief Internal Auditor of their respective organisation (para 2.4.8).

6.2 Following discussion between the Chief Financial Officer, the Health Board Director of Finance and the Council Section 95 Officer it is proposed that the internal audit service for the Integration Joint Board be provided by Inverclyde Council internal audit and that the Council's Chief Auditor be appointed as Chief Internal Auditor for the Integration Joint Board.

6.3 It has been confirmed that the Accounts Commission is responsible for appointing external auditors for Integration Joint Boards and the Accounts Commission has appointed Audit Scotland to undertake this role. These appointments are for 1 year only as 2015/16 is the final year in the current round of audit appointments. New 5-year appointments will be made from 2016/17.

6.4 It should be noted that Audit Scotland have separately begun a national performance audit looking at the integration of health and social care services and are leading on an assessment of the progress made in implementing the reforms, working closely with the Care Inspectorate and Healthcare Improvement Scotland.

7.0 FINANCE AND EFFICIENCY

7.1 The proposed Financial Performance and Audit Committee will scrutinise the financial and efficiency performance and reporting on behalf of the Integration Joint Board.

The Chief Financial Officer will be responsible for providing assurance on the system of internal financial control to the Financial Performance and Audit Committee on behalf of the Health Board and Council. That system of internal financial control will be based on a framework of regular management information, Financial Instructions, administrative procedures (including segregation of duties), management and supervision and a system of delegation and accountability. In doing this the Chief Financial Officer will be reliant on both the Health Board and Council's systems of internal control.

7.2 Costs for external audit are not yet quantified, but anticipated to be no more than £5,000 per year. The Public Bodies (Joint Working) (Scotland) Act 2014 and its associated guidance propose that internal audit services should be provided by one of the parent bodies on a donated basis.

8.0 PROPOSALS

8.1 It is proposed that the IJB should create a Financial Performance and Audit Committee, and agree the remit and powers as set out in the report. It is also proposed that the IJB should agree the composition of the committee and appoint members, and should direct the Chief Officer to develop and implement a Service Level Agreement with the Council's Chief Internal Auditor agreeing the scope of internal audit activity and functions in relation to the IJB.

9.0 IMPLICATIONS

Finance:

9.1 Costs for external audit are not yet quantified, but anticipated to be no more than £5,000 per year. The Public Bodies (Joint Working) (Scotland) Act 2014 and its associated guidance propose that internal audit services should be provided by one of the parent bodies on a donated basis.

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:

9.2 Standing Order 13 of the IJB's Standing Orders for Meetings regulates the establishment by the IJB of the Financial Performance and Audit Committee.

Human Resources:

9.3 There are no human resources implications in respect of this report.

Equalities:

9.4 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.

10.0 LIST OF BACKGROUND PAPERS

10.1 Scottish Public Finance Manual 2011.

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 5

Report To:	**Integration Joint Board**	**Date:**	**10 November 2015**
Report By:	**Brian Moore** **Chief Officer** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/18/2015/HW**
Contact Officer:	**Helen Watson** **Head of Planning, Health Improvement and Commissioning.**	**Contact No:**	**01475 715285**
Subject:	**SCHEDULE OF REPORTS**		

1.0 PURPOSE

1.1 The purpose of this report is to seek approval for a cycle of reports to be presented at future meetings of the Integration Joint Board. The proposed schedule covers routine reports, and there are likely to be additional reports at each meeting to keep Members apprised of HSCP business. The schedule includes a proposed meeting cycle for the IJB Financial Performance and Audit Committee, should this be approved.

It should also be noted that the schedule does not preclude Members directing the Chief Officer to deliver additional specific reports.

2.0 SUMMARY

2.1 The schedule outlines the regular reports and updates due to be presented at future meetings of the Integration Joint Board and Financial Performance and Audit Committee, and identifies the senior officers responsible for ensuring that the reports are compiled.

3.0 RECOMMENDATIONS

3.1 That the Board approve the schedule contained within the report.

Brian Moore
Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

4.1 Following the establishment of the Health and Social Care Partnership, the Integration Joint Board had its inaugural meeting in August 2015. The Board will meet on a minimum of five times each year to oversee the business of the HSCP. It is proposed that these meetings take place every:

- May
- September
- November
- January
- March

It is also proposed that the IJB Financial Performance and Audit Committee meets every:

- May
- September
- January

The schedules below outline a number of regular reports that the IJB can expect to receive. There are likely to be other papers at the meetings, reflecting current business of the HSCP (for example, the January meeting will receive a paper describing the Equality Duty of the IJB, although this will not necessarily be an annually recurring paper).

May Reports	Responsible Officer
Finance Report	Chief Financial Officer (CFO)
Annual Financial Statement	CFO
Annual Schedule of Reports 2015/16	Head of Planning, Health Improvement and Commissioning (HPHIC)
Governance of Externally Commissioned Services	HPHIC
Delayed Discharge Update	Head of Health & Community Care (HHCC)
Health Centre Progress Report	HPHIC
GIRFEC Implementation Annual Report	Head of Children & Families and Criminal Justice (HCFCJ)
Immunisation Annual Report	HPHIC
Health & Safety Annual Report	HPHIC
Performance Annual Report	HPHIC
Governance of Externally Commissioned Services Annual Report	HPHIC
Update on Hosted Services	To be Confirmed

September Reports	Responsible Officer
Finance Report	CFO
Governance of Externally Commissioned Services	HPHIC
Delayed Discharge Update	HHCC
Strategic Plan Progress Report (including Workforce, Organisational Development and Market Facilitation Plans)	HPHIC
Performance Exceptions Report	HPHIC
Mental Health Community and Inpatient Services Annual Report	Head of Mental Health, Addictions and Homelessness (HMHAH)
Complaints Annual Report	HPHIC
Prescribing Update	Lead Pharmacist
Immunisation and Vaccination Annual Report	HPHIC
Criminal Justice Annual Report	HCFCJ

November Reports	Responsible Officer
Finance Report	CFO
Governance of Externally Commissioned Services	HPHIC
Delayed Discharge and Winter Pressures	HHCC
Clinical and Care Governance Report	HHCC
Health Centre Progress Report	HPHIC
Communications Framework	HPHIC
Chief Social Work Officer's Annual Report	Chief Officer
Clinical Services Strategy Annual Update	HPHIC

January Reports	Responsible Officer
Finance Report	CFO
Governance of Externally Commissioned Services	HPHIC
Delayed Discharge and Winter Pressures	HHCC
Freedom of Information Annual Report	HPHIC
Learning Disability Services Annual Report	HHCC
Care Inspectorate Gradings Annual Report	HPHIC
Performance Exceptions Report	HPHIC
Self-Directed Support Report	HHCC
Child Protection Committee Annual Report	HCFCJ
Alcohol and Drug Partnership (ADP) Annual Report	HMHAH
Annual Property & Assets Management Plan Update	CFO

March Reports	Responsible Officer
Finance Report	CFO
Governance of Externally Commissioned Services	HPHIC
Reshaping Care for Older People Annual Report	HHCC
Strategic Plan and subsequent Progress Report	HPHIC
Delayed Discharge and Winter Pressures	HHCC
Carers Annual Report	HHCC
Dementia Strategy Update	HMHAH
Health Improvement Annual Report	HPHIC
Specialist Children's Services Annual Report	HCFCJ
Advice Services Annual Report	HPHIC
Property and Assets Management Plan	CFO
Staff Governance Annual Report	HPHIC
Records Management Plan Update	HPHIC

4.2 The proposed regular reports to the Financial Performance and Audit Committee are as follows.

May Reports	Responsible Officer
Finance Report	Chief Financial Officer (CFO)
Annual Financial Statement	CFO
Internal Audit Annual Plan	Chief Internal Auditor
Risk Register	HPHIC

September Reports	Responsible Officer
Finance Report	Chief Financial Officer (CFO)
Risk Register	HPHIC
Governance of Externally Commissioned Services Annual Report	HPHIC

January Reports	**Responsible Officer**
Finance Report	Chief Financial Officer (CFO)
External Audit Annual Plan	External Auditor
N.B. Both the External and Internal Auditor will be present and Members will have the opportunity for private discussion.	

4.3 In addition to the regular January reports outlined above, in January 2016 the Chief Officer will present reports to the IJB in relation to Clinical and Care Governance; Complaints Annual Report, and a report describing the IJB Equalities duties.

5.0 FINANCE

5.1 Financial Implications: Costs for external audit are not yet quantified, but anticipated to be no more than £5,000 per year. The Public Bodies (Joint Working) (Scotland) Act 2014 and its associated guidance propose that internal audit services should be provided by one of the parent bodies on a donated basis.

One off Costs

Cost Centre	**Budget Heading**	**Budget Years**	**Proposed Spend this Report £000**	**Virement From**	**Other Comments**

Annually Recurring Costs/ (Savings)

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

LEGAL

5.2 There are no legal issues within this report.

HUMAN RESOURCES

5.3 There are no human resources issues within this report.

EQUALITIES

5.4 There are no equality issues within this report.

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.

6.0 CONSULTATION

6.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with the Senior Management Team.

7.0 LIST OF BACKGROUND PAPERS

7.1 N/A.

INVERCLYDE
HSCP
Health and Social Care Partnership

AGENDA ITEM NO: 6

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10 November 2015**
Report By:	**Brian Moore Chief Officer Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/14/2015/HW**
Contact Officer:		**Contact No:**	**01475 712722**
Subject:	**Health & Social Care Partnership – Financial Report 2015/16 as at Period 5 to 31 August 2015.**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Inverclyde Integration Joint Board of the Revenue and Capital Budget current year position as at Period 5 to 31 August 2015.

2.0 SUMMARY

REVENUE PROJECTION 2015/16

2.1 The total Health and Social Care Partnership revenue budget for 2015/16 is £121,369,000 with a projected overspend of £168,000 being 0.14% of the revised budget.

2.2 The Social Work revised budget is £49,232,000 and is projected to overspend by £163,000 (0.33%), a reduction in the overspend reported to the Health & Social Care Committee in September of £296,000. The projected overspend is mainly due to current package costs of external homecare offset in part by vacancies within internal homecare. Due to the under occupancy of temporary furnished flats at the Inverclyde Centre, there is a projected overspend within the homelessness service of £137,000.

2.3 This position assumes that the current projected overspend of £428,000 on Children & Families external accommodation can be met from the earmarked reserves. This requires that the Health & Social Care Committee and thereafter Policy & Resources Committee agree to prudentially borrow £1.1 million to fund the reprovision of the Neil Street Children's home thus freeing up £1.1 million from the earmarked reserve.

2.4 It should be noted that the 2015/16 budget includes agreed savings for the year of £1,073,000 with a current projected under recovery of £110,000 due to delays against original plans.

2.5 The Health revenue budget is £72,602,000 and is projected to overspend by £5,000 (0.01%).

2.6 The Health budget for 2015/16 includes £44,580 local savings, currently projected to be achieved in full.

2.7 Prescribing is projected to budget, and given the volatility of prescribing forecasts, a cost neutral position is being reported within GG&C, reflecting the established risk sharing protocols. Inverclyde HSCP is £96,000 (1.8%) overspent on the year to date. HSCP variances are currently being investigated by the relevant HSCP Prescribing Advisors

CAPITAL 2015/16

2.8 The Social Work capital budget is £3,627,000. The original profiling for Neil Street Children's Home replacement unit for 2015/16 was significantly overstated; this has been corrected resulting in slippage of £288,000 (43.5%) for 2015/16.

2.9 The reprofiled budget for 2015/16 is £356,000, spend to date equates to 2.25%. Building work is due to commence on Neil Street in 2015/16 and scheduled for completion 2016.

2.10 The Health capital budget is currently held centrally by Capital Planning.

EARMARKED RESERVES 2015/16

2.11 The Social Work Earmarked Reserves for 2015/16 total £2,600,000 with £2,439,000 projected to be spent in the current financial year. To date £547,000 spend has been incurred which is 2.24% of the projected 2015/16 spend. The spend to date per profiling was expected to be £520,000 therefore no slippage has been incurred.

2.12 It should be noted that the reserves reported exclude those earmarked reserves that relate to budget smoothing, namely: Deferred Income and Children's Residential Care, Adoption & Fostering.

3.0 RECOMMENDATIONS

3.1 That the IJB note the current year revenue budget projected overspend of £168,000 for 2015/16 as at 31 August 2015.

3.2 That the IJB note the current projected capital position:

- Social Work capital projected slippage of £288,000 in the current year.

3.3 That the IJB note the current Earmarked Reserves position.

3.4 That the IJB note the position on Prescribing.

3.5 That he IJB note the Social Work budget virements as detailed at Appendix 7.

Brian Moore
Chief Officer
Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

4.1 The purpose of the report is to advise the IJB of the current position of the 2015/16 HSCP revenue and capital budget and to highlight the main issues contributing to the 2015/16 budget projected overspend of £168,000 (0.14%) and the current capital programme position of £288,000 (43.5%) slippage.

4.2 The current year consolidated revenue summary position is detailed in Appendix 1, with the individual elements of the Partnership detailed in Appendices 2 and 3, Social Work and Health respectively. Appendix 4 shows the year to date position for both elements of the Partnership. Appendix 5 provides the capital position. Appendix 6 provides detail of earmarked reserves. Appendix 7 details budget virements. Appendix 8 provides detail of the employee cost variance by service.

5.0 2015/16 CURRENT REVENUE POSITION: £168,000 PROJECTED OVERSPEND

5.1 SOCIAL WORK £163,000 PROJECTED OVERSPEND

The projected overspend of £163,000 (0.33%) for the current financial year remains predominantly due to current package costs within External Homecare offset, in part, by turnover within Internal Homecare. This is a reduction in projected costs of £296,000 since the last report to the Health & Social Care Committee. The material projected variances and reasons for the movement since last reported are identified, per service, below:

a. **Strategy: Projected £35,000 (1.78%) underspend**

The projected underspend is due to turnover from vacancies. There are additional costs being incurred in this area for the Afghan Refugee Resettlement Scheme which are being fully funded by Central Government.

b. **Older People: Projected £363,000 (1.67%) overspend**

The projected overspend is £363,000 which is an increase of £199,000 since period 3. Homecare and Residential and Nursing purchased places have been raised as budget pressures in the 2016/18 budget requesting an extra £300,000 from 2017/18 which is on top of the £250,000 extra funding already approved for 2016/17. The projected overspend comprises:

- additional external provider costs in Homecare of £411,000 (an increase of £19,000).
- vacancies within internal Homecare of £193,000 (a decrease of £33,000).
- savings still to be identified and employee costs overspends totalling £65,000
- a projected overspend of £45,000 within Residential and Nursing purchased places, per the current number of clients receiving care. This was projected as a £103,000 underspend at period 3 (an increase of £148,000) and has changed due to a net increase of 19 clients. £100,000 funding from the Delayed Discharge earmarked reserve has been used to reduce the projected overspend to £45,000.

Various overspends totalling £35,000.

There will be ongoing monitoring of this budget with some flexibility to further contain costs within the Integrated Care Fund and Delayed Discharge funding.

c. **Learning Disabilities: Projected £3,000 (0.04%) overspend**

The projected overspend of £3,000 was previously an underspend of £32,000. The

projected overspend comprises:

- £181,000 underspend on client commitments (a decrease of £206,000 due to new & changed care packages),
- £57,000 overspend on transport costs (an increase of £19,000 due to external hires and non-routine vehicle costs),
- £77,000 shortfall in income received from other local authorities (an improvement of £21,000 since period 3),
- £34,000 overspend in employee costs due to additional support costs (a decrease of £23,000),

£11,000 overspend on catering in the day centre (a decrease of £5,000).

The transport and employee costs relate to client packages and a review of budgets will be undertaken to align these to reflect current activity and package costs.

The current year budget includes £360,000 pressure funding (£200,000 from the 2013/15 budget and £160,000 2015/17 budget). The current projection includes an assumption that costs will be incurred for new clients and clients moving from a hospital to a community care setting, the timings of which are not yet known. Work is ongoing with the service to identify the costs and timings of new packages.

In addition to the revenue budget a further £40,000 pressure funding was added to earmarked reserves for equipment.

d. **Mental Health: Projected £37,000 (3.24%) underspend**

The projected underspend is £1,000 more than in period 3 and is primarily due to turnover of £23,000 and a client commitment underspend of £71,000 based on current vacancies and client package costs.

e. **Children & Families: Projected £147,000 (1.42%) underspend**

The projected underspend is £466,000 less than projected at period 3. The main reason for the change in projection relates to the proposed use of £1.1 million prudential funding rather than earmarked reserves for the replacement Children's Homes costs. If approval is granted by the Policy & Resources Committee to allocate £75,000 from the recently approved Kinship Care funding to prudentially fund the £1.1 million cost of the Children's Homes, then the earmarked reserve can be utilised to meet the current projected overspend of £428,000 on residential accommodation.

The underspend comprises turnover of £85,000, underspends on client package costs of £100,000 offset by a number of small overspends.

f. **Physical & Sensory: Projected £76,000 (3.52%) underspend**

The projected underspend is £3,000 less than previously reported and is due to £12,000 overspend on transport costs, a projected underspend in client package costs of £19,000 and an over-recovery of income of £64,000.

g. **Addictions / Substance Misuse: Projected £12,000 (1.11%) overspend**

The projected overspend is mainly due to turnover savings offset by the increase in client package costs.

h. **Support & Management: Projected £7,000 (0.34%) underspend**

The underspend mainly relates to turnover.

i. **Assessment & Care Management: Projected £48,000 (3.39%) underspend**

The projected underspend mainly relates to turnover from vacancies.

j. **Homelessness: Projected £137,000 (18.68%) overspend**

The projected overspend of £137,000 is £19,000 less than previously projected due to reduced rental costs. The projected overspend reflects the under occupancy of the Inverclyde Centre and the temporary furnished flats, which is a continuing trend from 2014/15. A report on Homelessness services will be presented to the January Committee.

5.2 HEALTH £5,000 PROJECTED OVERSPEND

The Health budget is £72,602,000 with the current projected overspend of £5,000. The significant projected variances, along with reasons for any significant movements, per service, are identified below.

a. **Children & Families: Projected £102,000 (3.72%) underspend**

Community underspend due to school nurses on health visiting courses being funded centrally and nurse vacancies which will be filled later in the year. There has been a reduction in bank nurse use.

b. **Health & Community Care: Projected £11,000 (0.26%) underspend**

Care Home Liaison Nurse budgets have transferred from central code, slight slippage as budget given at mid-point, staff at lower point. Diabetes funding now received. It was indicated this may be reduced this year but the funding was received in full.

c. **Management & Administration: £105,000 (4.12%) underspend**

Rates non-recurring surplus due to re-banding of Health Centres. Funding has been received to cover an unfunded receptionist and cleaning income has increased.

d. **Learning Disabilities: Projected £35,000 (6.31%) underspend**

The projected underspend remains due to vacancies which will not be filled pending redesign of the service. Some of the underspend has been used to fund one off pieces of work/equipment.

e. **Addictions: Projected £59,000 (3.13%) underspend**

The projected underspend remains due to turnover within nursing and psychology, posts in the process of being recruited to. Psychology post will be covered by board wide post. Workforce savings now achieved from Addictions.

f. **Mental Health Communities: Projected £121,000 (5.4%) underspend**

Underspend partly due to vacancies which are in the process of being recruited to. There is a further underspend due to an advocacy order for £108,000 raised last year in error and reversed in this financial year. Drug costs have been less for the past few months, service manager investigating as service advises that drug use has not reduced.

g. **Mental Health Inpatients: Projected £518,000 (5.56%) overspend**

Overspend partly due to increased special observations, in particular earlier in the year. IPCU had 2 eating disorder patients due to vacant consultant post at Stobhill, 2 IPCU patients on constant 2:1 observation and boarding in a number of patients from Glasgow also on 2:1. There are also high levels of sickness and unfunded protection costs.

Special observations cost to M05 - £180,000

Unfunded protection cost to M05 - £66,000

Adult Medical budget is forecast to overspend by £140,000 due to new consultant posts costing substantially more than budget.

h. **Prescribing: Nil Variance**

Prescribing is projected to budget, and given the volatility of prescribing forecasts, a cost neutral position is being reported within GG&C, reflecting the established risk sharing protocols. Inverclyde HSCP is £96,000 (1.8%) overspent on the year to date. HSCP variances are currently being investigated by the relevant HSCP Prescribing Advisors.

i. **Planning & Health Improvement: Projected £80,000 (7.81%) underspend**

Underspend due to funding not confirmed until well into the year, timing issue.

6.0 INTEGRATED CARE FUND (CHANGE FUND)

6.1 The original allocation over service areas for 2015/16 was:

Service Area Budget 2015/16	£'000	
Acute – Health	95	6%
HSCP – Health	390	25%
HSCP – Council	1,001	64%
Community Capacity - Health		
Community Capacity - Council	76	5%
Grand Total	**1,562**	100%
Funded By:		
Change Fund Allocation	1,760	
Top slice savings	-161	
Total Funding	**1,599**	

6.2 The Change Fund Executive Group meet on a regular basis and review all projects in detail. The latest current year position is:

Service Area Budget 2015/16	Current Budget £'000	Projected Outturn £000	Projected Variance £000
Acute – Health	95	95	0
HSCP – Health	390	390	0
HSCP – Council	1,001	1,004	3
Community Capacity - Health			0
Community Capacity - Council	76	76	0
Grand Total	**1,562**	**1,565**	**3**
Projected Over Commitment / (Slippage) at 31 August 2015			**3**

The costs will continue to be managed within the available resources and to ensure nil slippage or overspend.

7.0 2015/16 CURRENT CAPITAL POSITION – £Nil

7.1 The Social Work capital budget is £3,627,000 over the life of the projects with

£356,000 reprofiled 2015/16, comprising:

- £346,000 for the replacement of Neil Street Children's Home
- £10,000 to finalise the expansion of Hillend respite unit.

7.2 There was an error in the figures included in the Period 3 reported to the Health & Social Care Committee which significantly overstated the projected spend in 2015/16. This has been corrected and there is slippage in the 2015/16 budget of £288,000 (43.5%) against the Neil St Children's Home Replacement project which is scheduled to be complete by November 2016. Appendix 5 details capital budgets and progress by individual project.

7.3 Capital budgets for Health are now held by Boards Capital Planning.

7.4 Appendix 5 details capital budgets and progress by individual project.

8.0 EARMARKED RESERVES

8.1 The Social Work Earmarked Reserves for 2015/16 total £2,600,000 with £2,439,000 projected to be spent in the current financial year. To date £547,000 spend has been incurred which is 2.24% of the projected 2015/16 spend. The spend to date per profiling was expected to be £520,000 therefore no slippage has been incurred.

8.2 It should be noted that the reserves reported exclude those earmarked reserves that relate to budget smoothing, namely: Deferred Income and Children's Residential Care, Adoption & Fostering.

9.0 VIREMENT

9.1 The IJB note the Social Work budget virements as detailed at Appendix 7.

10.0 IMPLICATIONS

10.1 **Finance**

All financial implications are discussed in detail within the report above.

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	Other Comments
N/A					

Legal

10.2 There are no specific legal implications arising from this report.

Human Resources

10.3 There are no specific human resources implications arising from this report

Equalities

10.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
X	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.

11.0 CONSULTATION

11.1 This report has been prepared by the Corporate Director, Inverclyde Health & Social Care Partnership and relevant officers within Partnership Finance and the Council's Chief Financial Officer have been consulted.

12.0 BACKGROUND PAPERS

12.1 There are no background papers for this report.

APPENDIX 1

INVERCLYDE CHCP

REVENUE BUDGET PROJECTED POSITION

PERIOD 5: 1 April 2015 - 31 August 2015

SUBJECTIVE ANALYSIS	Approved Budget 2015/16 £000	Revised Budget 2015/16 £000	Projected Out-turn 2015/16 £000	Projected Over/(Under) Spend £000	Percentage Variance
Employee Costs	46,714	46,819	46,980	161	0.34%
Property Costs	2,084	2,112	1,953	(159)	(7.53%)
Supplies & Services	61,946	62,497	62,469	(28)	-0.04%
Prescribing	16,909	16,909	16,909	0	0.00%
Resource Transfer (Health)	9,203	9,203	9,203	0	0.00%
Income	(15,487)	(15,622)	(15,428)	194	(1.24%)
Contribution to Reserves	0	(84)	(84)	0	0.00%
	121,369	**121,834**	**122,002**	**168**	**0.14%**

OBJECTIVE ANALYSIS	Approved Budget 2015/16 £000	Revised Budget 2015/16 £000	Projected Out-turn 2015/16 £000	Projected Over/(Under) Spend £000	Percentage Variance
Strategy / Planning & Health Improvement	3,089	3,005	2,890	(115)	(3.83%)
Older Persons	21,346	21,764	22,127	363	1.67%
Learning Disabilities	6,969	7,165	7,132	(33)	(0.46%)
Mental Health - Communities	3,345	3,383	3,225	(158)	(4.67%)
Mental Health - Inpatient Services	9,310	9,310	9,828	518	5.56%
Children & Families	13,085	13,091	12,842	(249)	(1.90%)
Physical & Sensory	2,156	2,160	2,084	(76)	(3.52%)
Addiction / Substance Misuse	2,923	2,923	2,875	(48)	(1.64%)
Assessment & Care Management / Health & Community	5,787	5,704	5,645	(59)	(1.03%)
Support / Management / Admin	4,530	4,584	4,472	(112)	(2.44%)
Criminal Justice / Prison Service **	0	0	0	0	0.00%
Homelessness	732	732	869	137	18.72%
Family Health Services	20,478	20,478	20,478	0	0.00%
Prescribing	16,909	16,909	16,909	0	0.00%
Resource Transfer	9,203	9,203	9,203	0	0.00%
Change Fund	1,507	1,507	1,507	0	0.00%
Contribution to Reserves	0	(84)	(84)	0	0.00%
CHCP NET EXPENDITURE	**121,369**	**121,834**	**122,002**	**168**	**0.14%**

** Fully funded from external income hence nil bottom line position.

PARTNERSHIP ANALYSIS	Approved Budget 2014/15 £000	Revised Budget 2014/15 £000	Projected Out-turn 2014/15 £000	Projected Over/(Under) Spend £000	Percentage Variance
NHS	72,602	72,602	72,607	5	0.01%
Council	48,767	49,232	49,395	163	0.33%
CHCP NET EXPENDITURE	**121,369**	**121,834**	**122,002**	**168**	**0.14%**

( ) denotes an underspend per Council reporting conventions

** externally funded

APPENDIX 2

SOCIAL WORK

REVENUE BUDGET PROJECTED POSITION

PERIOD 5: 1 April 2015 - 31 August 2015

	2014/15 Actual £000	SUBJECTIVE ANALYSIS	Approved Budget 2015/16 £000	Revised Budget 2015/16 £000	Projected Out-turn 2015/16 £000	Projected Over/(Under) Spend £000	Percentage Variance
		SOCIAL WORK					
6	25,242	Employee Costs	25,236	25,341	25,018	(323)	(1.27%)
	1,441	Property costs	1,361	1,389	1,230	(159)	(11.45%)
	951	Supplies and Services	740	737	808	71	9.63%
	479	Transport and Plant	371	381	466	85	22.31%
	1,024	Administration Costs	735	759	845	86	11.33%
6	33,967	Payments to Other Bodies	34,612	35,132	35,341	209	0.59%
	(14,349)	Income	(14,288)	(14,423)	(14,229)	194	(1.35%)
7	0	Contribution to Earmarked Reserves	0	(84)	(84)	0	0.00%
	48,755	**SOCIAL WORK NET EXPENDITURE**	**48,767**	**49,232**	**49,395**	**163**	**0.33%**

	2014/15 Actual £000	OBJECTIVE ANALYSIS	Approved Budget 2015/16 £000	Revised Budget 2015/16 £000	Projected Out-turn 2015/16 £000	Projected Over / (Under) Spend £000	Percentage Variance
		SOCIAL WORK					
	2,037	Strategy	2,065	1,981	1,946	(35)	(1.77%)
	21,716	Older Persons	21,346	21,764	22,127	363	1.67%
	6,395	Learning Disabilities	6,414	6,610	6,612	2	0.03%
	1,020	Mental Health	1,106	1,144	1,107	(37)	(3.23%)
	9,793	Children & Families	10,344	10,350	10,203	(147)	(1.42%)
	2,128	Physical & Sensory	2,156	2,160	2,084	(76)	(3.52%)
	1,097	Addiction / Substance Misuse	1,040	1,040	1,051	11	1.06%
	2,219	Support / Management	1,980	2,034	2,027	(7)	(0.34%)
	1,477	Assessment & Care Management	1,584	1,501	1,453	(48)	(3.20%)
1	0	Criminal Justice / Scottish Prison Service	0	0	0	0	0.00%
2	0	Change Fund	0	0	0	0	0.00%
	873	Homelessness	732	732	869	137	18.72%
	0	Contribution to Earmarked Reserves	0	(84)	(84)	0	0.00%
	48,755	**SOCIAL WORK NET EXPENDITURE**	**48,767**	**49,232**	**49,395**	**163**	**0.33%**

( ) denotes an underspend per Council reporting conventions

1 £1.6m Criminal Justice and £0.3m Greenock Prison fully funded from external income hence nil bottom line position.
2 Change Fund Expenditure of £1.3 million fully funded from income.
3 £9 million Resource Transfer / Delayed Discharge expenditure and income included above.

4		
	Original Budget 2015/16	48,767
	Pay & Inflation etc.	548
	Budget transfer to SDS Earmarked Reserve	(84)
	Transport virement	1
	Revised Budget 2015/16	49,232

5 There are currently 641 clients receiving Self Directed Support care packages.
6 Within Older Peoples Services £354k of vacancies have been offset by purchased Homecare costs.
7 Council contribution to Self Directed Support earmarked reserve

APPENDIX 3

HEALTH

REVENUE BUDGET PROJECTED POSITION

PERIOD 5: 1 April 2015 - 31 August 2015

2014/15 Actual £000	SUBJECTIVE ANALYSIS	Approved Budget 2015/16 £000	Revised Budget 2015/16 £000	Projected Out-turn 2015/16 £000	Projected Over/(Under) Spend £000	Percentage Variance
	HEALTH					
21,816	Employee Costs	21,478	21,478	21,962	484	2.25%
698	Property	723	723	723	0	0.00%
4,310	Supplies & Services	5,011	5,011	4,532	(479)	(9.56%)
21,224	Family Health Services (net)	20,477	20,477	20,477	0	0.00%
16,225	Prescribing (net)	16,909	16,909	16,909	0	0.00%
9,042	Resource Transfer	9,203	9,203	9,203	0	0.00%
(1,677)	Income	(1,199)	(1,199)	(1,199)	0	0.00%
71,638	**HEALTH NET EXPENDITURE**	**72,602**	**72,602**	**72,607**	**5**	**0.01%**

2014/15 Actual £000	OBJECTIVE ANALYSIS	Approved Budget 2015/16 £000	Revised Budget 2015/16 £000	Projected Out-turn 2015/16 £000	Projected Over/(Under) Spend £000	Percentage Variance
	HEALTH					
3,017	Children & Families	2,741	2,741	2,639	(102)	(3.72%)
3,707	Health & Community Care	4,203	4,203	4,192	(11)	(0.26%)
2,652	Management & Admin	2,550	2,550	2,445	(105)	(4.12%)
573	Learning Disabilities	555	555	520	(35)	(6.31%)
1,829	Addictions	1,883	1,883	1,824	(59)	(3.13%)
2,126	Mental Health - Communities	2,239	2,239	2,118	(121)	(5.40%)
9,238	Mental Health - Inpatient Services	9,310	9,310	9,828	518	5.56%
851	Planning & Health Improvement	1,024	1,024	944	(80)	(7.81%)
1,156	Integrated Care Fund	1,507	1,507	1,507	0	0.00%
21,224	Family Health Services	20,478	20,478	20,478	0	0.00%
16,225	Prescribing	16,909	16,909	16,909	0	0.00%
9,040	Resource Transfer	9,203	9,203	9,203	0	0.00%
71,638	**HEALTH NET EXPENDITURE**	**72,602**	**72,602**	**72,607**	**5**	**0.01%**

( ) denotes an underspend per Council reporting conventions

APPENDIX 4

REVENUE BUDGET YEAR TO DATE

PERIOD 5: 1 April 2015 - 31 August 2015

SOCIAL WORK SUBJECTIVE ANALYSIS	Budget to Date £000	Actual to Date £000	Variance to Date £000	Percentage Variance
SOCIAL WORK				
Employee Costs	18,657	17,900	(757)	(4.06%)
Property costs	1,020	806	(214)	(20.98%)
Supplies and Services	575	668	93	16.17%
Transport and Plant	276	341	65	23.55%
Administration Costs	644	475	(169)	(26.24%)
Payments to Other Bodies	24,062	23,161	(901)	(3.74%)
Income	(10,177)	(10,005)	172	(1.69%)
SOCIAL WORK NET EXPENDITURE	**35,057**	**33,346**	**(1,711)**	**(4.88%)**

HEALTH SUBJECTIVE ANALYSIS	Budget to Date £000	Actual to Date £000	Variance to Date £000	Percentage Variance
HEALTH				
Employee Costs	9,319	9,276	(43)	(0.46%)
Property Costs	293	293	0	0.00%
Supplies	1,051	1,097	46	4.38%
Family Health Services (net)	8,265	8,265	0	0.00%
Prescribing (net)	7,093	7,093	0	0.00%
Resource Transfer	3,835	3,835	0	0.00%
Income	(519)	(519)	0	0.00%
HEALTH NET EXPENDITURE	**29,337**	**29,340**	**3**	**0.01%**

( ) denotes an underspend per Council reporting conventions

APPENDIX 5

INVERCLYDE CHCP - CAPITAL BUDGET 2015/16

Period 5: 1 April 2015 to 31 August 2015

Project Name	Est Total Cost £000	Actual to 31/3/15 £000	Approved Budget 2015/16 £000	Revised Est 2015/16 £000	Actual to 31/08/15 £000	Est 2016/17 £000	Est 2017/18 £000	Future Years £000	Start Date	Original Completion Date	Current Completion Date	Status
SOCIAL WORK												
Hillend Respite Unit (note 1)	87	77	10	10	0	0	0	0	28/05/14		14/11/14	Increase of one bed within respite unit. Building work is completed and the £7k overspend is met from the capital programme.
Neil Street Children's Home Replacement	1,858	114	661	346	8	1,369	29	0	01/02/16	31/03/16	31/11/16	Design work complete. Planning approval in place. Tender documents being prepared.
Crosshill Children's Home Replacement	1,682	0	0	0	0	157	1,435	90	01/04/14	31/03/17		Design phase will commence 2016/17
Social Work Total	**3,627**	**191**	**671**	**356**	**8**	**1,526**	**1,464**	**90**				
HEALTH												
Health Total	0	0	0	0	0	0	0	0				
Grand Total CHCP	**3,627**	**191**	**671**	**356**	**8**	**1,526**	**1,464**	**90**				

Note:
1. The expansion of the service is funded from a contribution from revenue reserves, as agreed by Policy & Resources Committee 24/09/13. The final total is subject to confirmation.

EARMARKED RESERVES POSITION STATEMENT **APPENDIX 6**

CHCP SUB COMMITTEE

Project	Lead Officer/ Responsible Manager	Total Funding 2015/16 £000	Phased Budget To Period 5 2015/16 £000	Actual To Period 5 2015/16 £000	Projected Spend 2015/16 £000	Amount to be Earmarked for 2016/17 & Beyond £000	Lead Officer Update
Self Directed Support / SWIFT Finance Module	Derrick Pearce / Andrina Hunter	216	77	88	132	84	SWIFT (£9k) & SDS (£123k). Work is continuing on the implementation of SDS & the SWIFT financial module.
Growth Fund - Loan Default Write Off	Helen Watson	27	0	0	2	25	Loans administered on behalf of DWP by the credit union and the Council has responsibility for paying any delinquent debt. This requires to be kept until all loans are repaid and no debts exist.
Integrated Care Fund/ Delayed Discharge	Brian Moore	1,349	306	351	1,349	0	The Integrated Care Fund is new funding to be received. Funding is currently being allocated to a number of projects including reablement, housing and third sector & community capacity projects. The total funding may change as the year progresses. Delayed Discharge funding is also be received and work is underway to allocate that to specific projects, including overnight home support and out of hours support.
Support all Aspects of Independent Living	Brian Moore	231	26	14	231	0	This reserve includes the Dementia Strategy of £70k and a contribution of £150k from NHS for equipment.
Support for Young Carers	Sharon McAlees	43	14	15	43	0	This reserve is for an 18 month period to enable the implementation of a family pathway approach to young carers, which will aim to develop a sustainable service to young carers and their families.
Caladh House Renovations	Beth Culshaw	449	5	7	449	0	Options for reprovision of service are being considered.
Welfare Reform - CHCP	Andrina Hunter	162	79	53	153	9	This reserve is to fund Welfare Reform within the CHCP. New Funding of £118k was allocated from P&RCommittee. The funding is being used for staff costs and projects, including Grand Central Savings, Inverclyde Connexions, starter packs and financial fitness.
Funding for Equipment - Adults with Learning Disabilities		40	0	2	40		This reserve is for the purchase of disabilty aids within Learning Disabilities and will be fully spent in 15/16 on the replacement of equipment that is no longer fit for purpose.
Information Governance Policy Officer	Helen Watson	83	13	17	40	43	The spend relates to the Council's Information Governance Officer.
Total		**2,600**	**520**	**547**	**2,439**	**161**	

APPENDIX 7

CHCP - HEALTH & SOCIAL CARE

VIREMENT REQUESTS

Budget Heading	Increase Budget £'000	(Decrease) Budget £'000
1. Assessment & Care Management - income		(41)
1. Delayed Discharge - income	41	
1. Assessment & Care Management - PTOB	84	
1. Service Strategy - PTOB		(84)
1. Children & Families - income		(49)
1. Business Support - income	49	
2. Older People - PTOB	489	
2. Children & Families - PTOB	59	
3. Assessment & Care Management - PTOB		(84)
4. Various - transport	1	
	723	**(258)**

Notes

1. Realignment of budgets to reflect management responsibility
2. Inflation allocation
3. Transfer to EMR for Self Directed Support
4. Transport budgets realigned corporately

APPENDIX 8

EMPLOYEE COST VARIANCES

PERIOD 5:   1 April 2015 - 31 August 2015

	ANALYSIS OF EMPLOYEE COST VARIANCES	Early Achievement of Savings £000	Turnover from Vacancies £000	Total Over / (Under) Spend £000
	SOCIAL WORK			
1	Strategy	0	(34)	(34)
2	Older Persons	0	(130)	(130)
3	Learning Disabilities	0	34	34
4	Mental Health	0	(23)	(23)
5	Children & Families	0	(85)	(85)
6	Physical & Sensory	0	(6)	(6)
7	Addiction / Substance Misuse	0	(7)	(7)
8	Support / Management	0	(12)	(12)
9	Assessment & Care Management	0	(38)	(38)
10	Criminal Justice / Scottish Prison Service	0	(38)	(38)
11	Homelessness	0	16	16
	SOCIAL WORK EMPLOYEE UNDERSPEND	**0**	**(323)**	**(323)**
	HEALTH			
12	Children & Families			
13	Health & Community Care			
14	Management & Admin			
15	Learning Disabilities			
16	Addictions			
17	Mental Health - Communities			
18	Mental Health - Inpatient Services			
19	Planning & Health Improvement			
	HEALTH EMPLOYEE UNDERSPEND		**0**	**0**
	TOTAL EMPLOYEE UNDERSPEND	**0**	**(323)**	**(323)**

1 Currently 11 vacancies along with maternity leave savings, with 6 of these posts potentially not filled this year.

2 Currently 7 vacancies which are in the process of being filled

3 Currently 41 vacancies along with maternity leave savings - NB offset by external costs due to recruitment issues

4 Currently 11 vacancies of which 9 are in the process of being filled, however turnover target & additional cover arrangements mean that there is currently an overspend predicted.

5 Currently 3 vacancies which are in the process of being filled

6 Currently 7 vacancies of which 4 are in the process of being filled

7 Currently 6 vacancies which are in the process of being filled

8 Variance not significant

9 Variance not significant

10 Variance not significant

11 Currently 3 vacancies which are in the process of being filled

12 Information not available at this time

13 Information not available at this time

14 Information not available at this time

15 Information not available at this time

16 Information not available at this time

17 Information not available at this time

18 Information not available at this time

19 Information not available at this time

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 7

Report To:	**Inverclyde Integration Joint Board**	**Date: 10 November 2015**
Report By:	**Brian Moore** **Chief Officer** **Inverclyde Health & Social Care Partnership (HSCP)**	**Report No: IJB/23/2015/HW**
Contact Officer:	**Helen Watson** **Head of Service** **Planning, Health Improvement & Commissioning**	**Contact No: 01475 715285**
Subject:	**BUSINESS UPDATE**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on a number of key workstreams that are currently underway or are projected to require HSCP or IJB action.

2.0 SUMMARY

2.1 The integration landscape and requirements of Integration Joint Boards are still evolving. As Scottish Government Policy is shaped around this agenda, it is important the IJB members are advised of emerging policies, issues or HSCP workstreams that are responding to specific situations. This paper provides a brief summary of such workstreams that are currently or soon to be live.

3.0 RECOMMENDATION

3.1 That the Integration Joint Board note the business update report and advise the Chief Officer if any further information is required.

Brian Moore
Chief Officer
Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

4.1 This report highlights current and emerging workstreams that IJB Members should be alert to.

Public Bodies (Joint Working) (Scotland) Act 2014

4.2 The latest Guidance Note published in September 2015 relates to the Roles, Responsibilities and Membership of the Integration Joint Board, and is appended to this report for ease of reference.

4.3 The main new points to note from the Guidance are:

i. Regulations for the production of an annual performance report against the National Outcomes (also attached). The IJB Reporting Schedule paper also presented to this meeting proposes that an Annual Performance Report should be presented to the IJB for approval in May of each year.

ii. An Annual Financial Statement must be published. The guidance for this is extensive (120 pages) so has not been appended but is available by link on page 5 of the Roles, Responsibilities and Membership of the Integration Joint Board Document. It is proposed in the IJB Reporting Schedule paper that the Annual Financial Statement should be presented to the IJB for approval in May of each year.

iii. The Public Records (Scotland) Act 2011 requires named public authorities to prepare and implement a Records Management Plan (RMP) which sets out proper arrangements for the management of their records. We will be invited by the Keeper of the Records of Scotland at some point to submit this plan for approval, however it would be prudent to begin preparations at an early date. It is proposed in the IJB Reporting Schedule paper that an RMP update should be presented to the IJB for approval in March of each year. Members should note that once our invitation from the Keeper has been received, additional reports may be required.

iv. The Freedom of Information (Scotland) Act 2002 requires that all Scottish Public Authorities maintain a publication scheme, setting out the types of information that a public authority routinely makes available. The IJB has a duty to develop and put in place a publication Scheme, along with a guide setting out what information it will make available. The annual IJB Reporting Schedule paper will form part of the scheme.

v. The Equality Act 2010 places an obligation on public authorities to take action to eradicate discrimination and to proactively promote equality of opportunity. In addition to this general duty, the IJB is required to develop a suite of equality outcomes, to be integrated into the Strategic Plan. The European Commission for Human Rights (ECHR) has offered to support us in developing our outcomes.

vi. Under the guidance on diversity, the Scottish Government's Programme for Government encourages public bodies to set a voluntary commitment for gender balance on their Boards of 50/50 by the year 2020. IJBs are expected to take positive action to support and enable greater diversity in the membership of and appointments to their Board.

4.4 Consultation: Amendment to Schedule 2 of the Scottish Public Services Ombudsman Act 2002

On 14th October the Scottish Public Services Ombudsman (SPSO) issued a consultation letter proposing an amendment to Schedule 2 of the Scottish Public Services Ombudsman Act 2002 to add IJBs to the listed authorities. If approved, this would bring IJBs into line with other public services in that they would be required to establish a complaints procedure that ultimately gives complainants recourse to the SPSO if they are not satisfied with the response of the organisation. The proposal in

the consultation is in line with our own ambitions to fully integrate complaints procedures.

4.5 Strategic Plan Update

At the August 2015 meeting of the IJB our Establishment Plan was approved. Since then, the Strategic Planning Group has been working on developing the substantive Three-Year Strategic Plan, incorporating the various plans that the Guidance sets out as also being required (for example, Workforce Plan; Organisational Development Plan; Market Facilitation Plan etc.). It is important that none of these plans are created in isolation, and we are keen to ensure that all of them contribute to the realisation of our vision and values. The Strategic Plan is being developed in full collaboration with our key stakeholders, including community representatives. The iterative process will ensure that contributions and views are actively sought throughout the development process. In addition to this, we will issue a draft version of the Plan for final consultation purposes, prior to the final presentation to the IJB. A full draft will be presented to the March 2016 meeting of the IJB.

4.6 Afghan Resettlement Scheme

Following an announcement by the Secretary of State for Defence, the National Security Council agreed a package of measures to offer locally engaged Afghan staff, who worked as interpreters for the armed forces, who are made redundant as a result of the withdrawal of UK forces, the option to relocate to the UK. Inverclyde Council agreed in 2014 to participate in the Afghan Resettlement Scheme with 12 families being offered the opportunity to relocate in Inverclyde.

To date six families have settled with support from the HSCP and other partners, and information is awaited from the Home Office on arrival dates for the further six. All 6 families have settled well in the area and their children are attending pre-5 services and primary schools locally. All the families have full refugee status and are registered with local primary care services and receive benefits whilst being supported to seek employment or further training.

A multi-agency partnership, chaired by the HSCP has been established which has been instrumental in settling and supporting the Afghan families to integrate within Inverclyde. In addition, Inverclyde HSCP has established a post of Refugee Integration Coordinator.

4.7 Syrian Resettlement Scheme

The current conflict in Syria has created a humanitarian crisis that has so far resulted in 4.5 million people fleeing the country to seek refuge elsewhere. On 7 September 2015 the Prime Minister announced that the UK would receive 20,000 refugees over the life of the current Parliament, 5 years.

Refugees who come to the UK through the resettlement scheme will be identified in camps in countries neighbouring Syria such as Lebanon, Turkey and Iraq. The UN Refugee Agency (UNHCR) will identify people who fit the criteria identified by the UK Government (the criteria is yet to be confirmed, but it is likely to be relaxed from the previous criteria of women and children at risk of violence, medical cases and victims of torture). Refugees will then be subject to security checks and provided with documentation before they leave the camp.

The refugees will be granted immigration status which will allow them to access the full range of welfare benefits, including housing benefit. Inverclyde Council has agreed to participate in this scheme and ten families will be offered relocation to Inverclyde with two families expected prior to Christmas 2015.

It is anticipated that the major challenges for the HSCP being involved in the Syrian

scheme will be financial, language-related and cultural, and work is on-going to mitigate these issues. There may in addition be complex health needs, therefore colleagues within NHS GGC are cited on Inverclyde's involvement.

Experience to date has highlighted an extremely positive partnership approach from a range of HSCP and wider Council services, and partner agencies which have helped the Afghan nationals to settle well within the local community. Learning from this work will be applied to our approach in supporting and resettling the Syrian families.

4.8 Rest Centre Arrangements

In October an unexploded mine was found in the River Clyde at Gourock. It was thought to be from WWII, but it was unclear whether it still presented a danger of detonating. On that basis a decision was made that it should be relocated for safe destruction. However it was assessed that there could be a risk of spontaneous detonation during the process of moving the mine so on that basis an evacuation of the immediate proximity, including any vulnerable people, had to be undertaken and a rest centre set up by HSCP staff in Clydeview Academy to receive those who had to be evacuated.

Gourock Health Centre was within the exclusion zone so had to be temporarily closed, however patients were contacted and appointments rescheduled wherever possible. HSCP staff coordinated the process and people were evacuated and then resettled with minimum fuss.

4.9 Partnership Beds update

Inverclyde HSCP continues with the process to procure 42 NHS Mental Health continuing care beds (30 for older people, 12 for adults). The procurement vehicle for the development and management of this facility is HUB West Scotland. Following conclusion of the stage two processes the Full Business Case was approved in early summer 2015. We are unable to progress to financial close until the resolution of the ongoing ESA10 classification issues. Current indications suggest this will be considered by the Office of National Statistics in November. This being the case, we would anticipate financial close in February 2016, and construction starting in March 2016.

4.10 Integration 5 Year Celebrations

Inverclyde CHCP was established in October 2010. To mark the 5 years of integration, a series of staff events have been held which focused on informing and involving staff in sharing practice and reflecting on our achievements of the last five years. These have included pop-up health bars within Health Centres, building a picture of our staff and the work they do by stories of a "day in the life of", and personal profiles and an event at the Beacon to showcase our work and the service we provide.

5.0 PROPOSALS

5.1 The content of this report is for noting only, and to ensure that IJB Members are informed about the business of the HSCP.

6.0 IMPLICATIONS

Finance:

6.1 There are no financial implications in respect of this report.

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:

6.2 There are no legal implications in respect of this report.

Human Resources:

6.3 There are no human resources implications in respect of this report.

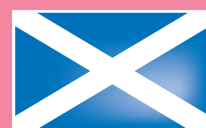
Equalities:

6.4 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.

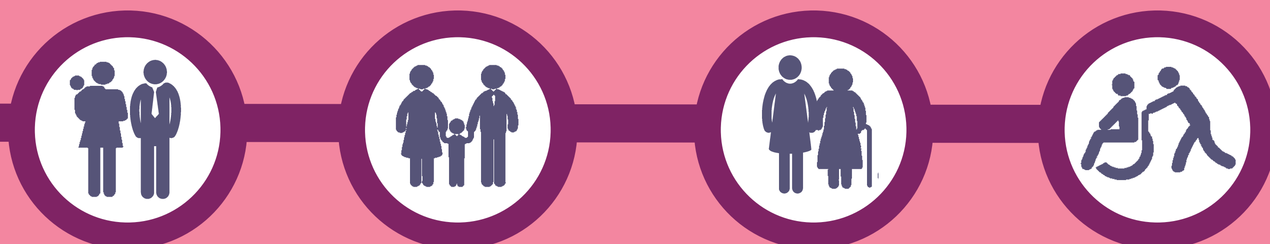
7.0 LIST OF BACKGROUND PAPERS

7.1 Roles, Responsibilities and Membership of the Integration Joint Board (Sept 2015);
Policy Note: The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014.
SPSO Consultation Letter (October 2015).



Roles, Responsibilities and Membership of the Integration Joint Board

Guidance and advice to supplement the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014



Health and Social Care Integration

Public Bodies (Joint Working) (Scotland) Act 2014

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The Aim of this Guidance

This guidance is intended for use by all members of an Integration Joint Board particularly the Chair - and provides further advice to supplement the existing legislation. The document focuses on the roles, responsibilities and membership of the Integration Joint Board.

Section 53 of the Public Bodies (Joint Working) (Scotland) Act 2014 ("the Act") sets out an Integration Joint Board is required to have regard to this guidance when exercising its functions under the Act. This guidance relates to Integration Joint Boards that must be established when a Health Board and Local Authority choose a Body Corporate Model of integration (under section 1(4)(a) of the Act).

Section 1: Role and Responsibilities of the Integration Joint Board

1.1 Role and remit of the Integration Joint Board

The Act puts in place arrangements for integrating health and social care, in order to improve outcomes for patients, service users, carers and their families. The Act requires Health Boards and Local Authorities to work together effectively to agree a model of integration to deliver quality, sustainable care services. Where a Health Board and a Local Authority agree to put in place a Body Corporate model, an Integration Joint Board will be established. This will see Health Boards and Local Authorities delegate a significant number of functions and resource to the Integration Joint Board, who will be responsible for the planning of integrated arrangements and onward service delivery.

The Health Board and Local Authority will set out within their integration scheme which of their functions they intend to delegate to the Integration Joint Board. The scope of the delegated functions will vary depending on local decision making but must adhere to the statutory minimum.

The functions that must be delegated by the Health Board to the Integration Joint Board as per the Act are set out in The Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014.

The functions that must be delegated by the Local Authority to the Integration Joint Board as per the Act are set out in The Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Regulations 2014.

The Integration Joint Board is responsible for the strategic planning of the functions delegated to it and for ensuring the delivery of those functions through the directions issued by it under section 25 of the Act. The Integration Joint Board will also have an operational role as described in the locally agreed operational arrangements set out within their integration scheme.

To fulfil its remit the Integration Joint Board will:

- Adhere to the content of any future regulations or guidance issued by Scottish Ministers
- Ensure stakeholder engagement
- Take into consideration national developments in policy and practice

1.2 Duties placed on Integration Joint Boards by the Public Bodies (Joint Working) (Scotland) Act 2014

- The Public Bodies (Joint Working) (Scotland) Act 2014, "the Act", places a duty on Integration Joint Boards to develop a strategic plan for integrated functions and budgets. For more information, please see the guidance on Strategic Commissioning Plans.
- Each Integration Joint Board must establish a strategic planning group to support the strategic planning process. For more information, **see section 1.5 of this guidance.**
- An Integration Joint Board must review its strategic plan at least every three years.
- Sections 4 and 31 of the Act set out the integration principles which underpin delivery of integrated health and social care services. These principles describe "how" integrated care should be planned and delivered. Integration Joint Boards are under a duty to have regard to these principles when preparing a strategic plan. For more information, please see the guidance on the Integration Planning and Delivery Principles.
- Section 37 of the Act places Integration Joint Boards under a duty to have regard to the National Health and Wellbeing Outcomes (the Outcomes) when preparing a strategic plan. These Outcomes are high-level statements of what Integration Joint Boards are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.
- Integration Joint Boards are required to issue directions to Health Boards and Local Authorities as to how integration functions are to be carried out. Details relating to this are set out in sections 26 and 27 of the Act.
- Integration Joint Boards are required to prepare an annual performance report. This must comply with the requirements of the Regulations on the Content of Performance Reports.
- An annual financial statement must be published setting out the total resources included in the plan for that year. For more guidance, please see the Professional Guidance, Advice and Recommendations for Integration Arrangements.
- A full list of guidance and advice published to support the Public Bodies (Joint Working) (Scotland) Act 2014, is available at http://www.gov.scot/HSCI.

1.3 Other key requirements of the Integration Joint Board

Integration Joint Boards are public bodies, and as such are subject to a range of other requirements. An Integration Joint Board must ensure that arrangements are established to comply with their duties as set out in legislation. Although the responsibility of compliance sits with an Integration Joint Board; Integration Joint Boards may choose to draw on the experience of and/or request support from their constituent Health Board and/or Local Authority to aid it in complying with the legislative requirements set out below. In such circumstances the Health Board and/or Local Authority would be expected to provide the support requested.

The Public Records (Scotland) Act 2011

Integration Joint Boards are designated as "Bodies Corporate" for the purposes of the Public Records (Scotland) Act 2011. They will be obliged, therefore, to comply fully as public authorities under the legislation.

The Public Records (Scotland) Act 2011 requires named public authorities to prepare and implement a records management plan which sets out proper arrangements for the management of their records. Records management plans must be agreed with the Keeper of the Records of Scotland (the Keeper) and regularly reviewed by authorities. The plan must account for all the public records for which the authority has responsibility.

The plan must detail the functions of each authority and the types of records created in pursuance of these functions. It will show the policies and procedures in place for the appropriate storage, retention, disposal, archiving and security of these records.

To assist public authorities to comply with their obligations, the Keeper has produced a model plan in the form of an annotated list of the elements that might be expected to be covered in a robust records management plan. In addition the Keeper has produced guidance that accompanies the model plan.

A Senior Officer of the Integration Joint Board will therefore be responsible for overseeing the development and implementation of the records management plan and for approving it prior to submission for the Keeper's agreement.

Further details on the National Records of Scotland and the Public Records (Scotland) Act 2011 Assessment Team and support they provide can be found on their website.

Records Management

It will be necessary for an Integration Joint Board to consider how Freedom of Information (Scotland) Act 2002 / Environmental Information (Scotland) Regulations 2004 obligations impact on its records management practices, including how information is stored. The **Code of Practice** on Records Management sets out recommended 'best practice'.

The records management plan will need to be clearly set out if information is held by the Integration Joint Board or the information held is owned by the Integration Joint Board or held 'on behalf of' the relevant Local Authority or Health Board. If a request is sent to an Integration Joint Board for information it holds 'on behalf of' the Local Authority or Health Board, the applicant should be informed by the Integration Joint Board that it does not hold the information and they should then be directed to the relevant Local Authority or Health Board.

Integration Joint Boards, Health Boards and Local Authorities may also wish to consider putting systems in place, for example, Memoranda of Understanding, to support effective handling of requests where the scope of which includes communications between the bodies, or information on topics of shared interest/joint working.

Data Sharing

Health Boards and Local Authorities will continue to be responsible for answering data access requests in relation to any data for which they are the Data Controller, however, for requests in relation to any data that Integration Joint Boards are responsible they will be responsible for answering any data access request.

Data (Subject) Access Requests

Data Access Requests *(called Subject Access Requests under the Data Protection Act 1998)* are requests by individuals for their personal data and work on the basis of whichever body is the Data Controller.

It is possible for the same data to be held by more than one public authority as a result of agreed sharing. Integration Joint Boards must ensure that data sharing arrangements set out in the integration scheme are in place and that it is clear how subject access requests are managed by both parties when shared data is involved.

Further information on Subject Access Requests can be found in the Subject Access Requests Code of Practice.

The Freedom of Information (Scotland) Act 2002 and Environmental Information (Scotland) Regulations 2004

The Freedom of Information (Scotland) Act 2002 - and the related Environmental Information (Scotland) Regulations 2004 - provide any applicant with the right to request – and be provided with - any recorded information held by Scotland's public authorities. If an authority does not wish to provide information it holds, an 'exemption' or (under the Environmental Information (Scotland) Regulations 2004) an 'exception' must be applied, for example, for legal advice or personal data.

Integration Joint Boards are a “public authority” for the purpose of Freedom of Information (Scotland) Act 2002. This means they are subject to both Freedom of Information (Scotland) Act 2002 and the related Environmental Information (Scotland) Regulations 2004, as well as other requirements of Freedom of Information legislation, and will be required to respond to information requests accordingly.

Integration Joint Boards should be aware of their responsibilities under this **Code of Practice** which sets out recommended guidance in the handling of information requests.

As Health Boards and Local Authorities are already subject to information access legislation, Integration Joint Board members are likely to already have an awareness of the requirements that Freedom of Information (Scotland) Act 2002 and the related Environmental Information (Scotland) Regulations 2004 place on officials and organisations.

While, in due course, Integration Joint Boards may wish to develop their own guidance and training, it is suggested that members may initially wish to familiarise themselves with existing guidance and training. For example, the Scottish Government guidance and training on information request handling.

Publication Scheme

Section 23 of Freedom of Information (Scotland) Act 2002 also requires that all Scottish public authorities subject to the Act maintain a publication scheme. A publication scheme sets out the types of information that a public authority routinely makes available. The Integration Joint Board will need to develop and put in place a publication scheme, along with a guide setting out what information it will make available.

It is important that consideration is given to the publication scheme – and associated guides to information – as early as possible. A publication scheme must be approved by the Scottish Information Commissioner. Information on publication schemes is available on the Commissioner’s website.

Office of the Scottish Information Commissioner (OSIC)

The Scottish Information Commissioner promotes and enforces both the public's right to ask for information held by Scottish public authorities and good practice by authorities.

The Commissioner’s staff have considerable experience in assisting authorities who are new to the Freedom of Information (Scotland) Act 2002 / Environmental Information (Scotland) Regulations 2004 responsibilities and will be pleased to help. They can be contacted on 01334 464610, or by email to enquiries@itspublicknowledge.info.

Ethical Standards in Public Life - Code of Conduct

Integration Joint Boards are "devolved public bodies" for the purposes of the Ethical Standards in Public Life (Scotland) Act. This means that each Integration Joint Board is required to produce a code of conduct for members. The code should be based on the model code of conduct for members of devolved public bodies.

Each Integration Joint Board is required to review this model code and adopt it, with or without modifications, as its own code of conduct; applying to all members and business of the Integration Joint Board. All members are required to sign the code of conduct. Some members may have already signed similar codes of conduct i.e. Code of Conduct for Councillors; however they are still required to sign the Integration Joint Board's code of conduct as their duties as Integration Joint Board members should be independent of the responsibilities that they may have by virtue of other posts.

The Standards Commission

The Standards Commission is an independent public body which encourages high ethical standards in public life through the promotion and enforcement of Codes of Conduct for those appointed to the Boards of devolved public bodies.

The Commissioner for Ethical Standards in Public Life in Scotland

The Commissioner is an independent office holder who works in two areas:

Public appointments, regulating how people are appointed to the Boards of public bodies in Scotland; and

Public standards, where the Commissioner can investigate a complaint about a Councillor or a member of a devolved public body who is alleged to have contravened the Councillors' or the appropriate public body's Code of Conduct. It is in this capacity that the Integration Joint Board would be under the remit of the Commissioner.

Equalities Duties

All public authorities in Scotland, including Integration Joint Boards, must comply with the public sector equality duty set out in the Equality Act 2010. The duty places an obligation on public authorities to take action to eradicate discrimination and to pro-actively promote equality of opportunity.

The duty has a two tier structure - a general duty set out in the Equality Act 2010, and specific duties set out in Regulations made by Scottish Ministers.

To better enable public authorities to locate equality data and evidence, the Scottish Government has developed an evidence finder.

The Scottish Government has also produced an evidence toolkit to help authorities source supporting evidence to help with their Scottish specific reporting duties.

Diversity

The Scottish Government expects all public bodies to champion diversity and mainstream equal opportunities in their work. Scottish Ministers particularly welcome under-represented groups having membership on Scotland's public bodies. The Scottish Government's Programme for Government encourages public bodies to set a voluntary commitment for gender balance on their Boards of 50/50 by 2020, with the aim of ensuring that Boards of public bodies are broadly reflective of the wider Scottish population. The Scottish Government has already committed to achieving gender balance on its Board by 2020. Public bodies, including Integration Joint Boards, are expected to take positive action to support and enable greater diversity in the membership of and appointment to their Board.

1.4 Liability arrangements for Integration Joint Boards and their members

Integration Joint Boards are eligible to join the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) which covers the following areas of liability:

- **Clinical Negligence**
- **Employers Liability**
- **Public Liability**
- **Personal Injury, Loss, Damage to Property or other Wrongful Act**
- **Dishonest, Fraudulent, Criminal or Malicious Activities**
- **Defamation**
- **Directors and Officers Liability**
- **Consequential or Ancillary Expense**
- **Financial Loss Suffered by Member as a result Fraud/Dishonesty/Theft**

The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000 (as amended) makes provision for Integration Joint Boards to apply to become a member of CNORIS. Membership is not compulsory, but represents a cost-effective alternative to arranging separate insurance. If an Integration Joint Board decides to become a member of CNORIS then they will be indemnified as above.

If an Integration Joint Board decides not to become a member of CNORIS then it will be necessary to ensure alternative arrangements are put in place to cover the Integration Joint Board and its members against any claims arising in relation to liabilities listed above.

1.5 The relationship between the Integration Joint Board and the strategic planning group

The Public Bodies (Joint Working) (Scotland) Act 2014 places a requirement on Integration Joint Boards to create a strategic plan for the area for which it is established. As part of this process, the Integration Joint Board must establish a strategic planning group. The Integration Joint Board must also determine the processes and procedures for the strategic planning group, subject to the provisions set out in section 32 of the Act.

In developing the processes and procedures for the strategic planning group, the Integration Joint Board must be mindful that the work of the strategic planning group does not end with the publication of the strategic plan.

After the strategic plan is published, the strategic planning group will continue to review progress of the plan, measured against the statutory outcomes for health and wellbeing, and associated indicators. Strong lines of communication will need to be established between the strategic planning group and the Integration Joint Board. This is needed to ensure that the strategic planning group can effectively communicate its findings to the Integration Joint Board which will help to inform and facilitate revisions to the strategic plan at least every three years.

A detailed explanation of the process for the development of the strategic plan can be found in the Strategic Commissioning Plan Guidance.

1.6 Appointing a Committee of an Integration Joint Board

Integration Joint Boards can appoint sub-committees should that be desirable. The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 extends the options available to an Integration Joint Board in effectively planning for the provision of services by permitting an Integration Joint Board to form a committee to carry out any of its functions as it sees fit. Any decision of such a committee must be agreed by the majority of the voting members who are members of the committee.

A committee of an Integration Joint Board can only exercise the functions conferred upon it by the Integration Joint Board. The purpose of the committee is to support the effective working of the Integration Joint Board on matters which have been devolved to it by the Integration Joint Board. This may be in an advisory capacity or, depending on the remit given by the Integration Joint Board, the committee may have decision making powers to carry out certain functions of the Integration Joint Board. In the interests of fairness and effective working, a committee of an Integration Joint Board must consist of equal numbers of representatives from each constituent authority, as set out in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 (article 17(3)).

An Integration Joint Board can appoint advisory members to sit on a committee from outside the membership of the Integration Joint Board, although, as before, any such decision must be agreed on by the voting members of the Integration Joint Board.

1.7 Complaints under Integration

Complaints about Integrated services

Where a Health Board and Local Authority choose a body corporate model of integration, the Health Board and Local Authority will remain the responsible bodies for the delivery of health and social care services. As such any complaints about service delivery will be dealt with through the existing health procedures and social care/social work complaints procedures.

To ensure complaints are joined up from the perspective of the complainants, Health Boards and Local Authorities are required to agree and set out within their integration schemes arrangements for the management of complaints relating to integrated service delivery and the process by which a service user, and those complaining on behalf of service users may make a complaint. The arrangements set out in the integration scheme cannot alter the underlying position, described above, that complaints are to be dealt with under existing health procedures and social care/social work complaints procedures.

The Health Board and Local Authority must ensure that the arrangements that they have jointly agreed are:

- Clearly explained
- Well-publicised
- Accessible
- Allow for timely recourse
- Complainants are signposted to independent advocacy services

Complaints about Integration Joint Boards

Integration Joint Boards are new public bodies and complaints may be raised against an Integration Joint Board in relation to particular functions, such as strategic planning. Complaints against the Integration Joint Board are not covered under current complaints procedures and therefore Integration Joint Boards will need to establish a complaints procedure in relation to the functions that have been delegated to them. In addition, where the Integration Joint Board has a greater involvement in the operational delivery of services, it may be that a complaint will be made in respect of a direction that the Integration Joint Board has issued. An Integration Joint Board will, therefore, require to operate suitable procedures for handling such complaints.

The Scottish Public Services Ombudsman and their internal unit, the Complaint Standards Agency, have developed a Model Complaints Handling Procedure which seeks to improve complaints handling across Scottish Public Services. The Scottish Public Services Ombudsman Model Complaints Handling Procedure Guidance places an emphasis on 'getting it right first time'. The Scottish Public Services Ombudsman Model Complaints procedure is firmly focused on quicker, simpler and more streamlined complaints handling with local, early resolution by empowered and well trained staff.

The Scottish Government expects Integration Joint Boards to implement a complaints handling procedure that embraces the structure, principles and time scales set out in the Scottish Public Services Ombudsman Model Complaints Handling Procedure Guidance.

The Scottish Government intends to consult on a proposal to add Integration Joint Boards to schedule 2 of the Scottish Public Services Ombudsman Act.

This will have the effect of providing for the Scottish Public Services Ombudsman to investigate actions of the Integration Joint Boards in carrying out its duties, or any service failure attributable to an Integration Joint Board. It cannot, however, investigate the merits of a decision taken within the Integration Joint Board's discretion, unless the established processes have not been followed in making that decision.

It is expected that there will only be a small number of complaints against an Integration Joint Board that can be investigated by the Scottish Public Services Ombudsman – most issues raised about, for example, strategic planning, will likely be about the merits of a decision rather than in relation to carrying out a consultation.

The proposed legislative change, once implemented will allow Integration Joint Boards to fulfil the final independent stage of the Scottish Public Services Ombudsman Model Complaints Handling Procedure.

Section 2: Membership of the Integration Joint Board

2.1 Minimum Membership

The Public Bodies (Joint Working) (Membership and Procedures of Integration Joint Boards) (Scotland) Order 2014 ("the Order") sets out requirements about the membership of an Integration Joint Board. This includes minimum required membership, and provision for additional members to be appointed.

The Integration Joint Board is created as a new legal entity that binds the Health Board and the Local Authority together in a joint arrangement. The membership of an Integration Joint Board reflects equal participation by the Health Board and Local Authority to ensure that there is joint decision making and accountability.

The Local Authority and the Health Board will set out the number of representatives that will sit on the Integration Joint Board within their integration scheme. The Order requires that the Local Authority and Health Board put forward a minimum of three nominees each. This number may be increased by local agreement, but the same number must be nominated by each party. Local Authorities can insist on nominating a maximum of 10% of their full number of Councillors. The Health Board and Local Authority may also agree that they will each nominate a larger number than this.

The Local Authority will nominate Councillors to sit on the Integration Joint Board.

The Health Board will nominate non-executive directors to sit on an Integration Joint Board. Where the Health Board is unable to fill all their places with non-executive directors, they can then nominate other members of the Health Board.

The Integration Joint Board will make decisions about how health and social care services are planned and delivered for the communities within their areas. To do this effectively, they will require professional advice, for example, to ensure that the decisions reflect sound clinical practice. It is also essential that Integration Joint Boards include key stakeholders within the decision making processes to utilise their advice and experience.

To ensure this, the Order sets out a minimum membership, but allows local flexibility to add additional nominations as Integration Joint Boards see fit. In addition to Health Board and Local Authority representatives, the Integration Joint Board membership must also include:

- The Chief Social Work Officer of the constituent Local Authority
- A General Practitioner representative, appointed by the Health Board
- A Secondary Medical care Practitioner representative, employed by the Health Board
- A Nurse representative, employed by the Health Board
- A staff-side representative
- A third sector representative
- A carer representative
- A service user representative
- The Chief Officer of the Integration Joint Board
- The Section 95 Officer of the Integration Joint Board

The Chief Social Work Officer of the Local Authority, Section 95 Officer of the Integration Joint Board and the health professionals will be appointed by the Health Board or the Local Authority because of the role they fulfil. The Chief Officer will be appointed by the Integration Joint Board and will provide a single point of accountability for integrated health and social care services.

The ways in which the members of the Integration Joint Board are to be identified and appointed to the Integration Joint Board will differ. The Integration Joint Board will co-opt the staff-side, third sector, carer and service user representative, and this should be done as soon as practicable once the Integration Joint Board is established. How the Integration Joint Board approaches the appointment of the staff-side, third sector, carer and service user representative members will be dependent on local circumstances, for example, through existing carers networks or the organisations operating within the area of the Integration Joint Board, therefore section **2.4** sets out principles that should be implemented in the identification of members.

Locally, the Integration Joint Board might wish to add additional members, perhaps because they are a key stakeholder locally or because the Integration Joint Board might seek more representation from a particular group. Alternatively, this might occur because the Health Board or Local Authority have included functions out with the minimum scope and they require additional professional advice.

If an Integration Joint Board is established by more than one Local Authority, the Order makes specific provision for how the minimum membership is to be determined.

2.2 Good Practice in the identification and appointment of members of Professional and Stakeholder members

The Order sets out the minimum required membership. All Integration Joint Board members have equal responsibility as Board members and the reference made between professional members and stakeholder members in the following section only reflects the difference in the routes of appointment.

The Order also makes provision for the Integration Joint Board to appoint additional professional and/or stakeholder members, as required.

To ensure that members are able to successfully fulfil the roles they are appointed to, sections **2.3** and **2.4** set out principles that should be implemented in the identification of members.

2.3 Professional Membership

The Order requires a minimum professional membership on the Integration Joint Board as follows:

- Appointment of a GP
- Appointment of a Nurse
- Appointment of a Secondary Care representative
- The Chief Officer of the Integration Joint Board
- The Section 95 Officer of the Integration Joint Board
- The Chief Social Work Officer of the constituent Local Authority

With the exceptions of the Chief Officer, the Section 95 Officer and Chief Social Work Officer, the Order provides some flexibility in the appointment of professional members. However, due to the particular skills and experience required, and the strategic nature of the professional roles on the Integration Joint Board, the Health Board, Local Authority and the Integration Joint Board should follow the principles below to ensure they identify the appropriate members of professional staff to fill these posts:

- The professional members appointed will bring professional experience and knowledge to inform the Integration Joint Board decision making in terms of planning, operational delivery and the effectiveness of major reforms. This advice will ensure the Integration Joint Board can fully take account of safety and quality of care matters. As such, the appointed person must be able to demonstrate the appropriate experience, skills and competencies to fulfil this role. The appointed member must demonstrate their ability to work at a senior level and have experience of operating at a strategic level;

- Professional members should have a named, appointed deputy, able to demonstrate a similar level of skill and experience as the substantive appointment. Deputies should be expected to attend only where absolutely necessary to ensure continuity of advice from the professional.

- The Health Board should ensure the appointed professional members have defined roles that are clearly set out, and held locally. The Health Board and/or Local Authority must ensure that they have time, resource and support to fulfil their responsibilities to the Integration Joint Board for the full term of their appointment.

- As effective strategic planning is key, the Health Board and Local Authority must ensure that the appointed professional members are given specific training and support to contribute effectively to the Integration Joint Board, where such training is required.

The above principles should also be considered when the Integration Joint Board opts to appoint additional professional members. However, in this case the application of each principle will depend on the nature and basis on which these additional members are appointed.

2.4 Appointment of Stakeholder members

In addition to the professional membership, the Order also requires stakeholder members be appointed to the Integration Joint Board as follows:

- A staff side member
- A third sector member
- A carer member
- A service user member

The ways in which stakeholder members will be identified and appointed to these positions on the Integration Joint Board will vary due to the local circumstances of each Integration Joint Board, such as type and number of the representative groups working within their area. Although there will not be a uniform approach in appointment of the stakeholder members, it is important that they are able to appropriately fulfil their roles. The Integration Joint Board should follow the principles set out below:

- Stakeholder members will reflect the views of the groups they represent on the Integration Joint Board; naturally the individuals that comprise these stakeholder groups will be diverse. As such, the appointed person must be able to demonstrate the appropriate experience and skill to reflect the breadth and diversity of views and situations of the individuals or groups that they represent.

- The Integration Joint Board should ensure the appointed member has the resources and support to fulfil their responsibilities to the Integration Joint Board for the full term of their appointment.

- As effective strategic planning is key, the Integration Joint Board must ensure that the appointed stakeholder members are given specific training and support to contribute effectively to the Integration Joint Board, where such training is required.

As with professional members, these principles should also be considered when the Integration Joint Board opts to appoint any additional stakeholder members. The implementation of each principle will depend on the nature and basis on which these additional members are appointed.

2.5 Induction of Members

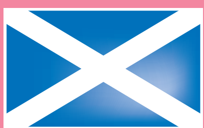
As well as their collective roles in carrying out the responsibilities of the Integration Joint Board, members will have individual roles to carry out to ensure that integrated health and social services are planned and delivered to improve outcomes for the communities they serve. In doing so, Integration Joint Board members must ensure that this is carried out effectively and in line with the integration delivery principles.

Integration Joint Board members will come from a variety of backgrounds. Some members may not have had much/any experience of sitting on the board of a public body. All Integration Joint Board members will require induction training to ensure that they are able to carry out their duties to the highest standard. The training and information requirements will of course vary from member to member, and Integration Joint Boards locally decide how best to organise and operate their induction training requirements.

All members should receive an induction; as a minimum this should cover the member's specific post requirements, roles, responsibilities and policies.

The Scottish Government have produced On Board: A Guide for Board Members of Public Bodies in Scotland which can be used as a standard induction pack covering generic issues such as roles and responsibilities of public bodies, and accountability and governance arrangements to supplement the tailored induction that individual Integration Joint Boards will wish to produce.

The Scottish Government has also produced **Leading the Journey of Integration: A Guide for Organisational Development Leaders** to support the development of Integration Joint Boards. The guide highlights the important roles that are required for the integration of health and social care to be a success. It sets outs key information paired with development exercises which can be used individually or collectively by an Integration Joint Board. The guide can be found on the Adult Health Social Care Integration Implementation Website.



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The Scottish Government
Riaghaltas na h-Alba

Health and Social Care Integration

Public Bodies (Joint Working) (Scotland) Act 2014

Guidance for Integration Financial Assurance

Introduction and Purpose

The purpose of this note is to provide advice to Health Boards, Local Authorities and Integration Joint Boards on a process of assurance to help make Integration a success.

The advice is based on a number of publications and on lessons learnt from the Highland partnership, which partners may find a useful resource and the details are included at the foot of the paper and in the annex.

Assurance and Integration

It has been noted[1] that many of the challenges of public sector mergers stem from the fact that they tend to be externally imposed on the bodies and that Boards/Councils and senior management teams often feel that they are being thrown into a process over which they have little control. This introduces additional risks to the success of the new arrangements and to existing operations during the transition period.

Audit Scotland's June 2012[2] report emphasised a number of lessons that public sector bodies can learn from to minimise these risks, including the importance of strong leadership, effective planning for transition and implementation and assessing performance.

An effective assurance process should enable the host body (whether an Integration Joint Board (IJB) in a corporate body arrangement; or a Health Board or Local Authority in a lead agency arrangement) to identify the resources delegated to it and the financial, legal or organisational risks involved; it should also help the delegating partners to quantify the risks to their respective operations. If planned and implemented in a logical sequence, it should allow the Health Board and Local Authority to maximise the benefits and minimise the risks from integration.

Typically, an assurance process covers three main areas:

- Legal
- Financial
- Operational

The focus of this guidance is on financial assurance, but it is recommended that partners coordinate their activities across the three domains as work in one area can often inform work in another.

A formal process of financial assurance will typically involve an exhaustive review of all relevant documents and records in an effort to assess the resources and risks associated with them. A similar process will be required for integration but it should be possible for partners to avoid some of the work by placing reliance on assurances from each other for their respective delegated resources and on the existing operational and financial knowledge of the shadow chief officer. This will clearly require a high degree of trust between the key officers.

It is recommended that Health Boards and Local Authority Directors of Finance and the shadow Chief Officer and shadow Chief Financial Officer of the IJB foster an assurance process based on mutual trust and confidence involving an open-book approach and an honest sharing and discussion of the assumptions and risks associated with the delegated services.

The assurance process should be proportionate to the potential risks and should cover the whole transition period from pre-integration, implementation and post integration.

Financial Assurance

Integration Joint Boards will be established during 2015/16 and so will not be able to formally participate in the financial assurance process until that point. One of most important items of business for a newly established Integration Joint Board will be to obtain assurance that its resources are adequate to allow it to carry out its functions and to assess the risks associated with this. In order to facilitate this, it is recommended that:

- The shadow Chief Officer and the shadow Chief Finance Officer work with the Health Board and Local Authority Directors of Finance in carrying out the assurance work up to establishment of the Integration Joint Board. Where the shadow Chief Finance Officer has not been identified, the Health Board and Local Authority Directors of Finance should provide advice to the shadow Chief Officer;

- The shadow Integration Joint Board should receive regular reports on the assurance work until the IJB is established and the IJB audit committee (or committee(s) carrying out equivalent function) should receive them thereafter; and

- The Health Board and Local Authority internal auditors provide a report to the Health Board and Local Authority audit committees (copied to the shadow Integration Joint Board) on the assurance process that has been carried out by the Health Board and Local Authority.

The financial assurance process should focus on two main areas: financial governance; and financial assurance and risk assessment for the delegated resources.

1) Financial Governance

The legislation sets out the finance provisions that must be included in the Integration Scheme and the Integrated Resource Advisory Group guidance (IRAG)and the model integration scheme provide further information on these.

The Health Board accountable officer and the Local Authority section 95 officer must ensure that these provisions enable them to discharge their responsibilities in respect of the resources that will be delegated to the Integration Joint Board; similarly, the shadow Chief Finance Officer must ensure that the provisions provide the IJB with the financial information and support systems to enable it to carry out its functions.

2) Financial assurance and risk assessment

In order to assess whether the resources delegated to the Integration Joint Board are adequate for it to carry out its functions, the shadow Chief Officer and shadow Chief Finance Officer must review the provisions in the Integration Scheme that set out the method of determining the

payments and amounts to be made available to the IJB; this should include both the method for setting the initial sums and that to be followed in subsequent years.

Assurance for the Initial sums

It is recommended that the initial sums should be determined on the basis of existing Health Board and Local Authority budgets, actual spend and financial plans for the delegated services. It is important that the plans are tested against recent actual expenditure and that the assumptions used in developing the plans and the associated risks are fully transparent.

To assist in this it is recommended that:

- The budget in the financial plan is assessed against actual expenditure reported in the management accounts for the most recent two/three years. Ideally, the roll forward of the budget for the delegated services and the actual expenditure over this period should be understood;

- Material non-recurrent funding and expenditure budgets for the delegated services and the associated risks are identified and assessed;

- The medium term financial forecast for the delegated services and associated assumptions and risks is reviewed;

- Savings and efficiency targets and any schemes identified are clearly identified and the assumptions and risks are understood by all partners. This is a key part of the assurance process and the experience from Highland partners is that it is a potential source of future disagreement (see annex A); it is advised that partners devote sufficient time to understand the targets, efficiency schemes and associated assumptions and risks;

- All risks should be quantified where possible and measures to mitigate risk identified. Risks could be classified as delivery of efficiency savings; on-going risks; emerging risks;

- The amount set aside for the IJB consumption of large hospital services is consistent with the methods recommended in the IRAG guidance on the set aside resource and that the assumptions and risks are assessed.

Partners should be aware that the financial regimes, cultures and terminology differ between Health Boards and Local Authorities with the potential for confusion when reviewing the budget- particularly in the definition of what represents a recurrently balanced budget. It is recommended that partners are clear about the definitions of the terms used in their assurance work.

In line with normal budget monitoring practice, it is advised that a review be carried out during the post integration period to compare actual performance against the assumptions in the plan.

A key lesson from the experience of Highland partnership is that partners may find it useful to consider treating the first year as a transitional year and agree to a risk sharing arrangement with adjustments being made through subsequent year's allocations; if partners adopt this approach, it is recommended that it is incorporated in the Integration Scheme.

Assurance for subsequent years
It is recommended that the method included in the Integration Scheme for determining the payments to the IJB in subsequent years is consistent with the approach set out in section 4.2 of the IRAG guidance. Similarly, it is recommended that the method included in the Integration Scheme for determining the amount to be set aside in subsequent years for consumption of large hospital services should be assessed against the methods recommended in the separate IRAG guidance on the set aside resource.

Role of the Audit Committees (or committee(s) carrying out equivalent function)

The introduction of integration arrangements and the establishment of the IJB audit committee (or committee(s) carrying out equivalent function) will have implications for the ongoing work of the Health Board and Local Authority audit committees. Advice on this is provided at section B2.6 of the IRAG guidance.

In addition, the audit committees will have an important role to play in the assurance process through assessment of the objectives, risks, and post integration performance results of the IJB.

Pre Integration-shadow period

The Health Board and Local Authority audit committees can help increase the likelihood for success of the new arrangements by verifying that officers have effective assurance processes in place. Preparations for integration may be too far advanced for full involvement of the audit committees in the preparatory stage, but where this is practical, it is recommended that they obtain assurance:

- On the finance provisions to be included in the Integration Scheme;
- On the plans for financial governance and financial assurance and risk;
- That lessons have been learnt from other integration projects (e.g. Highland partnership); and
- That the predetermined financial metrics that officers will use in future to assess whether integration has met its objectives have been identified and that a process for obtaining baseline data is in place.

It is recommended that the audit committees are provided with a report, produced jointly by the Health Board and Local Authority Chief Internal auditors (and copied to the shadow IJB), on the assurance work that has been carried out by the Health Board and Local Authority. This report should be produced sufficiently in advance of the date of delegation of functions and resources (published in the Strategic Plan) to allow for consideration by the audit committees.

The arrangements for obtaining financial assurance should be set out in the Annual Governance Statements of the Health Board, Local Authority and Integration Joint Board for both the year prior to and the year of, delegation of functions and resources.

Implementation

The audit committee of the Integration Joint Board once established (or the committee(s) carrying out an equivalent function) should be provided with the assurance report and should:

- Review the finance provisions to be included in the Integration Scheme to ensure that they enable the IJB to carry out its functions;
- Formally assess whether the resources to be made available to the IJB are adequate for it to deliver its objectives and that the associated risks and assumptions are reasonable and clearly understood;
- That the respective risk management arrangements have been updated to incorporate the risks introduced by integration. See IRAG guidance section B2.2.

Advice for cases where the IJB cannot obtain assurance that its level of resources are adequate will be provided by the policy team in due course.

Post Integration

The post-integration period is a critical stage of the change process and the audit committees (or the committee(s) carrying out an equivalent function) have a key role in assessing whether the objectives of integration are on line to be achieved. It is recommended that the three audit committees (or the committee carrying out equivalent function in the IJB) are provided with a post integration report within the first year of the establishment of the IJB to evaluate the actual risk and financial performance against the pre-integration assumptions, performance on relevant integration milestones, identify lessons learned and assess whether the IJB is on course to deliver the long-term benefits.

The results of the review should be shared with the Scottish Government to enable wider learning.

Role for Internal Audit

It is recommended that the report (on the assurance process carried out by the Health Board and Local Authority) is a joint report by the Chief internal Auditors of the Health Board and Local Authority.

Further Resources

1. Audit Scotland: Learning the lessons of public body mergers. Good practice guide
2. Scott-Moncrieff Briefing: Mix with Care- Mergers in the Public sector
3. Deloiite: The role of the Audit Committee in the merger & Acquisition cycle.
4. Charities Commission: Checklist for due diligence
5. HFMA. Combining NHS bodies. A practical checklist for mergers and acquisitions synopsis

Annex A: Lessons from Highland Partnership

NHS Highland (NHSH) and The Highland Council (THC) established a lead agency arrangement in April 2012, in which adult social care services and resources were delegated to the health board; and children's community health services and resources were delegated to the local authority. The following note summarises the experience of the partners and the main lessons learnt in the first years of the partnership.

General

NHSH and THC did not undertake 'due diligence' in the legal sense. It is important to recognise the fact that the two partners entered into a Partnership Agreement on a high-trust basis with buy-in from all key senior players. The general view expressed was that it would be impossible to remove all the risk from the process of entering into a Lead Agency arrangement and there had to be a balance between understanding the risks and 'just doing it'.

There was exchange of budgetary information in advance of the transfer and meetings with counterparts to understand the composition of the budgets. Clearly, it will always be the case that the 'transferring' organisation will inevitably have a much more detailed understanding of the budgets, pressures, risks etc than the 'receiving' organisation and in our view it is impossible for a transfer to take place without some degree of trust. Probably the key lessons learnt were:

Budgets

- There needs to be a mutual acceptance that the first year must be a transitional year. This allows the 'receiving' organisation to begin to get to grips with the budgets, service pressures etc.

- There needs to be clarity around risk sharing / risk transfer. Whilst this will never cover every scenario it is clear we did not set this out in sufficient detail in Highland. This caused some significant difficulties towards the end of the first year and towards the end of the second year.

- There needs to be clarity about the reporting arrangements and the responsibilities. For example – do we report every month? Every quarter? Do we just report variances or do we present action plans to address these. If so, which organisation takes the decisions around any actions that might be challenging? If there is a significant adverse variance does the 'host' reduce services unless the 'commissioner' provides more funding? Or does the host need to look for savings elsewhere in its portfolio. These scenarios were briefly addressed in the Partnership Agreement but in a fairly simplistic way (with the default being that the two DoFs...and then the two CEOs...should resolve any differences). In effect this is what happened (although it required senior political and senior non-executive input, plus senior operational input as well as the DoFs / CEOs).

- The cultures and terminology differ between the two organisations. In the context of budget setting perhaps the most significant difference is the definition of what represents a recurrently balanced budget.

- The financial regimes differ – most notably the ability of councils to carry reserves / have year-end variances versus the requirement on Health Boards to break-even each and every year. Although this was a known issue right from the start it still led to some misunderstandings

during the first year and perhaps a mutual briefing on respective financial regimes might have been useful.

Efficiency Savings

Very similar issues to the budget issues above. Probably the only additional issue is the degree to which existing efficiency savings programmes already in train are explained / and 'owned' by the organisation delegating the functions. This issue probably gave rise to the most significant disagreement between the two organisations (i.e. the degree to which the savings programme 'inherited' by the other party was understood / owned and deliverable).

Financial Planning

Again – similar issues but in particular there needs to be clarity around the timescales and 'ground rules' for budget setting – particularly in relation to cost pressures and efficiency savings. We found that timelines differed. We also had to take a view as to whether NHSH ought to play into the THC budget setting process in a traditional way (i.e. of submitting pressures and savings plans for agreement or otherwise) or whether we employed more of a 'commissioning' approach where the THC agreed a quantum of funding and NHSH took the decisions as to what savings to make, pressures to fund etc. In practice we began with a model towards the 'commissioning' end of the spectrum but have moved back towards a more traditional approach, with NHSH being represented on the THC senior management team as part of the budget setting process.

Service Planning

In theory this takes place in the Adult Strategic Commissioning Group. However – by definition – this is a high level Group setting high level principles. Therefore, the strategic approach to commissioning is therefore reasonably well defined. Less well defined is operational service planning – for example the extent to which the Council should be involved in redesigns. This brings into play the different governance regimes and in particular the role of local councillors.

Local councillors have a keen interest in Adult Social Care services provided in their locality and will often take up issues with NHSH as the provider. In theory they should take their issues to THC officials (as 'commissioners') in order for them to take up issues with NHSH as provider, but in reality councillors will want a direct line of sight. They will also take a keen interest in any efficiency plans that may affect services in their area. Another difference in governance is the fact that NHS executive directors are full Board members with 'voting rights' whereas council officials can only make recommendations to Council. This is not an issue for the vast majority of business but potentially might be an issue for very significant matters.

Health and Social Care Integration Directorate
Integration and Reshaping Care Division

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Chief Officers of Integration Joint Boards;
NHS Chief Executives (Territorial Boards);
Healthcare Improvement Scotland;
Local Authority Chief Executives;
SOLAR;
SOLACE;
COSLA;
Care Inspectorate;
Scottish Local Government Partnership;
Scottish Public Service Ombudsman.

14 October 2015

Dear Colleagues

Consultation letter

The Public Bodies (Joint Working) (Scotland) Act 2014[1](the Act) puts in place arrangements for integrating health and social care, in order to improve outcomes for patients, service users, carers and their families. Integration Joint Boards will be new public bodies and as such they will not be covered by existing legislation in relation to complaints raised against their duties.

The Scottish Government has issued guidance on the Roles, Responsibilities and Membership of the Integration Joint Board[2]. This details the arrangement and principles by which Integration Joint Boards are currently expected to handle complaints against them.

The Scottish Government however proposes to make an amendment to Schedule 2 of the Scottish Public Services Ombudsman Act 2002 ("the 2002 Act") to add Integration Joint Boards to the 'listed authorities' set out in Schedule 2 of the 2002 Act, which will mean there will be a legal requirement for Integration Joint Boards to establish a complaints procedure. This letter sets out the reasons for the proposal, explains the effect of the changes, and seeks views on the proposal.

<u>Proposed Legislative changes</u>

The Scottish Public Services Ombudsman Act 2002[3] ("the 2002 Act") sets out, among other things, a list of public bodies [and persons] subject to investigation by

[1] The Public Bodies (Joint Working) (Scotland) Act 2014
[2] Roles, Responsibilities and Membership of the Integration Joint Board

the SPSO. Investigation by the SPSO is, in the view of the Scottish Government, an appropriate final independent stage for an IJB complaints procedure. For an IJB to have a complaints procedure which complies with the SPSO model complaints procedure, it is necessary for complaints to be able to be referred to the SPSO.

As new bodies, Integration Joint Boards do not currently appear on the list of bodies, set out in Schedule 2 of the 2002 Act, which may be investigated by the SPSO. The Scottish Government are proposing to make an Order in Council under section 3(2) [4]of the 2002 Act to amend this list. Adding Integration Joint Boards to Schedule 2 to the 2002 Act provides for the SPSO to have the investigatory powers set out in section 5(1)[5] of the 2002 Act, subject to the restriction in section 7[6].

Effect of the proposed legislative changes

The above changes will have the effect of providing for the SPSO to investigate actions of the Integration Joint Boards in carrying out its duties, or any service failure attributable to an Integration Joint Board. The SPSO cannot, however, investigate the merits of a decision taken within the Integration Joint Board's discretion, unless there has been maladministration in the taking of that decision.

Within these limitations it is expected that there will only be a small number of complaints against an Integration Joint Board that can be investigated by the SPSO – most issues raised about, for example, strategic planning, will likely be about the merits of a decision rather than in relation to carrying out a consultation.

Additionally, including Integration Joint Boards in Schedule 2 would also place a legal requirement on Integration Joint Boards to have a complaints handling procedure in place for complaint in relation to their duties (as required by section 16A (2)(a) of the
2002 Act). Currently there is no such legal requirement for Integration Joint Boards. The complaints procedure will also have to comply with the SPSO's principles on complaints handling procedures.

Views

We are taking this opportunity to invite comments on the proposal to add Integration Joint Boards to the list of the bodies set out in Schedule 2 of Scottish Public Services Ombudsman Act 2002 which will mean there will be a legal requirement for Integration Joint Boards to establish a complaints procedure.

You are asked to indicate whether or not you support the proposed amendment to the Scottish Public Services Ombudsman Act 2002 and the inclusion of Integration Joint Boards in the list of bodies set out in Schedule 2. If you do not support the proposals we would ask you to provide details outlining your concerns about the proposed amendment.

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[3] The Scottish Public Services Ombudsman Act 2002
[4] Section 3 and schedule 2 – Persons liable to investigation.
[5] Matters which may be investigated
[6] Matters which may be investigated: restrictions

A full list of those who have been invited to respond has been set out at **Annex A**

I would be grateful if you could send your response, using the template provided at **Annex B** to the following e-mail address IRC@scotland.gsi.gov.uk **by 12 November 2015.**

If you have any queries in relation to this letter please contact me via e-mail brian.nisbet@gov.scot or on 0131 244 3588.

Yours sincerely

Brian Nisbet
Integration and Reshaping Care Division

Annex A List of invited respondents

1. East Ayrshire Integration Joint Board
2. North Ayrshire Integration Joint Board
3. South Ayrshire Integration Joint Board
4. Argyll and Bute Integration Joint Board
5. East Dunbartonshire Integration Joint Board
6. East Lothian Integration Joint Board
7. East Renfrewshire Integration Joint Board
8. Edinburgh City Integration Joint Board
9. Inverclyde Integration Joint Board
10. Midlothian Integration Joint Board
11. North Lanarkshire Integration Joint Board
12. Renfrewshire Integration Joint Board
13. Shetland Islands Integration Joint Board
14. West Dunbartonshire Integration Joint Board
15. South Lanarkshire Integration Joint Board
16. West Lothian Integration Joint Board
17. Perth and Kinross Integration Joint Board
18. Dundee City Integration Joint Board
19. Angus Integration Joint Board
20. Dumfries and Galloway Integration Joint Board
21. Fife Integration Joint Board
22. Clackmannanshire and Stirling Integration Joint Board
23. Falkirk Integration Joint Board
24. Western Isles Integration Joint Board
25. Glasgow Shadow Integration Joint Board
26. Orkney Shadow Integration Joint Board
27. Scottish Borders Shadow Integration Joint Board
28. Moray Shadow Integration Joint Board
29. Aberdeen City Shadow Integration Joint Board
30. Aberdeenshire Shadow Integration Joint Board
31. NHS Ayrshire and Arran
32. NHS Borders
33. NHS Dumfries and Galloway
34. NHS Fife
35. NHS Forth Valley
36. NHS Grampian
37. NHS Highland
38. NHS Greater Glasgow and Clyde
39. NHS Lanarkshire
40. NHS Lothian
41. NHS Orkney
42. NHS Tayside
43. NHS Shetland
44. NHS Western Isles
45. Aberdeen City Council
46. Aberdeenshire Council
47. Angus Council
48. Argyll and Bute Council
49. City of Edinburgh Council
50. Clackmannanshire Council
51. Comhairle nan Eilean Siar
52. Dumfries and Galloway Council
53. Dundee City Council
54. East Ayrshire Council
55. East Dunbartonshire Council
56. East Lothian Council
57. East Renfrewshire Council
58. Falkirk Council
59. Fife Council
60. Glasgow City Council
61. Highland Council
62. Inverclyde Council
63. Midlothian Council
64. Moray Council
65. North Ayrshire Council
66. North Lanarkshire Council
67. Orkney Islands Council
68. Perth and Kinross Council
69. Renfrewshire Council
70. Scottish Borders Council
71. Shetland Islands Council
72. South Ayrshire Council
73. South Lanarkshire Council
74. Stirling Council
75. SOLAR
76. SOLACE
77. COSLA
78. Care Inspectorate
79. Healthcare Improvement Scotland
80. Scottish Local Government Partnership
81. Scottish Public service Ombudsman

Annex B – Consultation Response

Name:

Organisation:

Position:

Question 1: Do you support the proposal to add Integration Joint Boards to the list of the bodies set out in Schedule 2 of Scottish Public Services Ombudsman Act 2002 which will mean there will be a legal requirement for Integration Joint Boards to establish a complaints procedure.?

Please place an X in one of the boxes below to indicate your views on the proposal.

Yes		**No**	

Question 2: If you do not support the proposed amendment, please outline the reasons for this below.

INVERCLYDE
HSCP
Health and Social Care Partnership

AGENDA ITEM NO: 8

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10th November 2015**
Report By:	**Brian Moore** **Chief Officer** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/15/2015/HW**
Contact Officer:	**Helen Watson** **Head of Planning, Health Improvement & Commissioning**	**Contact No:**	**01475 715285**
Subject:	**UPDATE ON PLANS FOR REPLACEMENT GREENOCK HEALTH CENTRE**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board on the progress of the new Greenock Health and Care Centre.

2.0 SUMMARY

2.1 NHSGGC invited a number of partnerships to carry out a Feasibility Study in August 2014, in anticipation that funding would be available to build a new health centre within the Greater Glasgow & Clyde area. The Greenock Health Centre submission was approved at the NHS Board's Quality and Performance meeting in January 2015 and it was agreed that this would go forward for a replacement Health Centre. Following this approval and the announcement by the Scottish Government to fund a new-build, a Project Board and Delivery Group were formed and an initial project plan developed. The membership of these groups includes a number of service, community and staff side representatives.

2.2 To date the HSCP has held four engagement workshops. The first was an AEDET Workshop (Achieving Excellence Design Evaluation Toolkit), and was delivered by Health Facilities Scotland looking at the quality of the existing health centre along with the access, the staff and patient environment as well as the space available. Following on from this, two Design Workshops were delivered by Architecture and Design Scotland which had representation from staff and community, looking at what the design of the facility must enable. This workshop also focused on the look and feel of the new build, the arrival area and the entrance space. The workshop allowed staff and community representatives to engage with the planning and design stage of the new development and influence what success might look like for a new health and care centre. The fourth was a Site Options Appraisal Workshop, and had representatives from key partners and community groups and was held in the Beacon Arts Centre. This had independent facilitation and also a presentation by the appointed architects regarding the potential sites. The workshop enabled the participants to express their preferences based on identified criteria.

2.3 An Initial Agreement has been developed, outlining the improvements that are envisaged through the development of a new health centre facility, and this will be submitted to the NHS Board for approval prior to formally submitting it to the Scottish Government. It had been

hoped that this would be the October 2015 NHS Board meeting, however a technical issue around procurement procedures and European Union requirements has stalled the process. We await resolution by the Scottish Government before submitting our Initial Agreement for formal approval.

Other public sector projects have been delayed across the whole of Scotland whilst a solution to the ESA 10 issue is sought.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the progress to date.

Brian Moore
Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

4.1 NHSGGC invited a number of partnerships to carry out a Feasibility Study in August 2014, in anticipation that funding would be available to build a new health centre within the Greater Glasgow & Clyde area. The Greenock Health Centre submission was approved at the NHS Board's Quality and Performance meeting in January 2015 and that this would go forward for a replacement Health Centre. Following this approval and the announcement by the Scottish Government to fund a new-build, a Project Board and Delivery Group were formed and an initial project plan developed. The Project Board assessed that the current Health Centre building is no longer fit for purpose and cannot service the population to best effect due to constraints of space, poor condition of the estate and lack of flexibility in how the existing building is able to be used. In assessing the options, the Project Board considered refurbishment and expansion, but the location, design and land footprint mean that this was not a feasible option. In considering improved ways of working to deliver better outcomes, premises are an important factor, and the most economical and sustainable option to emerge from the assessment was for a new-build facility.

4.2 NHSGGC's purpose, as set out in the Board's Corporate Plan 2013-2016 is to "Deliver effective and high quality services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health in equalities." This is entirely in line with NHSScotland's strategic priorities, particularly in relation to the 2020 Vision and Quality Strategy. From the HSCP perspective, our planning is underpinned by the five strategic themes.

- Early intervention and preventing ill-health
- Shifting the balance of care
- Reshaping care for older people
- Improving quality, efficiency and effectiveness
- Tackling inequalities

4.3 In scoping the options, the Project Board has considered that the future model of service provision needs to be delivered from premises that are fit for purpose. The premises need to support the level of integrated working required to make a more positive impact on reducing unequal health outcomes and supporting self-management, particularly in regard to multi-morbidities. The current facilities have been assessed as not meeting the basic needs, so the "Do Nothing" option is not viable. The poor repair and ongoing maintenance of the building mean that from a repairs perspective it is "money hungry". There is a current maintenance backlog of £933k which will only grow in the future. The preferred solution is a new-build facility, to be delivered within an overall funding envelope of £19M.

4.4 The proposal for a new Greenock Health Centre is therefore vitally important in terms of tackling health inequalities, promoting supported self-management, fostering the principles of multi-disciplinary anticipatory approaches and maximising effectiveness in how the HSCP works with colleagues in the Acute Sector. It will also contribute to local economic generation and the wider Council and Community Planning Partnership objectives of improving population health and valuing citizens by providing modern, well-equipped public spaces and buildings.

4.5 In considering new ways of working we have considered who is affected by our proposal and worked to engage their views at an early stage. We have also

considered how our objectives align with and help to deliver the wider strategic NHS priorities, both at national and NHSGGC levels (section 3.2). Finally, we have taken account of the key external factors that influence or are influenced by our proposal.

4.6 NHSScotland's strategic investment priorities are aligned to the Quality Strategy as:

- Person centred.
- Safe
- Effective quality of care.
- Health of population.
- Value and sustainability.

These themes and priorities directly reflect the vision and values of the HSCP and its ambitions to deliver a healthier future for Greenock and Inverclyde through improved working practice and better integration, both across health services and between health, social care, Community Planning and the local voluntary and Independent sectors.

The HSCP is committed to deliver these priorities by retaining a focus on the five themes above, the Inverclyde Single Outcome Agreement objectives, and the nine national outcomes noted below.

- Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.
- Outcome 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.
- Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Outcome 5: Health and Social Care services contribute to reducing health inequalities.
- Outcome 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.
- Outcome 7: People using health and social care services are safe from harm.
- Outcome 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.
- Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications: NHSGGC is leading on this project and will hold the budget. The HSCP will work within the constraints of that budget.

One off Costs

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

Annually Recurring Costs/ (Savings)

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

LEGAL

5.2 The ESA10 issue needs to be resolved however this will be managed by the NHS Board via the Scottish Government.

HUMAN RESOURCES

5.3 There are no human resources issues within this report.

EQUALITIES

5.4 Tackling inequalities is one of the key drivers in our proposed operating model, so we anticipate a positive impact for those groups that experience a more negative experience of care and outcomes.

Has an Equality Impact Assessment been carried out?

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

6.0 CONSULTATION

6.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation as noted within the body of the report.

7.0 LIST OF BACKGROUND PAPERS

7.1 N/A.

INVERCLYDE
HSCP
Health and Social Care Partnership

AGENDA ITEM NO: 9

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10th November 2015**
Report By:	**Brian Moore** **Chief Officer** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/16/2015/HW**
Contact Officer:	**Helen Watson** **Head of Planning, Health Improvement and Commissioning.**	**Contact No:**	**01475 715285**
Subject:	**COMMUNICATION FRAMEWORK**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board of the Communication Framework designed to deliver key messages about the purpose and activity of the Integration Joint Board and Health and Social Care Partnership to staff, partners and the general public.

2.0 SUMMARY

2.1 The aim of the framework is to highlight how we will deliver key messages to all stakeholders including staff, service users and families, partner agencies and the general community.

2.2 The report sets out the key objectives of the framework, which refers to the various methods we will use in communicating with our staff and stakeholders

2.3 In addition the framework outlines the route for approval prior to issuing each Integration Joint Board communication.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board approves the Communication Framework.

Brian Moore
Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

4.1 **Aim of the Framework**

The aim of the Communication Framework is to make everyone with an interest in the Health and Social Care Partnership more aware of the purpose and activities of the organisation. It is important that staff working within the organisation: providers of services commissioned by the organisation; users of the organisation's services and their families, as well as members of the wider community and local partner organisations are receiving our messages in the way we intend to deliver them. It is also important that these key messages are conveyed simultaneously to all of our partners and stakeholders and that they know where to access these communications. This approach will help towards building the profile of an inclusive and inviting organisation committed to enabling partners to participate in its future development and towards its overarching aim of improving the lives of Inverclyde people.

4.2 **Context**

National

In line with Scottish Government policy, Health and Social Care services across the country are now developing integrated services to individuals requiring support, based on their own needs and preferred outcomes. Inverclyde has had integrated services since 2010, so we are building on these arrangements rather than creating new ones.

4.3 **Local**

Inverclyde Integration Joint Board has voting and non-voting members representing the parent bodies, Inverclyde Council and NHS Greater Glasgow and Clyde; service users and carers, and the independent and voluntary sector providers. In order to ensure that all partners and stakeholders are aware and kept informed of the business of the HSCP, it is vital that we establish a communications approach to ensure that we convey key messages to all of our partners about current developments in a clear, consistent and agreed way.

4.4 **Objectives of the Communication Framework**

- We have a robust and effective system in place for communications both internally and externally.
- Staff and other stakeholders have access to the same information and are kept informed of developments at the same time.
- Staff, service users and carers feel valued and connected with the organisation and feel they can contribute ideas.
- Staff, service users and carers feel better informed and engaged.
- We aim to create a more open and better understanding in the wider community of what we do as an organisation.
- We are able to showcase good practice and give information on how we are performing.

4.5 **Methods of Communication** (Target audiences and Approval routes)

The table below outlines the various proposed forms of communication, and who the target audience is likely to be, including the route for approval and processing communications. The table makes reference to "Corporate Communications". By this we mean the Council and NHS Greater Glasgow & Clyde Corporate Communications Teams, and we will be required to develop a Service Level Agreement between these teams and the IJB. In the interests of openness, IJB papers will be released to the public in advance of each IJB meeting, and we will consider press releases after each IJB.

Who	Audience	Method	Approved by	Delivered by
Integration Joint Board Members	General Public	Press Statement	Chair/Vice Chair	Corporate Communications
		Annual Report/ Newsletter	IJB	HSCP Communications Group
HSCP internal	Staff	Weekly Bulletin/ Newsflash emails	Service Managers and above	HSCP Communications Group
		Council-ICON NHS-Staffnet	Service Managers and above	Corporate/HSCP Communications
		Team /Chief Officer's Brief	Content agreed by Head of Service and above	HSCP Communications Group
		Events Calendar	Website Editors	Website Editors
HSCP external	Service Providers	Providers Forum	Service Manager and above	Quality and Development Service
	General Public	Website	Service Managers and above	Website Editors
		Display Screens	Service Managers and above	HSCP Communications Group
		Press Statement	Approved by Chief Officer	HSCP Communications Group
		Social Media	Service Managers and above	HSCP Communications Group

4.6 We will continue to identify additional and innovative ways of communicating with all our stakeholders. The role of the HSCP Communications Group, which draws together representatives from across the organisation is to ensure that we are constantly updating and improving our methods of communication and engaging with staff, as well as, the general public and other parties. In addition we need to ensure that our communication is as effective as it can be and ensure that monitoring and evaluation is built into our action plan.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications: There are no additional costs associated with this report.

One off Costs

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

Annually Recurring Costs/ (Savings)

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

LEGAL

5.2 There are no legal issues within this report.

HUMAN RESOURCES

5.3 There are no human resources issues within this report.

EQUALITIES

5.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

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

6.0 CONSULTATION

6.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with the Council's Corporate Communications Team.

7.0 LIST OF BACKGROUND PAPERS

7.1 N/A.

INVERCLYDE
HSCP
Health and Social Care Partnership

AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10th November 2015**
Report By:	**Brian Moore Chief Officer Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/20/2015/BC**
Contact Officer:	**Beth Culshaw Head of Health and Community Care**	**Contact No:**	**01475 715283**
Subject:	**Delayed Discharge Performance and Winter Planning 2015/16**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board on performance towards achieving the target for Delayed Discharge and arrangements for co-ordinated winter planning in Inverclyde.

2.0 SUMMARY

2.1 The Delayed Discharge target reduced from 4 weeks to 2 weeks on 1 April 2015, reflecting the ongoing strategic commitment to Shifting the Balance of Care.

2.2 It has been agreed through the NHS GG&C whole system planning group that each HSCP will produce an operational plan with a particular focus on the winter period, complementing the Acute Plan, in recognition of the correlations between winter activity and service pressures.

3.0 RECOMMENDATIONS

3.1 Members are asked to note the progress towards achieving the target, including the Winter Plan, and the ongoing work to maintain performance.

Brian Moore
Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

4.1 From April 2015 the target for Delayed Discharge, which had been in place since 2013, decreased from 4 weeks to 2 weeks. NHS Greater Glasgow and Clyde has also reported on the number of bed days lost due to Delayed Discharges, as this provides a more complete picture of the impact of hospital delays.

4.2 There is a proposal for a new target to discharge a higher proportion of patients within 72 hours of being ready for discharge. We have therefore started to measure the number of patients discharged within 72 hours of being ready. This data will be reported on in future reports alongside the associated bed days lost

5.0 PERFORMANCE

5.1 We continue to maintain positive performance in relation to the 14 day Delayed Discharge target.

We have consistently achieved zero delays of more than 4 weeks since February 2015 and zero delays over 2 weeks since April 2015 (Appendix A, Chart 3). In October the census data showed that we again had zero service users staying longer than 14 days with 4 service users who were medically fit awaiting support packages to be arranged.

There is an increase in bed days lost for patients under 65 which reflects 2 adults who are currently in a Learning Disability Continuing Care bed facility (i.e., not an acute hospital facility), waiting for support packages and suitable safe accommodation to be arranged. These individuals have complex and changing needs and will take longer than the 14 day target to establish a support plan with accommodation to meet their needs as these facilities do not currently exist. The number of bed days has increased though the HSCP are currently negotiating as to whether they are exempt from the Delayed Discharge targets.

The overall performance indicates positive outcomes for service users who are returning home or moving on to appropriate care settings earlier and spending less time inappropriately in hospital.

5.2 The trend in the number of service users experiencing a delay in discharge from hospital is illustrated below.

Table 1

2015	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
No. of Individual delays	23	18	16	19	14	16	20	23	24

This performance is set against a background of increasing referrals for social care and community supports following discharge (Appendix A, Chart 1). During September 2015, 135 individuals were referred for social care support of which 37 people required a single shared assessment indicating complex support needs. A total of 24 individuals were identified as being delayed following the decision they were medically fit for discharge.

5.3 Work with colleagues at Inverclyde Royal Hospital continues to demonstrate the effectiveness of early commencement of assessments regarding future care needs in achieving an appropriate, timely and safe discharge. The result is that the majority of individuals are assessed and discharged home as soon as they are deemed

medically fit for discharge, including those requiring a home care package and residential care placement.

6.0 STEP UP BEDS (INTERMEDIATE CARE)

6.1 In order to meet the increasing demand on services related to a complex ageing population, we continue to develop new services and increase capacity within existing services. Whilst we are confident in the arrangements to facilitate discharge, we continue to see an overall rise in unplanned admissions and it remains extremely challenging to consistently reduce the level of delayed discharges and lost bed days associated with these admissions.

6.2 From late summer and early autumn each year we begin to see an increase in admissions which continues over the winter period resulting in an increase in inpatient bed days. Evidence suggests that the longer an older person's length of stay, there is an increased likelihood of deterioration in their ability and independence. This impacts on the chances of successfully returning to live in their own home and increases the risk of hospital acquired infection.

6.3 The HSCP are currently developing the provision of Step Up beds located within the care home sector in Inverclyde. The service will be within a residential care setting with rehabilitation and enablement support provided by HSCP staff. This partnership approach may require a tender process to establish a service for 12 months with an option for a further period if the initiative proves successful.

The intention is to fund this service through existing budgets and use of the Integrated Care Fund to specifically allow recruitment of key staff such as a physiotherapist and an occupational therapist.

The ability to provide an alternative such as Step Up beds during the peak winter period should not only reduce unnecessary admissions but contribute to better outcomes for individuals.

7.0 WINTER PLANNING 2015/16

7.1 It has been agreed through the NHS GG&C whole system planning group that each HSCP will produce an operational plan with a particular focus on the winter period. The Winter Plan addresses 12 key themes set out in the Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20), and the 6 Essential Actions.

7.2 The Winter Plan (Appendix 2) identifies and addresses the local issues across primary care and community services for which Inverclyde Health and Social Care Partnership is responsible. The plan will closely complement the Acute Winter Plan and will support NHS GG&C whole system planning.

7.3 The Winter Plan will also complement and feed into Inverclyde Council contingency planning with particular reference to the 'Planning for Winter' initiative.

7.4 The primary focus of our Winter Plan is to ensure that people avoid admission to hospital wherever possible and have as speedy a journey through secondary care as possible should an admission be unavoidable.

7.5 A Winter Planning Operational Group has been established and includes representation from each relevant HSCP service. The group will meet weekly throughout the winter period. (November 2015 – January 2016) and will use local performance data to plan responses to extra pressure on the system as they arise.

This group will link closely to the Strategic Discharge Planning Group to ensure effective response across the partners building on the current work around the Home First Strategic Action Plan.

7.6 A rolling action log will be maintained and reported weekly to the Chief Officer and Head of Health and Community Care. These actions include:

- Safe and effective admission/discharge continues in the lead up to and over the festive period and also into January.
- Workforce capacity plans and rotas for the winter/festive period are agreed in October 2015.
- Facilitation of discharge at weekends and bank holidays.
- Delivering seasonal flu vaccination to public and staff.
- Communication plans.
- Effective analysis to plan for and monitor winter capacity, activity, pressures and performance.

A report analysing the activity, performance and pressures during the winter will be provided to the IJB at the end of the winter period.

8.0 PROPOSALS

8.1 Partnership working across the HSCP and Inverclyde Royal Hospital has focussed on improving our discharge processes and is informed by the Joint Improvement Team *'Home First'* document.

8.2 We continue to utilise and update our Home First Strategic Action Plan, monitored at a monthly Strategic Discharge meeting attended by senior managers of the HSCP and Inverclyde Royal Hospital. This plan will inform the specific actions identified in the Winter Plan.

8.3 There is a continued focus to develop integrated and joint improvements to continually improve the hospital journey and discharge processes.

8.4 We will continue to develop our performance monitoring with an emphasis on the hospital discharge pathway and in particular the outcomes for service users, their families and carers.

8.5 We will work with partners in the care home sector to establish a residential Step Up facility in Inverclyde. The service will focus on avoiding unnecessary hospital admissions and support service users to return to their own home.

9.0 IMPLICATIONS

Finance

9.1 There are no specific financial implications from this report. All activity will be contained within existing budgets.

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

9.2 None.

Human Resources

9.3 There are no Human Resource implications at this time.

Equalities

9.4 Has an Equality Impact Assessment been carried out?

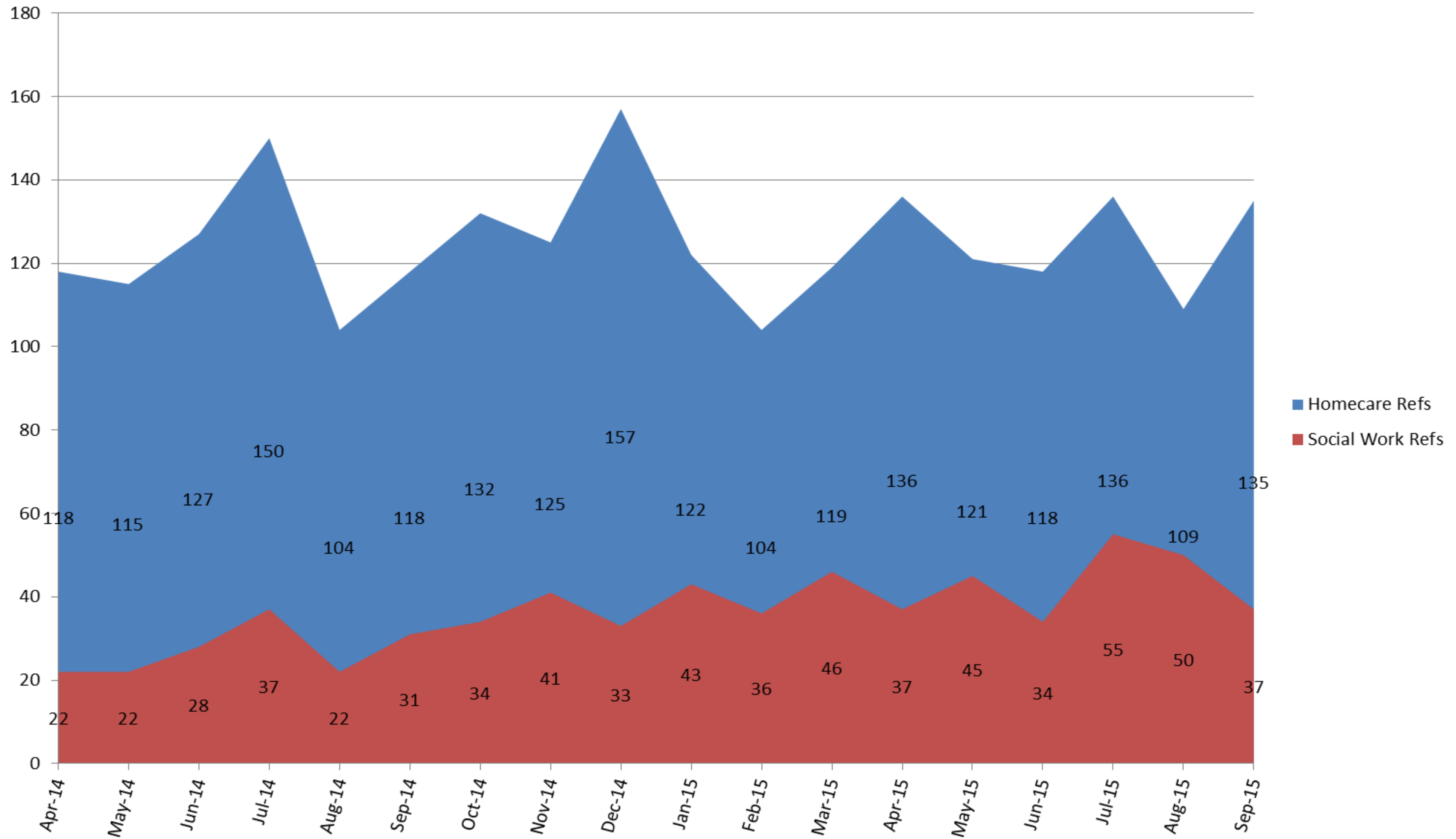
	YES (see attached appendix)
√	NO -

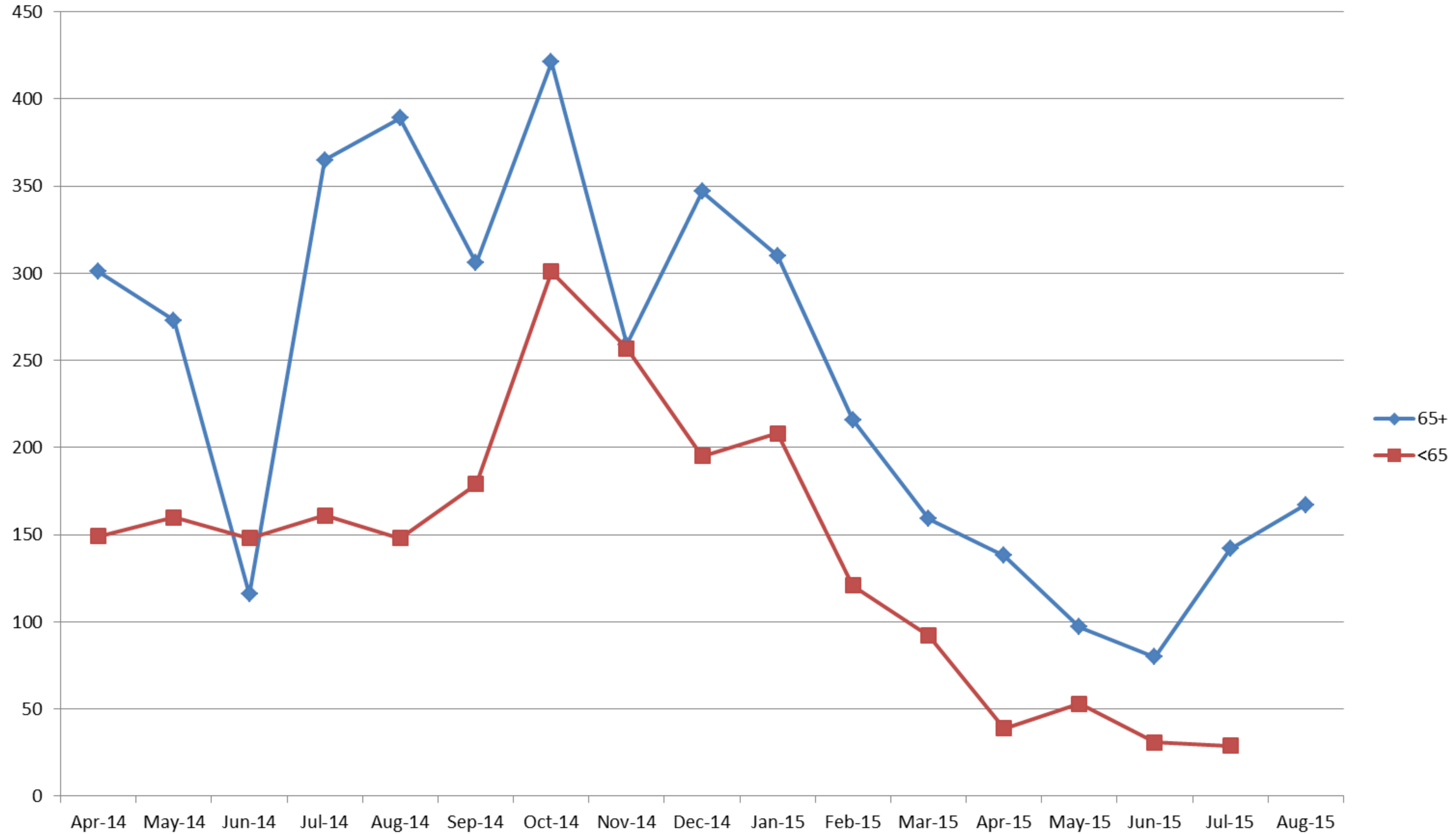
10.0 CONSULTATIONS

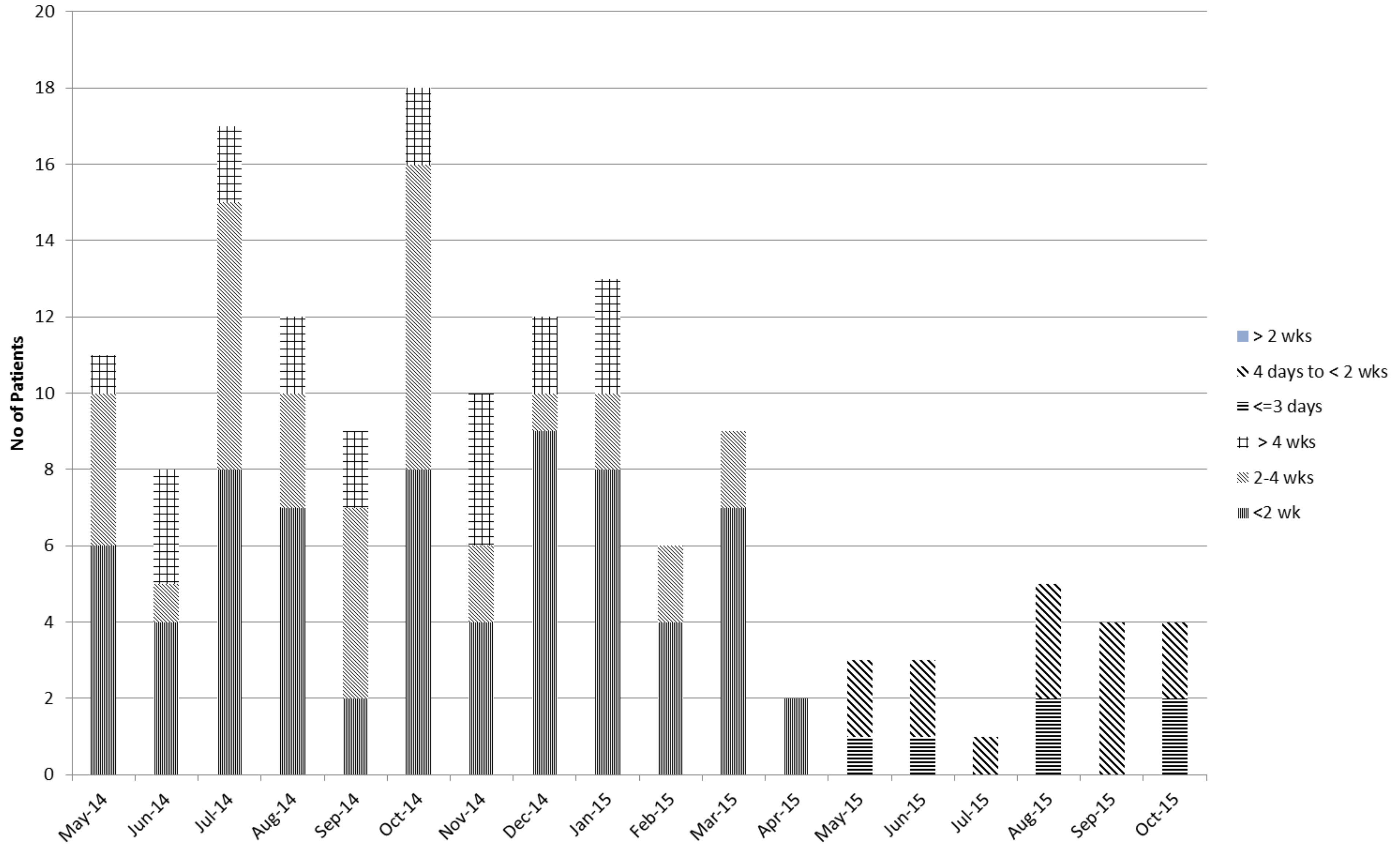
10.1 The Inverclyde Delayed Discharge Plan is jointly developed alongside our partners in NHS Greater Glasgow and Clyde.

11.0 LIST OF BACKGROUND PAPERS

11.1 Inverclyde HSCP Winter Plan 2015/16.


IRH Discharge Team - Referrals
180
160
140
120
100
80
60
40
20
0
Homecare Refs
Social Work Refs
118 115 127 150 104 118 132 125 157 122 104 119 136 121 118 136 109 135
22 22 28 37 22 31 34 41 33 43 36 46 37 45 34 55 50 37
Apr-14 May-14 Jun-14 Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15


Bed Days Lost to Delayed Discharges by Age Group
450
400
350
300
250
200
150
100
50
0
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
65+
<65
Awiting ISD Bed Days Lost Data for Aug and Sep 15 (Due end of Oct 15)



Delayed Discharges at Census
No of Patients
20
18
16
14
12
10
8
6
4
2
0
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
> 2 wks
4 days to < 2 wks
<=3 days
> 4 wks
2-4 wks
<2 wk

Inverclyde
Health & Social Care Partnership

Draft Winter Plan

2015/16

Version 5
16.10.15

(Author: Derrick Pearce, Service Manager Quality and Development and Alan Brown, Service Manager Assessment and Care Manager)

1. Introduction

Health and Social Care Partnerships have a critical role in the wider service system which enables the delivery of effective unscheduled care. It has been agreed through the NHSGG&C whole system planning group that each HSCP will produce an operational unscheduled care plan with a particular focus on the winter period.

These plans will cover:

- The community service aspects of the 6 essential actions (Appendix 1)
- Delayed discharge
- Measures to reduce admissions and attendances
- Delivery of key service features including single point of access, Care Home support and Anticipatory Care
- Continuity and resilience
- Developing an agreed set of indicators to monitor performance
- Planning with GPs for the two long bank holidays

This Winter Plan identifies and addresses the local issues across the primary care and community services for which Inverclyde Health and Social Care Partnership is responsible, to support the NHSGG&C whole system planning as detailed above.

2. Winter Planning Arrangements

A Winter Planning Operational Group has been established and meetings have been arranged to take place on a weekly basis. The purpose of the group is to discuss the development and subsequent delivery of the Winter Plan and identify any issues that require to be addressed, or escalated, to enable appropriate actions to be put in place. This will help to ensure that service users receive safe, person centred, effective care to minimise unscheduled hospital admissions and reduce delays in discharges throughout the winter, and in particular, the festive period.

The membership of this group is as follows:

- Service Manager – Assessment and Care Management **(Chair)**
- Service Manager - Older People **(Vice Chair)**
- Senior Nurse - Adult Community Nursing
- Programme Manager – Integrated Care
- Project Manager – Primary Care
- Service Manager – Quality and Development

In addition to our Winter Planning Operation Group we will make use of our already established local Operational Hospital Discharge Group and Strategic Discharge Group which meet on a weekly and fortnightly basis respectively, involving staff from across community, primary and secondary care, to harness collective resources to manage demand and capacity.

3. Key Themes

The local planning arrangements are described under the twelve key themes set out in the Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20).

In addition, the planning arrangements described have integrated the relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance* (Appendix1).

The 12 Key Themes are:

1. Safe and effective admission/ discharge continues in the lead up-to and over the festive period and also into January
2. Workforce capacity plans and rotas for winter/festive period are agreed in October 2015
3. Whole system activity plans for winter: post-festive surge/ respiratory pathway
4. Strategies for additional winter beds and surge capacity
5. The risk of patients being delayed on their pathway is minimised
6. Discharge at weekends and bank holidays
7. Escalation plans tested with partners
8. Business continuity plans tested with partners
9. Preparing effectively for norovirus
10. Delivering seasonal flu vaccination to public and staff
11. Communication plans
12. Effective analysis to plan for an monitor winter capacity, activity, pressures and performance

Key headlines relating our areas of action are as follows:

From late summer/autumn each year we begin to see an increase in admissions over the winder period and associated increased in bed days used. Once admitted to hospital, the longer the older persons length of stay becomes, the more likely the deterioration in their ability and independence. This impacts on the chances of their ability to return to live independently and increases the risk of hospital acquired infection. **The primary focus of our winter plan, therefore, is to <u>ensure that people avoid admission to hospital</u> wherever possible and have <u>as speedy a journey through secondary care as possible</u> should an admission be unavoidable.**

i. Safe and effective admission/ discharge continues in the lead up-to and over the festive period and also into January

- We have developed a *Home First Strategic Discharge Action Plan* for our area which facilitates partnership working across primary and secondary care. We use our *Home First Strategic Discharge Action Plan* at each Operational and Strategic Hospital Discharge Group to drive joint action in relation to improved hospital discharge
- Ongoing close joint working with colleagues in Inverclyde Royal Hospital (IRH), including making good use of the 'Huddle' model, continues to demonstrate the effectiveness of early commencement of assessment regarding future care needs in achieving an appropriate, timely and safe

discharge. The result is that the majority of individuals are assessed and discharged home as soon as they are deemed medically fit for discharge, including those requiring home care packages or a residential care placement.

- We are building on work we are already undertaking linked to the Inverclyde Interface Working Pilot from 2014/15. We intend to link work-streams related to High Resource Initials (HRI), demand and capacity data analysis and intervention space analysis to augment our intelligence across the winter period, and crucially in the post-festive surge which is anticipated. We know that making best use of our the data we have and lessons we have learned will provide richer intelligence about how our local population access and make use of services across the system, meaning we can be more tactical in our approach to managing this.
- Our focus on modernisation and continuous improvement is a core factor in our winter planning, and planning for joint actions related in unscheduled care generally. In order to meet the increasing demand on services related to the aging population, particularly, we have continued to develop new services and increase capacity with existing services. Despite this we do continue to see an overall rise in unplanned admissions to hospital. It remains extremely challenging to consistently reduce the level of delayed discharged and lost bed days which these admissions.
- We continue to progress integrated actions to improve the secondary care journey, transitions across branches of the system, and specifically the hospital discharge process.
- We are actively exploring the potential for staff in A&E to have access to SWIFT (the social work client management database used in Inverclyde). This would allow for real time access to information about the person's current community supports and packages of care and inform decisions around admission. Linked to this we are progressing the development of access to the clinical portal for relevant teams to aid communication and information sharing, alongside data linking programmes with the LIST team from ISD
- We are building on the recent redesign of the hospital discharge social work team inform a review of nursing input to hospital discharge.

ii. ***Workforce capacity plans & rotas for winter / festive period agreed by October***

- Service leads will be responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity during the festive period, and immediately following the four day holiday periods This will be confirmed by an assurance memo in October
- We are actively scoping the range of nursing/medical interventions in the community to ensure arrangements are fit for purpose and aligned well to support admission avoidance.

iii. ***Whole system activity plans for winter: post-festive surge.***

- The HSCP will contribute to the whole system activity planning and ensure representation at winter planning groups.
- The Chief Officer links with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.

iv. ***Strategies for additional winter beds and surge capacity.***

- The HSCP will respond where possible to support acute services in managing surge capacity. HSCP Assessment and Care Management will provide a reduced staff rota the week between the public holidays with a minimum of two staff on duty to support surge activity. Additional capacity to respond to particular increases in service demand can be resourced from the wider local social work teams if required.

v. ***The risk of patients being delayed on their pathway is minimised.***

- Anticipatory structures have been supported to ensure that potential areas of need, particularly in respect of the adults with incapacity (AWI) are best met and AWI delays minimised.

vi. ***Discharges at weekend & bank holiday.***

- The Adult Community Nursing service and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.

vii. ***Escalation plans tested with partners.***

- Escalation plans will be prepared and shared across services to ensure a whole system approach to implementing actions that minimise potential issues.
- The establishment of an early alert system will be explored to enable GP practices to highlight unexpected increases in demand for appointments.
- The Hospital Discharge team will provide a reduced staff rota the week between the public holidays where a minimum of 50% staff are on duty. Additional capacity to respond to particular increases in service demand can be resourced from other social work teams if required.

- Commissioned services have contingency arrangements in place and link between the HSCP commissioners and strategic commissioning team, and providers to share information and identify any issues that require to be escalated will be utilised.

viii. Business continuity plans tested with partners.

- Business Continuity Plans (BCP) for the HSCP are in place and are being reviewed.
- GP Practices and Pharmacies have BCPs in place that include a 'buddy system' should there be any failure in their ability to deliver essential services.

ix. Preparing effectively for norovirus.

- Information distributed to Care Homes will be shared by the HSCP Strategic Commissioning Team. We will do this for all providers as and when any Long Term Care providers advise us of any infection outbreak etc.

x. Delivering Seasonal Flu Vaccination to Public and Staff

- All HSCP staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions. The Community Nursing service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination
- HSCP staff are actively encouraged to be vaccinated and local peer vaccination sessions are in place.

xi. Communication to Staff & Primary Care Colleagues

- To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will;
  - Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links
  - Circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices
  - Collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C Board.
  - Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.

xii. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

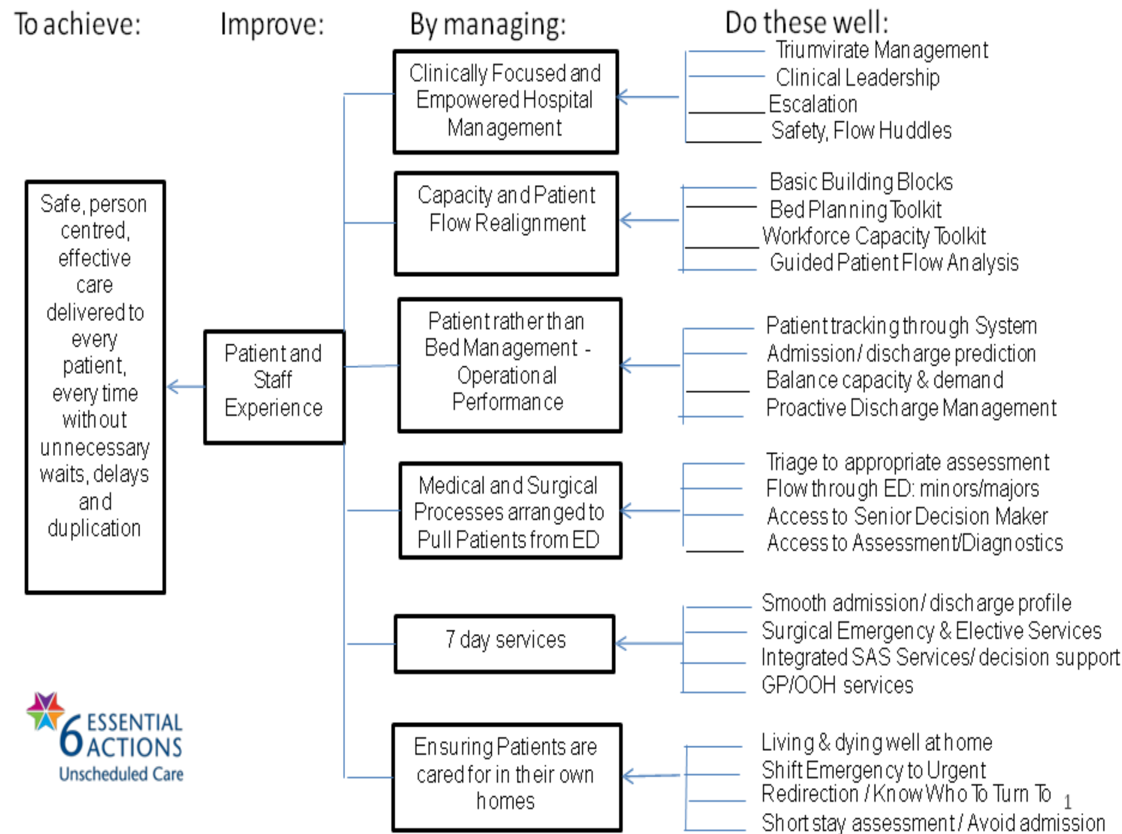
- The actions set out in this Winter Plan will be monitored and analysed to identify and potential improvements to inform future predictive modelling and planning.

Particular measures that will be monitored include;

- Staff levels/absence etc
- Bed days lost to delayed discharge
- Bed days lost to delayed discharge for AWIs
- Emergency admissions age 75yrs+
- Percentage uptake of flu vaccinations by staff
- Percentage uptake of flu vaccinations by GP population
- Demand and capacity (including GP practices)
    - Bombardment rates for key services, such as homecare and community nursing at point of discharge where no package previously in place
    - Long term care bed occupancy and vacancies
    - Admissions to hospital from care homes
    - Referrals to Discharge Team (at point of medical fitness etc)

- A detailed rolling action log will be maintained and updated at each Winter Planning Group meeting. This will be submitted each week to the HSCP Senior Management Team meetings to provide the up to date position and how we are responding.
- A report analysing the activity, performance and pressures will be provided at the end of the winter planning period.

Appendix 1



INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10 November 2015**
Report By:	**Brian Moore** **Chief Officer** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/17/2015/HW**
Contact Officer:	**Helen Watson** **Head of Planning, Health Improvement and Commissioning.**	**Contact No:**	**01475 715285**
Subject:	**NHS Greater Glasgow & Clyde Clinical Services Strategy 2015**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board of the NHS Greater Glasgow & Clyde Clinical Services Strategy.

2.0 SUMMARY

2.1 In 2011, the Scottish Government set out its strategic vision for achieving sustainable quality in the delivery of healthcare services across Scotland, in the face of the significant challenges of Scotland's public health record, our changing demography and the economic environment.

The 2020 Vision provides the strategic narrative and context for taking forward the implementation of the Quality Strategy, and the required actions to improve efficiency and achieve financial sustainability.

The Scottish Government's 2020 Vision is that by 2020 everyone is able to live longer, healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self-management
- Hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

2.2 In response to the challenges of the 2020 vision, in February 2012 NHS Greater Glasgow and Clyde (NHSGGC) agreed to establish the Clinical Services Fit for the Future Programme to review services and prepare a single clinical strategy for NHSGGC for 2015 onwards. In establishing the Review the Health Board recognised the need to:

- Integrate acute services across the whole Board area and ensure that there is equity of access to this level of care across NHSGGC.

- See acute services as part of a wider system of care including primary and community care that also requires to be considered to meet the challenges of the 2020 Vision and to deliver the integrated health and social care changes from 2015 onwards.
- Recognise the changing landscape of health care with the developments in technology and treatments.

2.3 The former Community Health & Care Partnership Sub-Committee was consequently briefed on the review's emerging conclusions at its October 2013 meeting.

2.4 At its meeting of 20th January 2015, the Health Board was presented with the final output of that clinical service review process by its Medical Director and then approved it as a clinical strategy to provide the basis for future service planning. This Clinical Services Strategy was then launched in April 2015 (attached).

3.0 RECOMMENDATION

3.1 It is recommended that the Integration Joint Board note the NHS Greater Glasgow & Clyde Clinical Services Strategy and request regular updates on the implementation of the plan.

Brian Moore
Chief Officer
Inverclyde HSCP

4.0 MAIN ISSUES

4.1 The key aims of the Strategy are to ensure that:

- Care is patient-centred with clinical expertise focused on providing that care in the most effective way and at the earliest opportunity within the care pathway;
- Services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- Sustainable and affordable clinical services can be delivered across NHSGGC;
- The pressures on hospital, primary care and community services are addressed.

4.2 The Strategy provides a framework to ensure that best clinical outcomes are achieved for patients and that services are:

- Safe and sustainable.
- Patient centred.
- Integrated between primary and secondary care.
- Efficient, making best use of resources.
- Affordable, provided within the funding available.
- Accessible, provided as locally as possible.
- Adaptable, achieving change over time.

4.3 In approving this Strategy, the Health Board's intention has been to continue to engage with stakeholders, including the new Integration Joint Boards within the Greater Glasgow & Clyde area as they are each established – the latter to specifically:

- Seek their support in adopting this as a shared clinical strategy.
- Seek to work together on planning service changes.
- Seek to engage on the refresh of the Health Board's Primary Care Strategy and the further development of primary and community services.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications:

One of the drivers for the Strategy is the reality that the health service is facing a period of rising demand resultant from demographic pressures at the same time as facing a period of significant financial constraint. It is therefore important that in planning for future services the funding available is spent effectively to ensure the best outcomes for patients. It should be noted that that imperative equally holds true for social care services as it does for the health care services described within the Strategy.

One off Costs – no one-off costs associated with this report have been identified at this time.

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

Annually Recurring Costs/ (Savings) - no annually recurring costs or savings associated with this report have been identified at this time. Any future change to the assessment of costs or savings will be brought to the IJB for further discussion.

Cost Centre	Budget	With	Annual Net	Virement	Other Comments

	Heading	Effect from	Impact £000	From (If Applicable)	

LEGAL

5.2 There are no legal issues within this report.

HUMAN RESOURCES

5.3 The Strategy recognises the importance of supporting the workforce to meet these future changes; and that effective implementation will require strong clinical leadership and commitment as well as a significant cultural shift across NHSGGC.

EQUALITIES

5.4 An acknowledged theme of the services model within the Clinical Services Strategy is the imperative on them to support and comply with the relevant duties under the Equality Act 2010.

Has an Equality Impact Assessment been carried out?

X	YES an Equality Impact Assessment has been carried out on the Clinical Services Strategy.
	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.

6.0 CONSULTATION

6.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with the senior management team and the CSS implementation team.

7.0 LIST OF BACKGROUND PAPERS

7.1 N/A

NHS Greater Glasgow and Clyde

Greater Glasgow and Clyde NHS Board

Board Meeting

Tuesday 20th January 2015 **Board Paper No. 2015/02**

Medical Director

CLINICAL SERVICES FIT FOR THE FUTURE: APPROVING THE CLINICAL STRATEGY

Recommendation:

The Board is asked to:

- **approve the clinical strategy developed from the clinical services review process**

1. INTRODUCTION AND PURPOSE

1.1 In February 2012 NHS Greater Glasgow and Clyde agreed to establish the Clinical Services Fit for the Future Programme to review services to prepare a single clinical strategy for NHS GGC for 2015 onwards. The purpose of this paper is to bring the output of the clinical service review process to the Board to enable it to be approved as a clinical strategy which will provide the basis for future service planning.

1.2 The key aims of the strategy are to ensure:

- care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- sustainable and affordable clinical services can be delivered across NHSGGC;
- the pressures on hospital, primary care and community services are addressed.

1.3 This strategy provides a framework to ensure that best clinical outcomes are achieved for patients and that services are:

- safe and sustainable;
- patient centred;
- integrated between primary and secondary care;
- efficient, making best use of resources;
- affordable, provided within the funding available;

- accessible, provided as locally as possible;
- adaptable, achieving change over time.

1.4 Board approval of this paper will enable:-

- the publication of the strategy providing a further opportunity to engage all stakeholders;
- engagement with the new Integration Joint Boards to adopt this as a shared clinical strategy and to work together on planning service changes;
- a platform for the development of implementation plans, including delivering changes to reflect the output of the Paisley development programme across the Board area;
- engagement with GPs, wider primary care contractors and with the new Health and Social Care Partnerships to refresh the Board's Primary Care Strategy and plan the further development of primary and community services.

2. SETTING THE SCENE: NHS SCOTLAND POLICY CONTEXT

2.1 In 2012 the Cabinet Secretary for Health, Wellbeing and Cities set out her strategic narrative and vision for achieving sustainable quality in the delivery of healthcare services across Scotland.

2.2 This vision for NHS Scotland is:

> **"By 2020 everyone is able to live longer healthier lives at home or in a homely setting with a healthcare system.**
>
> **There will be integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the patient at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as possible, with minimum risk of re-admission."**
>
> ***Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision***

2.3 This vision provides the context for taking forward the implementation of the Healthcare Quality Strategy for Scotland and the required actions to improve efficiency and achieve financial sustainability and for the development of our approach to planning clinical services fit for the future.

2.4 The actions outlined for NHS Scotland which drive the requirement to reshape our services are:

- We need a shared understanding with everyone involved in delivering healthcare services which set out what they should expect in terms of support, involvement and reward alongside their commitment to strong visible and effective engagement and leadership which ensures a real shared ownership of the challenges and solutions.

- We need to develop a shared understanding with the people of Scotland which sets out what they should expect in terms of high quality healthcare services alongside their shared responsibility for prevention, anticipation, self management and appropriate use of both planned and unscheduled/ emergency healthcare services, ensuring that they are able to stay healthy, at home, or in a community setting as long as possible and appropriate.

- We need to secure integrated working between health and social care, and more effective working with other agencies and with the Third and Independent Sectors.

- We need to prioritise anticipatory care and preventative spends, e.g. support for parenting and early years.

- We need to prioritise support for people to stay at home/in a homely setting as long as this is appropriate, and avoid the need for unplanned or emergency admission to hospital wherever possible.

- We need to make sure people are admitted to hospital only when it is not possible or appropriate to treat them in the community - and where someone does have to go to hospital, it should be as a day case where possible.

- Caring for more people in the community and doing more procedures as day cases where appropriate will result in a shift from acute to community-based care. This shift will be recognised as a positive improvement in the quality of our healthcare services, progress towards our vision and therefore the kind of service change we expect to see.

2.5 The direction underpinning this vision sees further focus on improving the quality of services, with expanded primary and community care, a focus on multi-morbidity and improving unscheduled and emergency care out with hospital where clinically appropriate. National work is currently underway between Boards and the Scottish Government to set out the steps which will need to be taken to deliver the 2020 Vision. This strategy provides our local basis to develop those changes.

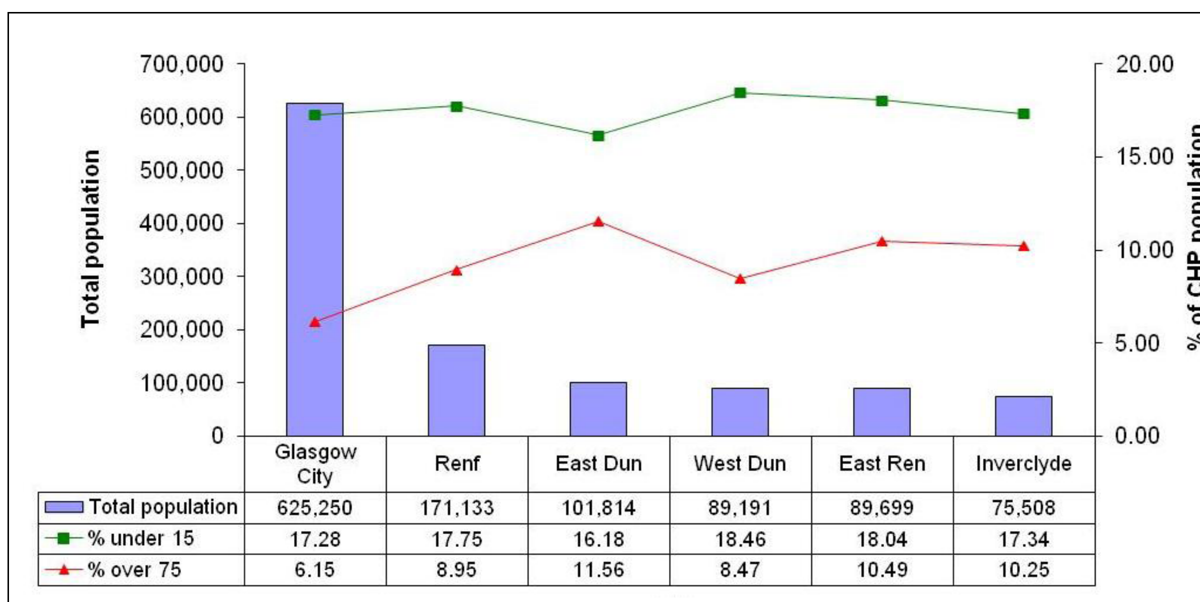
2.6 In addition to this context, a further important point of context for this clinical strategy is the establishment from April 201 of Integrated Health and Social Care Partnerships. Successful development of the new integrated partnerships will be key to the achievement of all of the strategic priorities and service models set out in this strategy which will frame our joint working with the Partnerships with shared responsibility for the strategic planning of acute services.

3. THE NHS GREATER GLASGOW AND CLYDE POPULATION HEALTH

3.1 In bringing forward this outcome of the CSR it is also important to restate the local context in which the CSR has been developed.

3.2 The Population of NHSGGC: Demographics

3.2.1 The current population and age profile is shown below. Our population is relatively young compared to other parts of Scotland, although this varies significantly between local authority areas. Women predominate in the older age groups.



3.2.2 The population of the NHS Greater Glasgow and Clyde area in 2010 was 1,203,870. This population is expected to increase overall by 2.4% by 2020. (See table below)

Age Group	Population 2010	Population 2015	% change by 2015	Population 2020	% change by 2020	Population 2025	% change by 2025
0-14	**194,562**	197,268	1.4	202,876	4.3	199,911	2.7
15-24	**166,320**	150,265	-9.7	137,743	-17.2	139,286	-16.3
25-34	**176,434**	193,672	9.8	184,614	4.6	166,623	-5.6
35-44	**167,002**	156,647	-6.2	172,422	3.2	187,458	12.2
45-54	**177,130**	177,566	0.2	159,827	-9.8	149,426	-15.6
55-64	**136,201**	147,198	8.1	164,852	21.0	165,878	21.8
65 & over	**186,221**	197,206	5.9	210,174	12.9	233,297	25.3
All Ages	1,203,870	1,219,822	1.3	1,232,508	2.4	1,241,879	3.2

3.2.3 During this time, the age profile of the population will continue to change. In common with much of Scotland, in most areas there will be a steep rise in the numbers and proportion of older people. The over 65 population will increase by 12.9% by 2020. This will impact differently across Greater Glasgow and Clyde with areas like East Dunbartonshire and East Renfrewshire already experiencing significant rises in numbers of older people, whilst Glasgow City is projected to see a short term decline in the numbers of older people, before following the same longer term trends. A small increase in the number of children together with a larger decrease in the number of people aged 15-29 will result in an overall reduction in the 0-19 age group.

3.2.4 It is a population with high levels of deprivation compared to the rest of Scotland. 30.4% of people in NHS Greater Glasgow and Clyde live in the 15% most deprived data zones (Scottish Index of Multiple Deprivation). This ranges from 3.1% in East Dunbartonshire, to over 50% North and East Glasgow.

3.2.5 Summary of key trends:

- The **top 10 causes of death** in Scotland account for 44% of all deaths. Each of the causes of death are amenable to prevention by not smoking; being a healthy weight; being physically active; drinking within recommended levels of alcohol and maintaining a healthy diet.

- **Population projections** estimate that Glasgow City is due to have a modest rise in population to 2033, whereas, all other local authorities in NHSGGC will have a decrease in population. This will be most marked in Inverclyde and East Dun.

- **Our population is ageing**. Between 1911 and 2008 there has been an increase in the number of people aged over 65 years in Scotland of 221%. However, NHSGGC is ageing at a markedly slower rate than the rest of Scotland.

- There are **wide variations within NHSGGC**. East Dumbarton experienced a 47% increase in people aged 65+ and Glasgow city a 25% decline between 1982-2007.

- **Forecasts predict the under 50's will shrink** from 70% in 2008 to 62% in 2033; whereas the over 50's will expand from 30% to 38%. The biggest increase is expected in the over 65's age group.

- **Dependency ratios are due to increase** to 2040 across NHSGGC. Within NHSGGC there are marked variations. Current dependency ratios vary from 44% in Glasgow City to 60% in East Renfrewshire by 2031 these are predicted to increase to 51% in Glasgow City to 91% in East Dunbartonshire and 89% in East Renfrewshire. A male born in East Glasgow can expect to live in a healthy state for 15 years less than a male born in East Dunbartonshire.

- **Older single person households are expected to increase**. It is anticipated these will account for 54% of households by 2031.

- Life expectancy and healthy life expectancy is lower in NHSGGC than the rest of Scotland. People living in NHSGGC can expect to have the **longest period of unhealthy life at 10.5 years.**

- Aging is associated with an increased burden on long term conditions and chronic disease.

- There will be a significant growth in the numbers of people with dementia as the population ages. There will be an estimated 18% increase in dementia in GGC by 2020. One in three people aged over 65 will die with a form of dementia and one in four hospital inpatients will have dementia (Alzheimer's Research Trust 2010)

3.2.6 In recent years across NHSGGC, there have been some significant improvements in health. Overall life expectancy has risen; rates of premature mortality have fallen, with particular improvements for Coronary Heart Disease. Cancer survival has improved significantly across a range of cancers. However, there remain many significant health challenges and marked inequality across NHS Greater Glasgow and Clyde. Overall,

average life expectancy in NHS Greater Glasgow and Clyde is well below the Scottish average (see below). Again, there is considerable variation between different parts of NHS Greater Glasgow and Clyde.

3.2.7 *Healthy* life expectancy in NHS Greater Glasgow and Clyde is even lower compared to the Scottish average. People in NHS Greater Glasgow and Clyde live for many years in ill health, with the consequent impact on quality of life, economic and societal contribution and need for services. Over the past 10 years, the gap in healthy life expectancy between the 20% most deprived and the 20% least deprived areas has increased from 8 to 13 years.

Life Expectancy at Birth by Gender 2007 - 2009 Source: NRS (formerly GRO(S))

CH(C)P	Male	Female
Glasgow City	71.1	77.5
East Dunbartonshire	78.3	83.1
East Renfrewshire	77.8	82
Renfrewshire	73.7	79.2
Inverclyde	73.1	79
West Dunbartonshire	72.5	78.4
NHSGGC	**73.1**	**78.9**
Scotland	**75.4**	**80.1**

4. THE CONTEXT OF ACUTE SERVICES PROVISION IN NHSGGC

4.1 Prior to the CSR NHSGGC had two separate approved acute strategies - one for Greater Glasgow, the Acute Services Review (ASR) agreed in 2002 and the other for Clyde (South Clyde in 2006/7 and North Clyde in 2009). The Clyde strategy has already been fully implemented and the Greater Glasgow ASR will be delivered during 2015. At that point the Acute Services Provision across NHS GGC will be as follows:

4.2 In establishing the CSR the Board recognised the need to:

- integrate acute services across the whole Board area and ensure that there is equity of access to this level of care across NHSGGC;
- see acute services are part of a wider system of care including primary and community care that also requires to be considered to meet the challenges of the 2020 Vision and to deliver the integrated health and social care changes from 2015 onwards;
- recognise the changing landscape of health care with the developments in technology and treatments and the requirement to ensure care is provided in a patient centred way.

4.3 The following sections describe the approach we took to review the organisation of clinical services and to consider what would be required to achieve the best health outcomes for patients. The critical characteristics of the review work were clinical leadership, whole system clinical engagement and intensive patient and public engagement

5. THE CASE FOR CHANGE AND CHALLENGES THIS STRATEGY NEEDS TO ADDRESS

5.1 The first stage in the CSR was to establish the case for change. This part of the process was also based on the views of a wide range of clinicians on what is currently affecting the clinical services and what is likely to impact on services in the future, as well as the opinions of patients of what they value in the current service and what they would want of future services.

5.2 Following extensive engagement with stakeholders the Case for Change was published in December 2012. This identified 9 key themes:

1. The health needs of our population are significant and changing.
2. We need to do more to support people to manage their own health and prevent crisis.
3. Our services are not always organised in the best way for patients[i].
4. We need to do more to make sure that care is always provided in the most appropriate setting;
5. There is growing pressure on primary care and community services.
6. We need to provide the highest quality specialist care[ii].
7. Increasing specialisation needs to be balanced with the need for co-ordinated care which takes an overview of the patient.
8. Healthcare is changing and we need to keep pace with best practice and standards.
9. We need to support our workforce to meet future changes.

5.3 Together these issues paint a picture of health services which need to change to make sure that we can continue to deliver high quality services and improve outcomes. As outlined in the earlier sections the years ahead will see significant changes to the population and health needs of NHS Greater Glasgow and Clyde. It is clear that not enough focus on prevention and support for people at an early stage in their illness can lead to poorer health outcomes, and to people accessing services and support at crisis points or at later stages of illness. The growing complexity of need, including multi morbidity and a wide range of care and support needs, mean that users and carers can feel inadequately supported and services can feel complex and fragmented. This poses significant challenges to the way we deliver health services and work with partner agencies, to ensure that our services adapt to these changing needs.

5.4 The health service is facing a period of rising demand resultant from demographic pressures at the same time as facing a period of significant financial constraint. It is therefore important that in planning for future services the funding available is spent effectively to ensure the best outcomes for patients. A more consistent and joined up approach is required across all parts of the system, targeting interventions and support where they are most needed. The case for change tells us that we need to improve outcomes by organising and delivering services differently to prevent ill health in the first place, to support patients with multiple conditions more effectively and to enable older people to live more independently. We also need to change our hospitals to ensure that high quality care is consistently available, that there is timely access for all to specialist care and that we have 24 /7 access to specialised emergency care.

The full case for change is at http://www.nhsggc.org.uk/content/

5.5 The core of this clinical strategy is based on the case for change and the detailed work done in eight workstreams to consider how we can address these challenges. These workstreams, to determine the service strategy for 2015-2020 and identify the future clinical service provision, cover:

- Population Health
- Emergency Care and Trauma
- Planned Care
- Child and Maternal Health
- Older People's Services
- Chronic Disease Management
- Cancer
- Mental Health

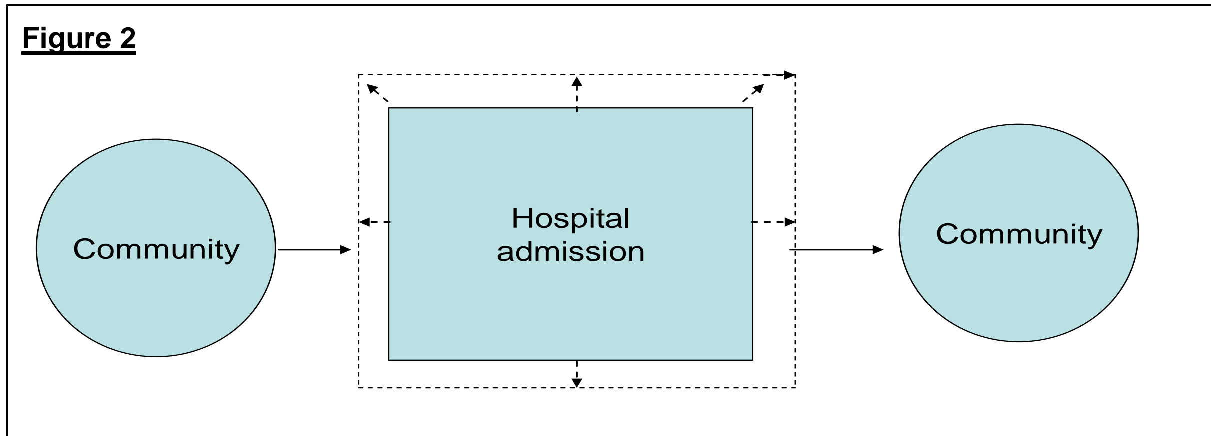
5.6 The detailed conclusions of this service models work are set out later in this paper

5.7 Meeting the challenge across the whole system

The diagrams below show the challenge we face across NHSGGC and the system we need to move towards in the future.

The current position is one where we face challenging demand pressures across a system in which 'hospital' and 'community' services are largely seen as separate, with often poor communication and joint planning across the system. While there are some good examples of joint working, these are not systematic and often on a small scale. The future demand pressures we face as a result of demographic and health changes mean that if we continue with the system as it is now, we would need an additional 500 acute beds by 2020. In an environment of constrained resources, the investment required for this would result in a vicious circle, with growing expenditure in acute hospital admissions and less money for investment in community services, which in turn reduces our ability to support people at home.

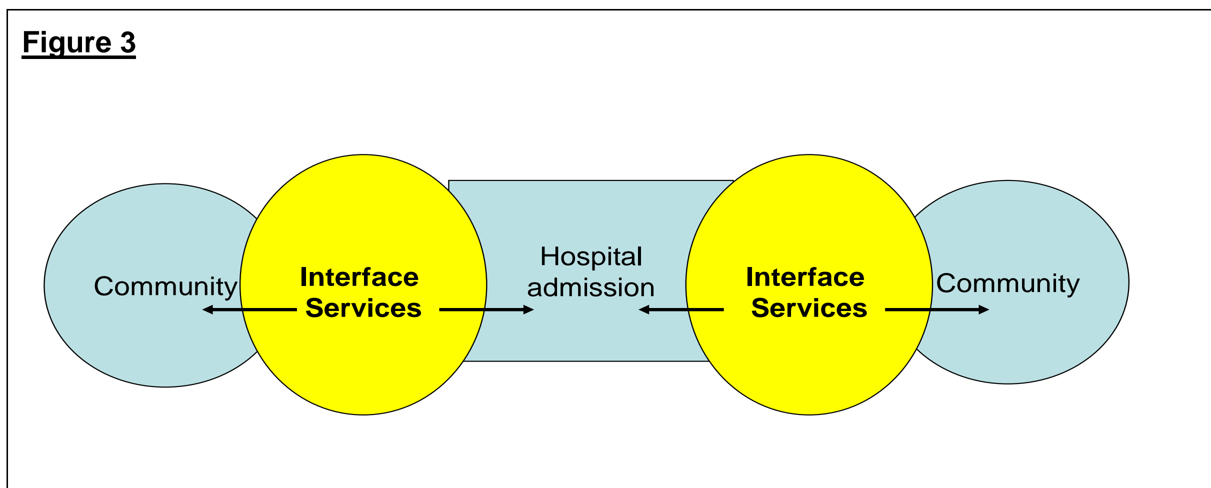
Figure 2



The system of care we want to move to sees a significant change focusing on providing care where it is most appropriate for the patient. This is based on strengthened 24/7 community services, acute services focused on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to face to face hospital visits.

Working differently at the interface (represented by the yellow circles below) may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

Figure 3



It is recognised that to change the system will require strong clinical leadership and commitment as well as a significant cultural shift across the organization to undertake this size of system change. To achieve this we require to:

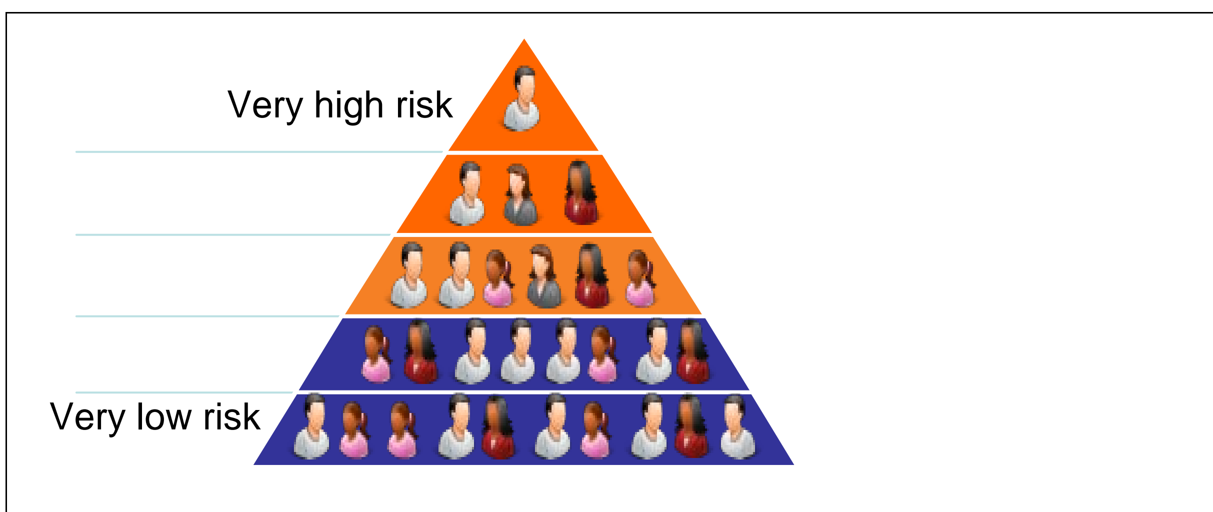
- think beyond artificial boundaries of 'hospital' and 'community';
- focus on patient pathway and needs at each stage;
- change the delivery of acute care: assess and direct to appropriate place of care;
- change the provision and accessibility of community services;
- create different ways of working at the interface.

5.8 This needs to build on the work of bringing clinical teams together to consider the problems and challenges facing the services, to jointly problem solve and plan services across the organisation for the future with shared responsibility for delivery of the new service models to maximise success.

5.9 Core components of the future health system

The overarching aim of this clinical strategy, based on the service models work, is to provide **a balanced system of care where people get care in the right place** from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services.

At the heart of this approach is the requirement to understand our population and provide care at the most appropriate level. Getting this right will enable more intensive support for those most in need, and supported self management with rapid access into services when required for the majority of the population.



This approach relies on a strong emphasis on prevention. It is therefore important that as part of the strategy we continue to emphasise the importance of health improvement and disease prevention. We need to encourage the population to improve their health and prevent disease, recognising that lifestyle choices in modifiable behaviours are responsible for around 80% of our current LTC disease burden. This requires all health care professionals to promote healthier lifestyles and to support the population to take responsibility for improving their own health by adopting healthier lifestyles.

The key characteristics of the clinical services required to support this approach are:

1. A system underpinned by timely access to **high quality primary care** providing a comprehensive service that deals with the whole person in the context of their socio-economic environment:

   - Building on universal access to primary care.
   - Focal point for prevention, anticipatory care and early intervention.
   - Management where possible within a primary care setting.
   - Focus for continuity of care, and co-ordination of care for multiple conditions.

2. A comprehensive range of **community services,** integrated across health and social care and working with the third sector to provide increased support at home:

- Single point of access, accessible 24/7 from acute and community settings.
- Focused on preventing deterioration and supporting independence.
- Multi-disciplinary care plans in place to respond in a timely way to crisis.
- Working as part of a team with primary care providers for a defined patient population.

3. Co-Coordinated care at **crisis / transition** points, and for those **most at risk**:

   - Access to specialist advice by phone, in community settings or through rapid access to outpatients.
   - Jointly agreed care plans with input from GPs, community teams, specialist nurses and consultants, with shared responsibility for implementation.
   - Rapid escalation of support, on a 24 / 7 basis.

4. **Hospital assessment** which focuses on early comprehensive assessment driving care in the right setting:

   - Senior clinical decision makers at the front door.
   - Specialist care available 24/7 where required.
   - Rapid transfer to appropriate place of care, following assessment.
   - In-patient stay for the acute period of care only (see Fig 4).
   - Early supported discharge to home or step down care.
   - Early involvement of primary and community care team in planning for discharge.

5. **Planned care** which is locally accessible on an outpatient / ambulatory care basis where possible:

   - Wider range of specialist clinics in the community, working as part of a team with primary care and community services.
   - Appropriate follow-up.
   - Diagnostic services organised around patient needs.
   - Interventions provided as day case where possible.
   - Rapid access as an alternative to emergency admission or to facilitate discharge.

6. **Low volume and high complexity care** provided in defined units equipped to meet the care needs:

   - Driven by clear evidence of the relationship between volume and outcome.

The service models which follow at section 6 onwards consider what needs to be in place to deliver these core components of care for specific groups of patients.

5.10 Enablers

Changing the system on this scale will require a significant cultural shift and clinical commitment across the organisation. In order to achieve this, services will have to be underpinned by a series of enablers and improvements to supporting systems, including:

- Supported leadership and strong clinical engagement across the system to develop and implement the new models.
- Building on the clinical portal to enable shared IT systems and records which are accessible to different professionals across the care system.
- Jointly agreed protocols and care pathways, supported by IT tools.
- Stratification of the patient population to ensure that care is targeted at the appropriate level with supporting anticipatory care plans in place.
- Ensuring that access arrangements enable all patients to access and benefit from services
- Increasing the education and information shared with patients and the public to support people to take more responsibility for their own care.
- Involvement of patients and carers in care planning and self management.
- Shared learning and education across primary, community and acute services.
- Governance and performance systems which support new ways of working.
- Information systems which enable us to gather the information we need to monitor whether the changes are working, including disaggregated data on activity and outcomes for equality groups.
- Integrated planning of services and resources.
- Ensuring that contractual arrangements with independent contractors support the changes required.

5.11 Benefits

It is anticipated that a successful move towards this system of care would result in:

- Patients being in control of their care and empowered to share decisions about it;
- A system of care which is easier to navigate for patients and professionals.
- Clinicians and other staff at all stages having the necessary information about the patient, with care better tailored to the patient's needs.
- Better patient experience and patient safety, and improved health outcomes with a particular improvement for patients with multi-morbidity.
- A reduction in health inequalities as the most vulnerable patients receive better access to holistic person centred care.
- Care which is provided in the most appropriate setting, relative to the patients needs.
- More cost effective use of resources with care focused on early intervention, better management of complex multi morbidity and a reduction in duplication of care.

Figure 4

What is Acute Care? Who needs to be admitted for inpatient care?

The definition of Acute Inpatient Care we propose is:

"Acute care is where people receive specialised support in an emergency or following referral for surgery, complex tests or other things that cannot be done in the community. Acute care usually provides treatment for a short period, until the person is well enough to be supported in the community again."

The European Appropriateness Evaluation Protocol Approach has been developed and used in a number of countries to support this definition. This considers admission criteria in relation to both severity of illness and intensity of service required:

Admission criteria – intensity of service

- Surgery or other procedure in 24 hours requiring general/ regional anaesthesia or equipment or other facilities only for inpatients.
- Vital signs monitoring at least every 2 hours.
- Intravenous medications and or/ fluid replacement
- Continuous or intermittent (at least every 8 hours) respiratory assistance.

Admission criteria – severity of illness

- Severe electrolyte or blood gas abnormality.
- Acute loss of sight or hearing (within 48 hours of admission).
- Acute loss of ability to move any body part (within 48 hours of admission).
- Persistent fever >38 for more than 5 days.
- Active bleeding.
- Pulse rate <50 or >140 per minute.
- Blood pressure systolic <90 or >200, diastolic <60 or >120.
- Sudden onset of unconsciousness (except transient unconsciousness).
- ECG evidence of acute ischaemia, suspicion of new myocardial infarction.

Experience of applying this tool indicates:

- The most influential factor determining the appropriateness of bed utilisation is how the care system in place manages the patient, rather than the characteristics of the patient.
- Therefore it is important to consider the service configuration and care delivery to effect change.

Significant additional and different capacity is required if patients are to be treated more appropriately:

- A shift away from acute inpatient setting to provide a wide spectrum of home and community based care.
- Improved assessment and diagnosis.
- Non acute beds with therapy support.

Going forward we need to determine where the threshold for acute inpatient care is set

- ***Too high: difficult to implement, risk of readmission, significant impact.***
- ***Too low: won't be radical enough to address the problems we face.***

We need to develop a more comprehensive range of services in community settings based on the services we currently have. This will require us to determine what capacity is needed to ensure that core primary care and community services are accessible when required. It will require us to test the alternatives to ensure they are safe and cost effective.

5.12 The next section of this document sets out the high level service models to support the delivery of care in a more balanced system as we go towards 2020, indicating the areas where services should be further developed and the core components to underpin the health care provision.

6. SERVICE MODELS

6.1 The groups which developed the service models were clinically led and were formed with representatives of the hospital, primary care and academic clinicians. The clinical working groups included patient representatives and were supported by wider patient reference groups, involving patients, carers and voluntary organisations. The process was also supported by a series of cross-cutting events to consider specific issues across the groups, including primary care and the third sector. In addition work has been undertaken in relation to tertiary services which has been fed into the work of the different clinical groups where indicated.

6.2 The groups focused on:

- Reviewing current services, future changes and possible models of care;
- Looking at evidence from research, good practice and innovation;
- Thinking about what needs to change – and what doesn't;
- Reviewing feedback from the engagement sessions with the patient reference groups.

6.3 Underpinning each work stream was a core set of activities to consider current pathways, delivery models, workforce requirements and the relationship between primary and secondary care to ensure efficient and effective patient pathways.

6.4 The outputs from each of the groups were brought together into a discussion paper and summary document in June 2013, which set out how the models developed by all of the groups come together into a series of changes to the overall system of care in NHSGGC, as well as highlighting specific service models from individual groups.

6.5 The discussion paper was shared widely across NHSGGC, with partner organisations and with patients and third sector organisations. This included:

- Presentations and discussions with groups of clinicians, including Medical Staff Associations, Senior Nurses and AHPs
- Through each of our Directorates in the Acute Division, and all six of our Community Health (and Care) Partnerships
- Discussions with GPs through locality groups
- A session with all Patient Reference Groups
- A dedicated session for third sector organisations
- Discussions with West of Scotland Regional Boards and other partner organisations.
- Discussion at joint planning groups with Local Authorities
- Information in StaffNews and through papers available on the intranet
- Discussion with the Area Partnership Forum and Staff Partnership Forums across GGC
- Regular updates to the Area Clinical Forum and advisory committees

6.6 The general feedback was very supportive of the direction of travel set out in the service models paper and welcomed the approach being taken to involve the whole system. The approach described in the service models paper was considered an appropriate response to the issues raised in the case for change. Issues raised in the feedback included:

- Interface services require to be further defined: there was some concern about what it might mean for specific services and seeking details about how it will be taken forward
- The need for more emphasis on the role and implications for primary care.

- The need for explicit mention of health and social care integration, and effective working with social care.
- Request for inclusion of some patient stories to illustrate the proposed changes more clearly.
- Lots of examples of good practice, where services are already moving towards the sorts of models set out in the paper.
- Strong support for the emphasis on assessment and senior decision makers.
- Strong support for the focus on multi-morbidity
- The need to make sure that the service models recognise the different needs and approaches required for frail elderly patients, and younger patients with multiple chronic diseases.
- Respondents were keen to see the approach tried out before it is fully implemented, particularly to test out the affordability of the model.
- An appreciation of the level of engagement so far, and a request for reassurance that all parties will be involved in working through the details to understand the implications and the detailed models.
- An emphasis on the need for increased engagement and involvement of social care going forward, particularly to consider the interrelationship with the integrated health and social care agenda.
- Patients were keen to stay involved with and informed about the process

6.7 The comments received were incorporated into the final version of the Service Models paper which forms the basis of this clinical strategy. The detail of the outputs of the service models work is set out later in this paper but it is particular important to highlight a number of key consistent themes.

6.7.1 Equalities

- In addition to this, future service models will have to support NHSGGC to comply with its duties under the Equality Act 2010 to remove discrimination, close the health gap as a consequence of poverty and social class, and address the needs of marginalised groups.

6.7.2 Overarching principles

- Focus on what care the patient needs
    - care provided based on need and individual circumstance
    - care delivered in the best way
- Focus on improving clinical outcomes and delivering a good patient and carer experience.
- Locally accessible on an outpatient / ambulatory care basis where possible
- In-patient care only where necessary.
- Low volume and high complexity care provided in defined units equipped to meet specialist care needs.
- Consistently meeting core standards of care: patients should be able to access the same standard of care wherever they are in Greater Glasgow and Clyde.
- Continually evolving to ensure the most appropriate treatment / intervention is offered.
- Care should be focused on reducing inequalities by ensuring access for the most disadvantaged
- Services should be provided in a non-discriminatory manner
- Supporting patients to have the best health possible.
- Research should be strongly supported and fostered.
- Services should be sustainable, both clinically and financially.

6.7.3 Issues for patients

- Concern about lack of joined up care, particularly for those with multiple conditions receiving support from different teams across primary care, community services and hospital outpatients and / or inpatients.
- Lack of communication between teams and with patients
- A desire to be able to manage conditions better themselves, with appropriate support
- The need for patients and carers to be valued as partners in care
- The importance of access to services, in terms of both time and physical location
- A broad range of issues impacting on people's health and ability to benefit from services, including the impact of the recession and welfare reform
- The challenge of ensuring that changes to services add up to real benefits for
- individual patients

6.7.4 The following comments reflect a view of what success would look like from a patient perspective:

> "I know who the main person in charge of my care is. I have one first point of contact. They understand both me and my condition."
>
> "The professionals involved with me talk to each other. I can see that they work as a team."
>
> "There are no big gaps between seeing the doctor, going for tests and getting the results."
>
> "I am as involved in decision making as I wish to be."
>
> "I understand my condition and am supported to manage my care."
>
> "Having someone identified to help coordinate my care is important."
>
> "Understanding who can help and support me, not just with my clinical care, is important."
>
> "Receiving care in a specialist unit is fine as long as I can access local services for follow up and advice."

7. FRAIL ELDERLY AND CHRONIC DISEASE

7.1 Core Elements of Service Models

7.1.1 There is significant overlap in the models emerging for frail elderly patients, and for those with chronic diseases. However, there are also areas where a dedicated focus on frailty, distinct from single or multiple long term conditions, is essential. And there is a clear group of younger patients, particularly in deprived areas, who experience multiple long term conditions long before they would be defined as 'older'. The common approaches and specific requirements are set out below, followed by the areas where separate emphasis or approach is required.

7.1.2 The evidence suggests that getting the basics right – integrated, multifaceted and coordinated primary, secondary and social care are much more important than any single tool approach. The following interventions are supported by consistent evidence

(http://library.nhsgg.org.uk) and should be linked into a coherent whole as part of a future strategic approach to change in NHSGGC:

- Shared, high-quality protocols across care settings
- Collaborative relationships between specialists and generalists
- Planned systems of collaborative care involving case management, systematic follow-up
- Improved integration of primary and secondary care
- High quality primary care
- Effective coordination of care and use of IT to support communication
- Effective self management/supported self care
- Multi-professional teams
- Explicit care planning
- information sharing with patients and among care providers
- Reliable methodology and application of risk stratification
- Ensuring that all health professionals ask about diet, smoking and physical activity in their consultations with patients
- Ensuring that all health professionals can direct people towards appropriate computerised decision support tools to ensure coherent protocols available and used by clinical staff
- Use of a range of professional specialists nurses (e.g. Specialist nursing has demonstrable benefits for asthma, COPD and heart failure and may be replicable for analogous long term conditions).

7.1.3 The core elements of the service model to deliver this include:

- **Anticipatory care planning** enables patients and professionals to plan for a change in health or social status, particularly for those at high risk of crisis.

  Plans need to be developed by multi-disciplinary teams including primary care, community services and hospital specialists.

  Successful implementation of plans require the ability to mobilise a wide range of support in community, including home care, aids and adaptations, housing, befriending and carer support in a timely manner, based on a 7 day model that can also support care in the evening and overnight.

- **High Quality Primary Care** Age and chronic diseases represent a significant proportion of patient contacts in primary care, and the majority of care is managed in a primary care setting. General practice and the services it connects to are critical to a focus on prevention, management of risk factors and continuity of care for those with long term conditions.

- **Front door assessment model** will require early comprehensive assessment with senior decision makers at the front door, identifying specialist input and appropriate management plans guiding treatment and care packages in all settings, to support chronic disease management and / or frailty.

- **Non-acute beds may have a place as alternative to admission or to enable step down care** – this model requires a smaller 'acute' element of care with more non-acute and community infrastructure. The non acute beds would need to have rigorous standards for patient throughput and clear outcomes. Further work is required to define this approach.

- **Managing multi-morbidity** -better integration of services across specialties within hospital, between hospital and the community, and between health and social services are crucial to the management of multi morbidity.

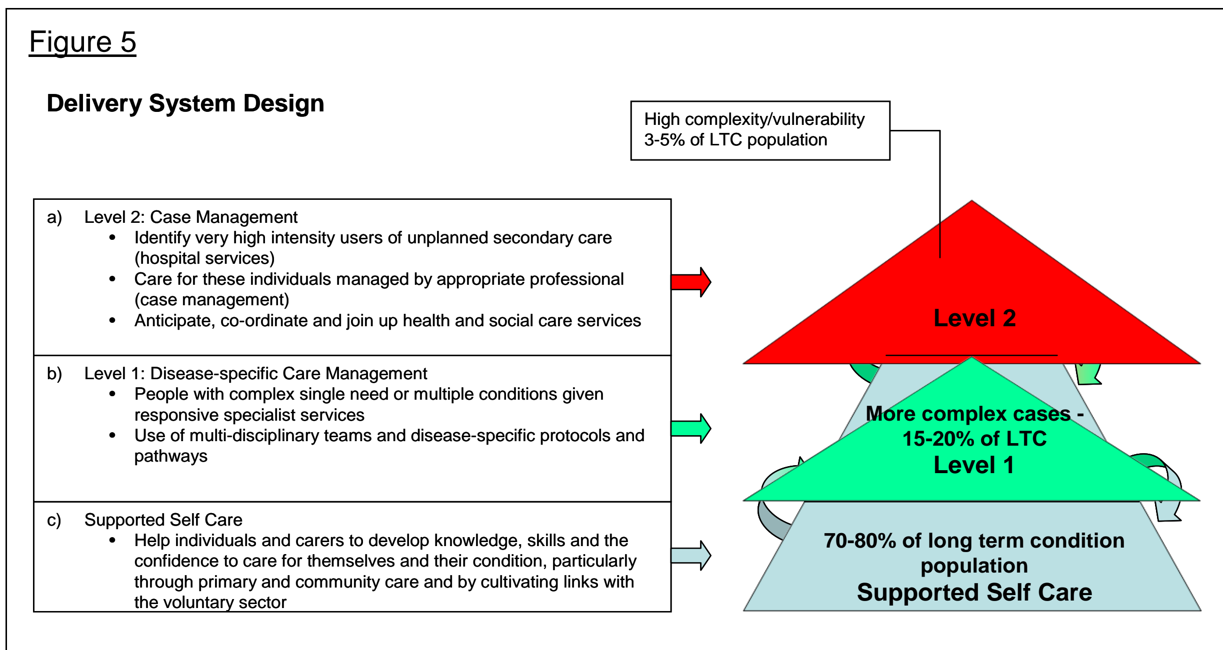
- **Inpatient Care focused on acute episode of care, with planning for rehabilitation and return home** – ensuring rehabilitation is available dependent on need not age, focused on ensuring return home at the earliest opportunity by supporting rehab care in the community.

7.1.4 These are considered in more detail below in relation to both Chronic Disease and Frail Elderly pathways.

7.2 Chronic Disease

7.2.1 Overall approach

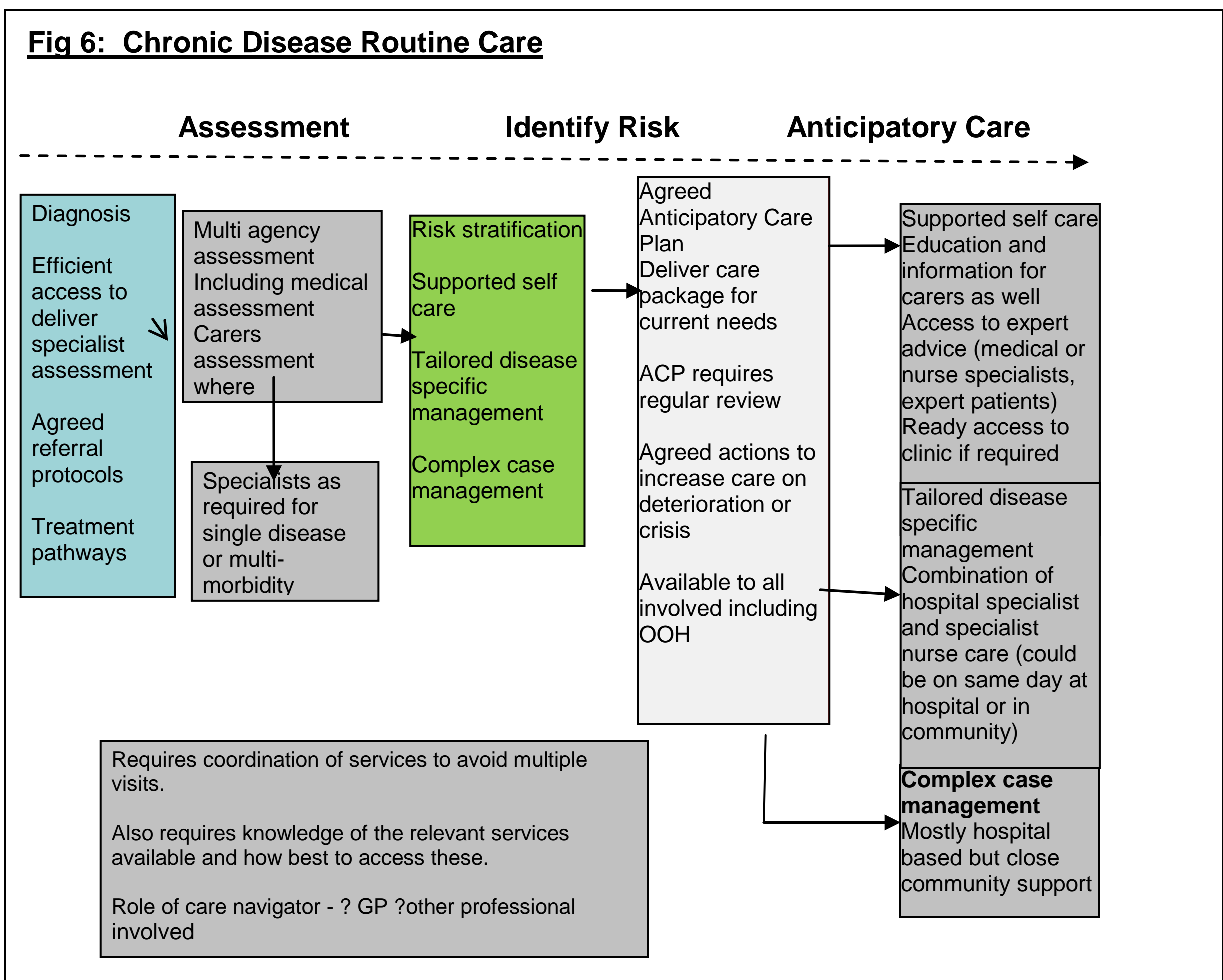
The proposed approach is based on risk stratifying the population by complexity and vulnerability, and providing care accordingly:



The key building blocks to support these models are listed below. A number of these are already in place, however the challenge is to ensure that they are consistently in place across the system, based on a 24/7 model, addressing the timing and volume issues currently facing many of these services.

Tailored Care - Care assistant - Physiotherapist/ OT - District Nurse - Community Pharmacy - Advanced Nurse Practitioner (generic) - Specialty Liaison Nurse - GP - Hospital Physician - Clinical Psychologist	**Advice** - Expert patient - GP - Nurse Specialist - Hospital Specialist - Acute Physician - Specialty Physician **Access to Hospital facilities and outpatients** **Intermediate care** **Out of hours advice and assessment** - Nurse provided - Expert Patient - 'Buddy system
Communication: Portal; e referral / direct referral	

These services need to work together effectively to provide both routine care, and to escalate support in response to a crisis or significant change in condition. These pathways are shown below at figures 6 and 7.



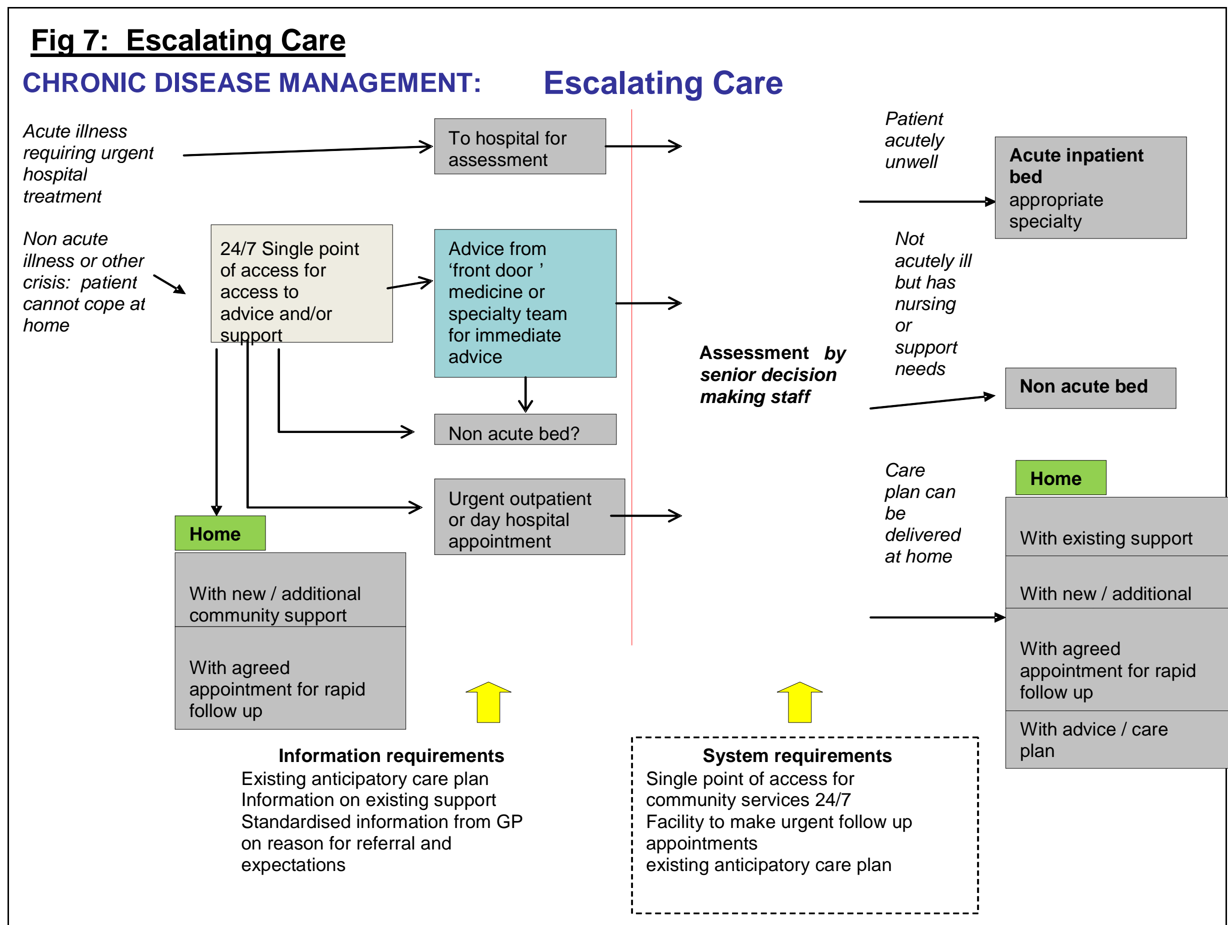


Fig 7: Escalating Care

7.2.2 Anticipatory care

A clear and responsive anticipatory care plan, which follows the patient and informs care in all settings, is a core part of this approach. While anticipatory care planning has been in development in NHSGGC in recent years, it is not yet a systematic multi-disciplinary approach focusing on those who would most benefit.

The agreed definition of anticipatory care in MHSGGC is "An integrated programme of defined preventive interventions delivered to individuals, operating across the continuum of primary, secondary and tertiary prevention. Its overall aim is to shift focus of service provision from reactive to preventive care, by adopting a whole population perspective across all aspects of service planning and delivery"

Anticipatory care planning is, by definition, planning of the above. It can be considered at an individual or population level. In both cases, it involves planning appropriate interventions that are i) evidence based; ii) connected to other interventions and services; and iii) applied across the entire continuum of disease, not just the latest stages.

Anticipatory care planning should be undertaken as early as possible – needs to start with diagnosis. Effective interventions relevant to that patient's needs should be delivered across the anticipatory care continuum, from primary prevention to end of life care. At each point along the continuum of primary, secondary and tertiary prevention, the objective is to control the underlying condition and prevent or delay progression of disease. Each stage of intervention in this process has a preventive component, a clinical management component and a self care component.

Health related behaviours, life circumstances and psychosocial factors all play an equally important role at each stage, not solely in primary prevention.

There are some good existing examples within NHSGGC of effective anticipatory care planning, including:

The Heart Failure Liaison Nurse Service cares for a well defined population of patients with chronic heart failure. These are referred from hospital and risk stratified to community or clinic care by the HFLNS. The HFL nurse will communicate with both the GP and the cardiologist about aspects of the care.

We would seek to roll out models such as this across GGC.

7.2.3 Multi morbidity

Developing better approaches to multi-morbidity has been a key theme of this Clinical Services Review. Within the pathways described above, the following elements will need to be developed further to establish a better approach to multi-morbidity:

- Continuing the work on QOF and Enhanced Services within primary care to bring together the management of different chronic diseases into a combined approach focusing on individual patient needs.

- Developing a better 'combined approach' to providing specialist input where patients are currently attending multiple outpatient clinics. This would focus on co-ordinating investigations, treatment and management so that any specialist input is managed in the context of the whole person and their environment not just narrow disease specific guidelines. This could be done through:

  - Shared clinics where there are common co-morbidities
  - Access to additional specialist input at chronic disease clinics (for example, specialist nurse input)
  - Improved access for GPs to specialist advice and opinion.

- Development of care navigator or case management roles to co-ordinate care and minimise visits and duplication, as well as improving co-ordination In some cases, this could be the GP, district nurse or specialist nurse as long as some form of designation occurs. There may be a need for another individual or care navigator in complicated cases. As with anticipatory care planning case management has been in development in NHSGGC in recent years, but is not as yet systematically in place focusing on those who would most benefit.

- Improving the identification and management of co-morbidities in emergency and inpatient settings. Co-morbidities are often a major reason for prolonged stays in hospital. Early generalist assessment to establish a comprehensive treatment and care plan for an individual will support better management of co-morbidities. Where a patient's care is transferred to a specific single condition specialist, we need to find better ways to enable input from generalist and / or other specialist, including the patient's general practitioner.

- Polypharmacy is often associated with multi-morbidity and carries with it a number of risks to patients. Medication reviews should be available on a regular basis to all

patients experiencing polypharmacy, and should be triggered by any acute or emergency episode of care.

- We know that multi-morbidity occurs is strongly linked to deprivation, occurring 10-15 years earlier in areas of high deprivation and encompassing both physical and mental health. Approaches to multi-morbidity therefore need to take account of a range of wider complex and challenging life circumstances which may act as barriers to patients' participation in new service models. Approaches to multi morbidity also need to focus on the changes in practice and behaviour required to take account of this.
- Multi-morbidity is a particular feature of patient contact in primary care, and we need to ensure that there is both sufficient capacity and support for effective approaches to managing multi-morbidity in a primary care setting, learning from current research activity in this area.

Illustration: for a patient, moving to the new model of care described might look like this:
Patient story

58 year old woman with diabetes, hypertension, chronic kidney disease and rheumatoid arthritis, is overweight and smokes and is unable to work.

Now: Has frequent appointments at hospital diabetic clinic, GP chronic disease reviews, podiatrist, renal clinic, hypertension clinic, rheumatology clinic. Frequent DNA because forgets appointments, doesn't see the point or doesn't have the bus fare to get there. This results in several acute admissions per year.

Future: Risk stratification flags up patient as high risk due to multi-morbidity; case review highlights multiple teams involved in care – case manager identified to develop a co-ordinated care plan involving the GP and appropriate specialists. Routine outpatient review minimized and clear triggers in place for return. Targeted support put in place and advice on diet and weight loss, smoking and benefits maximisation.

7.3 Frail Elderly

7.3.1 Overview

The older people group focused on 'frailty' as distinct from older people with other single conditions or multiple chronic diseases, with no additional functional problems. This reflects the fact that older people are cared for across all services, that amongst older people there is wide variety in terms of health and function, and that treatment should be needs based and not age based.

The main premise of the group is that specialist geriatric input should be focused on the frail elderly or those with 'frailty syndromes'. Stroke pathways are described in section 7.

What is frailty?

Frailty can be defined as a syndrome of multi-system reduction in physical capacity as t result of which an older person's function may be severely compromised by mir environmental challenges, giving rise to the condition of 'unstable disability'.

Older people tend to present to clinicians with non-specific presentations or frailty syndrome

in contrast to the classical presentations seen in younger people. The reasons behind the no specific presentations include the presence of multiple co-morbidities, disability a communication barriers. The ability to recognise and interpret non-specific syndromes is ke as they are markers of poor outcomes:

- ***Falls***
- ***Immobility***
- ***Delirium and dementia***
- ***Polypharmacy***
- ***Incontinence***
- ***End of life care***

These indicators should be the basis of simple assessment tools adapted to all settings – community, hospital 'front door' and inpatient.

The core pathways and components of care for frail elderly are set out in the diagrams below (figures 8-10):

<u>Figure 8: Community support</u>

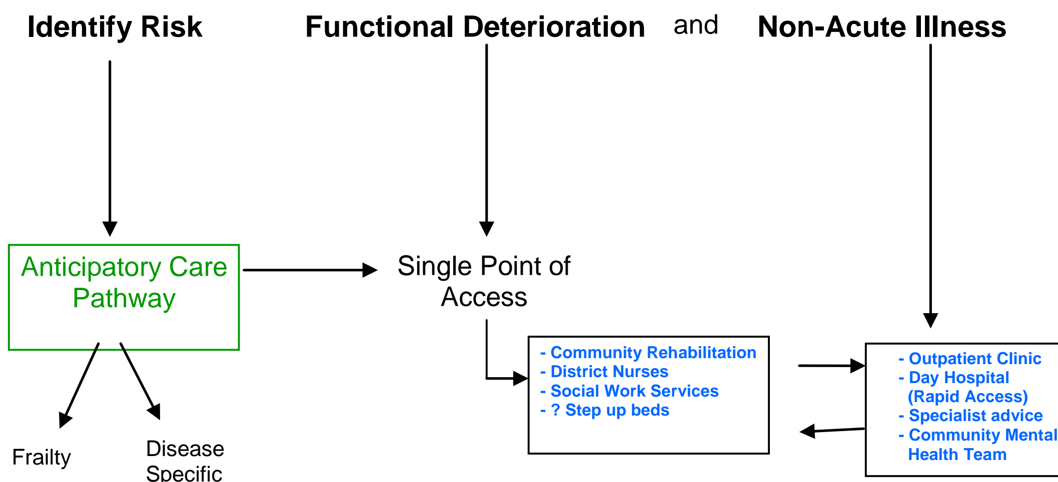


Illustration: For a patient, moving to the new model of care described might look like this:

Patient story

80 year old man with mild dementia and mobility problems, lives alone, has daily home care visits. Daughter lives 10 miles away, works full time and has small children but tries to visit several evenings a week.

Arrives one evening to find her father has an upset stomach and has been unable to get to the toilet quickly enough, and has fallen.

Now: Daughter unsure of where to get help, so phones NHS24. GP arrives, suggests admission to hospital. Patient admitted, investigated and treated for stomach bug. Confusion increases in strange environment, and mobility decreases as he stays in bed until his stomach is better. Stays in hospital for several weeks and now doubt about return home.

Future: Patient has been identified at risk due to mobility issues, dementia and living alone and has anticipatory care plan, informed by Comprehensive Geriatric Assessment, which sets out steps to take if he is ill or needs additional support. Daughter is able to see on the plan who to contact. Crisis team responds quickly, assesses father and helps to clean up and get him to bed. Arrangements made for GP to visit in the morning. Additional support put in place for a few days to ensure he is drinking enough and to support mobility until he is better. Care needs are reassessed and patient is given an alarm and increased support, with planned ongoing review.

Figure 9: Front door/hospital pathway

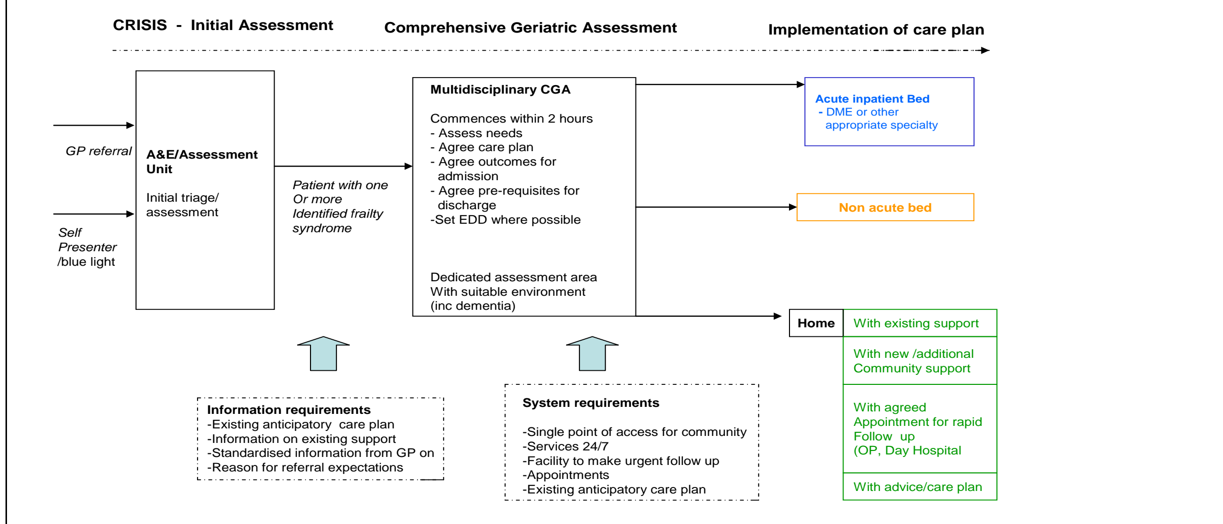
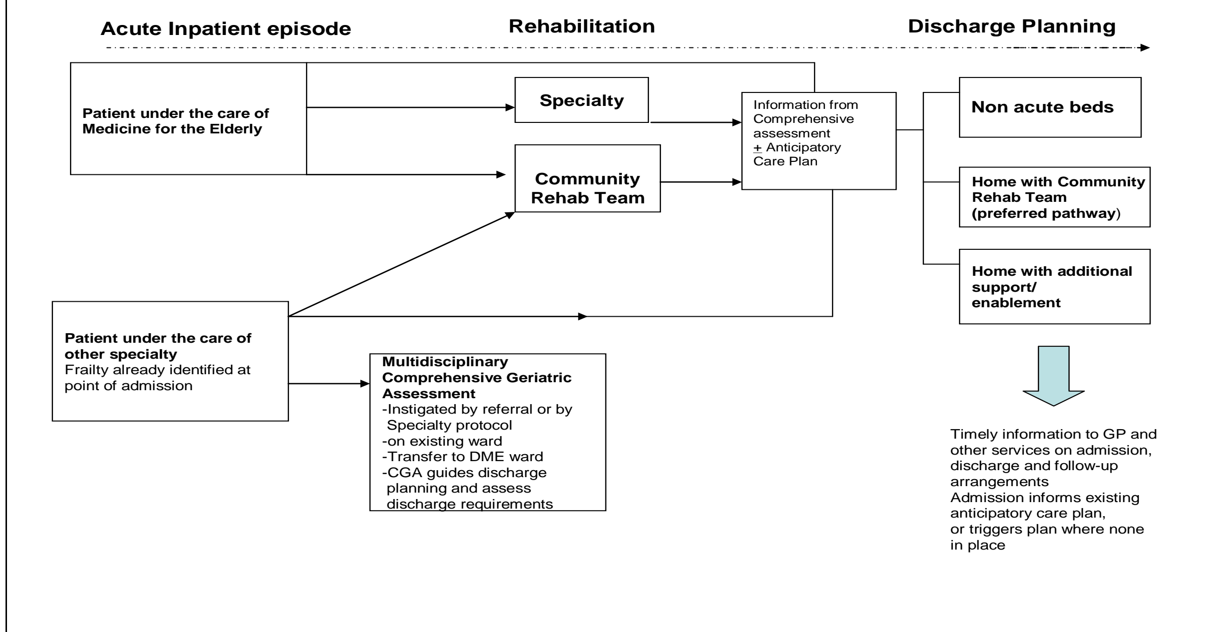


Figure 10: Inpatient Pathway (Frailty)



7.3.2 Anticipatory care

Anticipatory care plans must include frailty as well as chronic disease management. This includes consideration of social care needs, carer support, isolation, function and ability to manage the activities of daily living, supported by the multi agency single shared assessment process. It should explicitly include consideration of options for when carers are unwell or unable to provide support for any reason. The plans must enable rapid escalation of support from health, social care and third sector agencies supported by a 24/7 single point of access.

7.3.3 Comprehensive Geriatric Assessment (CGA)

CGA is strongly evidence based and drives the model for frail elderly. The pathways set out above enable CGA to be carried out in a community setting with specialist input through geriatric outpatients and day hospital services, and in acute settings with the presence of senior geriatric specialists at the front door.

Figure 11: The evidence base for comprehensive geriatric assessment

There is robust evidence to support multidimensional assessment and multi-agency management of older people leading to better outcomes, including reduced readmissions, reduced long term care, greater satisfaction and lower costs.

Comprehensive Geriatric Assessment (CGA) is defined as ‘a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up’.

While integrating standard medical diagnostic evaluation, CGA emphasises a quality of life and functional status, prognosis, and outcome that entails a workup of more depth and breadth. The hallmarks of CGA are the employment of interdisciplinary teams and the use of standardised instruments to evaluate function, impairment, and social support.

Comprehensive Geriatric Assessment should be available to patients with one or more identified frailty syndrome within 2 hours of A&E attendance (14 hours overnight) and should drive the treatment and care plan both within hospital and in the community. CGA needs to be available within the community, at the hospital front door and in inpatient settings. It is a key requirement that information which may inform CGA, and the outcome of the assessment, is passed through the system consistently and is easily accessible and useable in a fast paced environment.

Delivering CGA in an emergency environment is challenging, and will require access to a separate quieter area (such as a medical assessment unit) with an appropriate environment.

Patients who have been admitted as inpatients (either emergency or elective) to any specialty, may subsequently exhibit frailty syndromes and require access to Comprehensive Geriatric Assessment. This should be available in all settings and specialties, as an assessment which drives a care or discharge plan, or to consider the appropriateness of transfer to specialist Geriatrics.

Figure 12: Falls

Falls are a common trigger of an emergency episode, and a key indicator of frailty. Falls must be a core part of broader approaches to risk assessment and care planning. This approach should include the following components, with timescales in line with the National Falls Bundles:

- Primary prevention based on falls assessment as part of general frailty assessment and anticipatory care planning, including self assessment
- Secondary prevention based on rapid notification of falls in both community and inpatient settings, leading to:
  - Falls assessment as part of more comprehensive frailty assessment
  - Individualised plan agreed with patient and actioned within 6 weeks. The plan should cover a range of interventions to prevent future falls taking account of related clinical needs, mobility issues, home and social environment and medication.
- Inpatient treatment where required (e.g. fracture) with access to Comprehensive Geriatric Assessment 7 days a week for Orthopaedic patients.
- Rehabilitation. Transfer to Geriatric Orthopaedic Rehabilitation Unit where appropriate. Multi-disciplinary discharge planning and discharge to community rehab teams for ongoing falls assessment and intervention.

Review and follow up. Review of plan within 6 months of commencement to update or close the plan

7.4 Dementia

Dementia is a syndrome caused by a number of illnesses in which there is a progressive functional decline in memory, reasoning, communication skills and the ability to carry out daily activities. It is increasingly present in patients presenting for a range of other health needs. Alongside this decline, individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering. These cause problems in themselves, complicate care, and can occur at any stage of the illness. Dementia was reviewed jointly by the Older People and Mental Health groups and is considered further in section 8, but assessment and response to dementia and associated symptoms must be a core part of assessment throughout the older people's pathways described above, in all settings of ca

7.5 Implementation challenges for this model

- Defining the alternative models to admission such as advice service to support patients in the community non-acute beds to enable step down care considering the how this might impact to create a smaller 'acute' element of care with more non-acute and community infrastructure. This will require further definition of categories of 'non-acute' patients and support required including the risk of change and deterioration in patients, level of nursing care required and any ongoing diagnostic requirements.

- Front door model – general assessment with quick access to specialist care for treatment where required and the staffing model to support.

- Sizing the different groups and input required, for example likely numbers with frailty syndromes will drive front door geriatric staffing model. This will be based on assessment of known demographic changes, assumptions re potential for avoiding admissions, and an assessment of the current proportion of admissions with frailty syndromes.

- Work to assess further potential for home based rehabilitation / re-ablement.

- Particular consideration needs to be given to end of life care and supporting alternatives to acute hospital admission, particularly where patients wish to die at home or supported in a community setting (see figure 13).

Figure.13: End of Life Care

A key group where acute admission may not be desirable is for end of life care. The approach to palliative and end of life care should be based on:

- Palliative care needs being identified as soon as possible with more effective use of the **Gold Standards Framework** (GSF) in primary care, the use of the **Support and Palliative Care Indicators Tool** (SPICT) in in/outpatient settings and the use of the **Support and Palliative Action Register** (SPAR) in care home/continuing care settings. This would allow appropriate, timely engagement in the process of **Anticipatory Care Planning** (ACP).
- Ongoing holistic assessment being undertaken by professionals with good communications skills and a knowledge and understanding of the disease process, likely symptomatic issues and an appreciation of where these needs could be met, in order that the ACP process can be engaged with in a realistic way by the patient and family. This may be the GP, District Nurse, Consultant, disease specific specialist nurse, ward staff, care home staff or any of this combination in partnership.
- Effective communication of priorities of care. Conversations could be initiated using the My Thinking Ahead and Making Plans (MTA&MP) communication tool and further details placed on **Key Information Summary** (KIS) or the **electronic Palliative Care Summary** (ePCS) which can be accessed by unscheduled care areas, the Out of Hours Services and the Scottish Ambulance Service.

The preferred place of care is influenced by many factors. Options should include:

- **Care at home**, with the facility for patients to be assessed at any time in a 24hour period with rapid access rehabilitation teams, increased home care provision or equipment. The need for an appropriately skilled, well coordinated multi agency service in the community with effective communication systems is essential to this.

- Patients, who need less acute interventions sometimes simply observed care, may be suitable for rapid admission to **non acute bed**.

- There will be an ongoing need for Acute Admission for patients with symptom issues that cannot be managed at home. There is also a need for a “wider team” (or “virtual team”) assessment of patients on admission

so that their palliative care needs are assessed promptly, their co-morbidities are taken into account and prioritised and a plan is made for that individual based on the above assessment. This could include referring patient immediately for Hospice admission or being able to get the patient home with enhanced community care.

- Rapid access to **hospice beds** for assessment, complex symptom control and end of life care may be appropriate for those with more complex care needs, not needing or wishing admission to an acute bed.

7.6 Mental Health

7.6.1 Introduction

The mental health clinical groups focused on the models of care required for:

- Adult Mental Health
- Dementia
- Drug and Alcohol Services

The overall approach which applies across these services is set out below, with condition specific examples given where appropriate.

7.6.2 Overview of the approach

The purpose of prevention, treatment and care activity in mental health is to deliver health outcomes, a positive user and carer experience from contact with services, and to contribute to user's progress towards recovery/living well with their illness.

Achievement of that purpose requires:

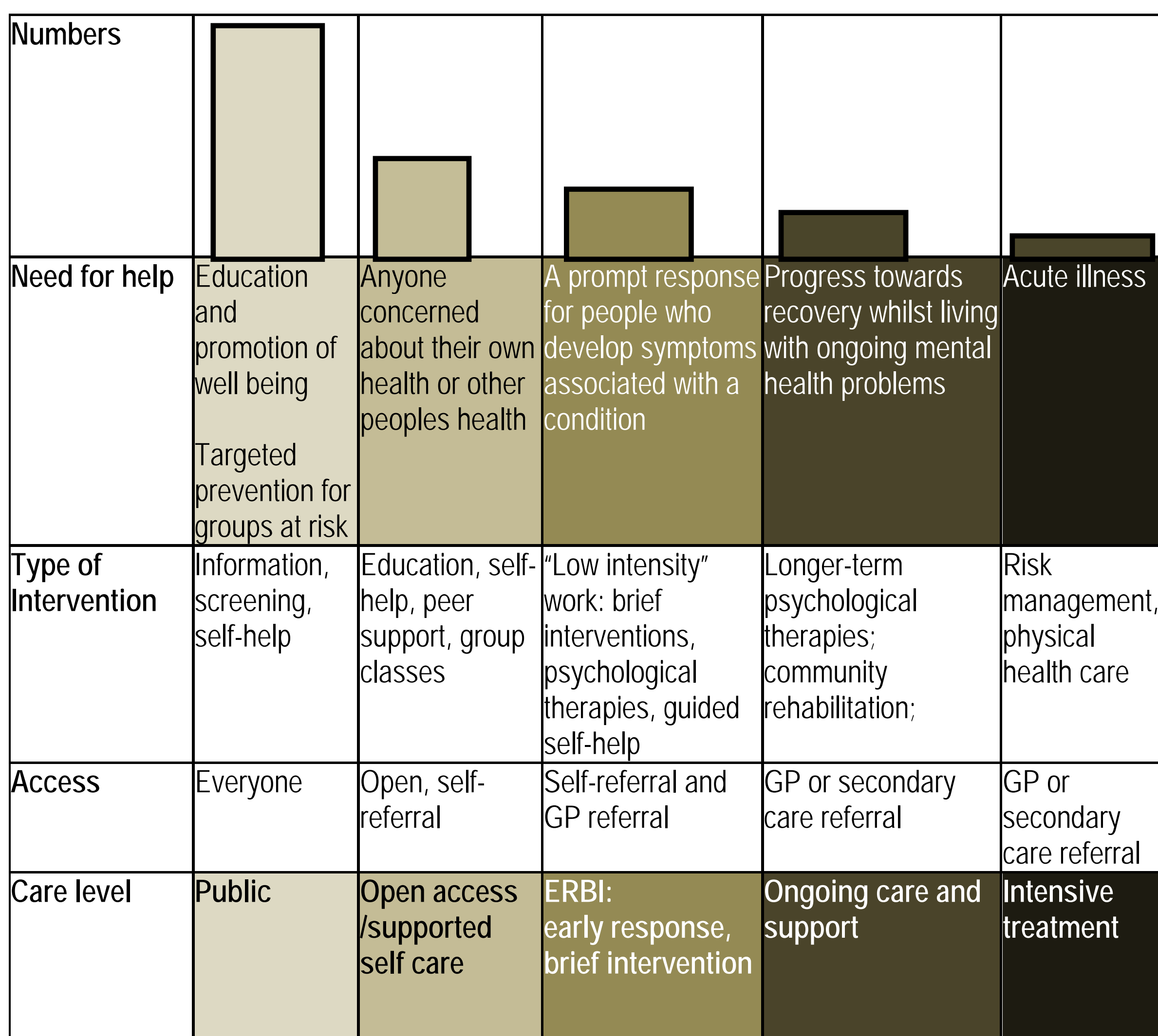
- A needs led structure of service delivery based on condition and frailty
- Interventions which are organised and delivered by condition
- Levels of intervention determined by the intensity and severity of the condition
- Interventions which are systematically delivered based on agreed condition specific care pathways consistent with evidence based/ best practice standards
- Users to be able to see their place on the care pathway
- Operational and team processes, practice, culture and pathways within and between teams which are organised and delivered to ensure:
    - Clinical interventions are systematically delivered based on the condition specific care pathways
    - Positive user experience in which carers and users are partners in care and feel well supported
    - Services are "easy in and easy out"
    - Interventions provide "everything you need and nothing more"
    - Patients with multiple morbidities receive coordinated rather than fragmented care
    - Care planning supports personal outcome based progress towards recovery/living well with the condition

7.6.3 <u>Clinical framework for prevention, treatment and care</u>

As with the approach described for physical chronic conditions, the overall approach is based on a stratified system of care, identifying need and responding at the most appropriate level of intensity.

The diagram (figure 17) below describes the overarching framework for mental health services. The Framework will be populated for each major clinical condition to set out the condition specific interventions and care pathway for that condition.

<u>Figure 17</u>



Numbers					
Need for help	Education and promotion of well being Targeted prevention for groups at risk	Anyone concerned about their own health or other peoples health	A prompt response for people who develop symptoms associated with a condition	Progress towards recovery whilst living with ongoing mental health problems	Acute illness
Type of Intervention	Information, screening, self-help	Education, self-help, peer support, group classes	"Low intensity" work: brief interventions, psychological therapies, guided self-help	Longer-term psychological therapies; community rehabilitation;	Risk management, physical health care
Access	Everyone	Open, self-referral	Self-referral and GP referral	GP or secondary care referral	GP or secondary care referral
Care level	Public	Open access /supported self care	ERBI: early response, brief intervention	Ongoing care and support	Intensive treatment

7.6.4 <u>Personal outcomes for service users and carers</u>

In their contact with services Service Users can expect:

- To define recovery goals together with the service
- Services support progress towards recovery /living well with their condition

People with mental health problems should be able to say that they have a positive experience of their contact with services and through this contact:

- I get the treatment and support I need when I need it
- Accessing services is straightforward
- I was diagnosed early
- I & those around me and looking after me feel well supported
- I am actively involved in decisions about my care
- I am treated with dignity and respect
- My care plan focuses on my recovery as I have defined it
- I have meaningful occupational interests and social involvement

7.6.5 Changes required to deliver the model

Moving towards this model will require the following changes:

1. Cease age based exclusions from access to service supports such as psychological interventions/crisis services and liaison psychiatry.

2. Shift from age based service configuration of adult and older people mental health services to needs based configuration of:

   - Mental Health 18+ (no upper age cut off, needs led transition based on physical frailty).
   - Dementia and Functional mental health combined with physical frailty service.

3. Consideration of service models for people with dementia given apparent commonality of health needs of people in acute wards and Older People Mental Health acute wards.

4. Address service gaps within the dementia care pathway:

   - Memory assessment service for early diagnosis of 2300 new patients per year in community setting.
   - Post diagnostic support services.

5. Review the functionality of services and teams to ensure their detailed operational processes are aligned to deliver the principles set out in sections 3, 4 & 5 above & in particular:

   - Systematic interventions of agreed condition specific care pathways.
   - Health outcomes.
   - Positive user and carer experience.
   - Recovery/living well with your condition.
   - “Easy in easy out”.
   - Coordinated management of multiple morbidities.

7.6.6 Implementation challenges for this model

Mental Health 18+

- Components of comprehensive service system are in place and no major service gaps per se
- Modest incremental further acute bed closures/balance of care shifts.

- Need to scope & size operational implications of shift to 18+ service for inpatient and community services.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

Dementia services

Resolve service model and relationships between mainstream acute and specialist dementia services to determine:

- Configuration of dementia services as integrated mainstream acute service or specialist dementia service.
- Size the dementia cohort and the challenging behaviour cohort to model workload implications of the configuration options for both acute and community services.
- Rework the bed model and site alignments between acute and MH sites to reflect the eventual agreed model and configuration of dementia services.
- Develop detailed service model and configuration of community based memory assessment services & post diagnostic support services.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

Drug and alcohol services

- Improve management of co morbidity between addictions and MH.
- Improve alignment between day services and community services.
- Improve access and support to substitute prescribing.
- Improve alignment of operational processes and recovery outcomes for service users.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

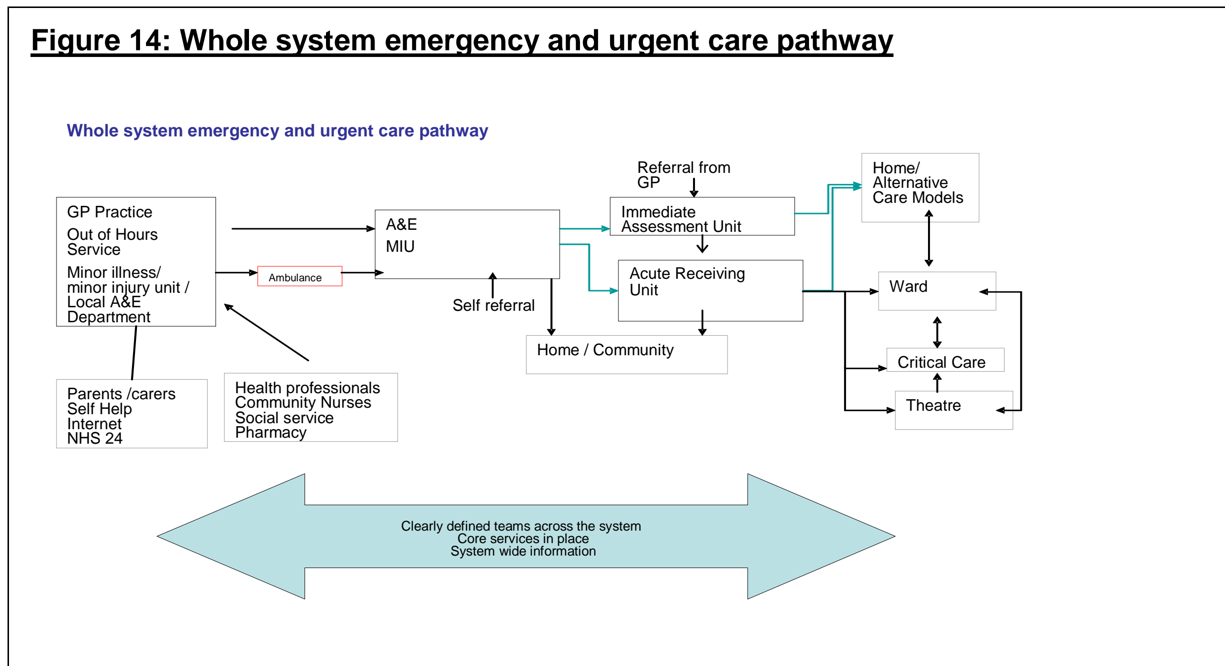
8. EMERGENCY CARE AND TRAUMA

8.1 Overview

Emergency services have to be able to respond appropriately to all patients who present. This section describes the proposed overall model for emergency services to meet standards and requirements for all patients and the changes to emergency services required to respond to the chronic disease and frailty pathways set out above (which form the majority of emergency admissions).

The overall pathway is summarised in the following diagram

Figure 14: Whole system emergency and urgent care pathway



8.2 Accessing emergency care

The key routes in to emergency care are set out below.

In-hours patients may:

- Call GP for an emergency appointment
- Call NHS 24 for advice and onward referral as appropriate
- Call other community service for an emergency appointment (e.g. Dental, Ophthalmology; Mental Health)
- Go to their pharmacy
- Call the Scottish Ambulance Service – who may treat on site, take to the Emergency Department or refer to another service (e.g. GP)
- Go directly to the Emergency Department/Minor Injury Units

Out of Hours patient may:

- Call NHS24 for advice with onward referral as appropriate and may be offered either GP OOH telephone advice, GP Out of Hours appointment; Minor Injury Unit or Emergency Department.
- Patients may choose to go directly to Minor Injury Unit, Emergency Department or walk-in to the GP Out of Hours service.
- Call the Scottish Ambulance Service – who may treat on site, take to the Emergency Department or refer to another service (e.g. GP)
- Call the Out of Hours District Nursing Service or other Community Services

8.3 Response to emergency assessment in all settings

When a patient is assessed in an emergency at any of the entry points above, a more flexible range of responses is required. A number of studies support the position that a much greater proportion of work could be undertaken as an outpatient or in an ambulatory setting including many acute medical emergencies. This requires our services to develop a

more “planned” urgent clinic approach to manage medical emergencies. Some examples are set out below:

Figure 15

Respiratory	Cardiology	Gastroenterology
- Community acquired pneumonia with a low CURB-65 score - Small pneumothorax - Asthma following British Thoracic Society guidance - Chronic obstructive pulmonary disease with supported home care - Asymptomatic pleural effusion	- Cardiac failure - Atrial fibrillation	- Upper gastro intestinal bleed with Rockall score of 0 - Lower gastro intestinal bleed with no haemodynamic compromise - Painless obstructive jaundice - Non-acute abdominal pain - Diarrhoea and vomiting
Endocrinology	**Infectious Diseases**	**General Medicine**
- Hyperglycaemia without ketosis - Hypoglycaemia with full recovery - Type 1 diabetes without ketosis - Electrolyte imbalances	- Cellulitis - Osteomyelitis	- DVT - Pulmonary embolism - Anaemia with no haemodynamic compromise - Syncope with low cardiac risk - Urinary tract infection

Based on the above position a number of services to support ambulatory emergency care are identified. These could be services that sit as part of the interface service model.

- Chronic obstructive pulmonary disease outreach
- Pleural disease clinics
- Rapid access chest pain clinics
- Transient ischaemic attack /stroke clinics
- Epilepsy clinic
- Pain management service
- Functional assessment teams and support teams
- Falls clinic
- Nurse specialists - diabetes, cancer, palliative care etc.
- Outpatient parenteral antibiotic teams
- Endoscopy services
- Heart failure team

A pre-requisite to changing how urgent and emergency care is provided is to ensure that there is quick and reliable access to GP appointments. This will allow patients to connect into the relevant services through their GP thus supporting patients accessing care in the right place at the earliest appropriate opportunity.

For most patients, the GP practice will be the first port of call for help or advice. Moving forward, we need to ensure that we have the right capacity in primary care to provide timely access to appointments for those who need to see a GP, and to build on the work of the access toolkit and productive general practice to provide a range of options for patients, including telephone advice where appropriate. This includes supporting GPs to free up

appointments by understanding and addressing the growing demand on primary care from multiple sources.

In addition to the disease specific approaches set out above, additional support to manage patients appropriately in the community could be provided through:

- Urgent access to specialist advice, for GPs to be able to discuss patients in an emergency situation.
- Urgent access to outpatient clinics (e.g. within 24 hours), directly bookable, where an immediate admission is not required.
- Single point of access to health and social care community services to provide immediate support at home where required.
- Access to step up beds where a patient requires additional support which cannot be provided at home, but does not require an acute admission.

It is also important that all services where people present as emergencies, work to the same common protocols with access to a consistent range of support services across GGC to ensure there is equity of access to care and that care is not escalated beyond the lowest level required.

To support this it will be important that all parts of the system can access the information about the patient, their ongoing care, e.g. their anticipatory care plan where applicable, to ensure the right intervention can occur.

8.4 Hospital Assessment and Admission

Once at hospital it is important to have clear patient pathways through each of the services. The major components of hospital emergency services are described below:

- Minor Injury Service
- Emergency Department
- Immediate Assessment Unit
- Acute Receiving Unit

8.4.1 Minor Injury Service

Nurse led Minor Injury Service led by Emergency Nurse Practitioners (ENPs) to provide treatment for a wide range of conditions including:

- Fractures of nose, shoulder, upper arm, elbow, forearm, wrist, hand (inc. fingers), knee, lower leg, ankle, foot and toes.
- Soft tissue injury including strains and sprains.
- Dislocations.
- Wounds.
- Burns.
- Minor head and neck injuries.
- Eye injuries and conditions.

This may be provided as part of a standalone Minor Injury Unit, or as an integral part of the Emergency Department, where the ENPs will work with medical staff as part of the wider emergency team.

8.4.2 Emergency Department

The Emergency Department provides care to patients with:

- Acute injury or illness associated with physiological derangement or threats to life or limb
- Acute undiagnosed illness or injury that requires time critical intervention to prevent long term impairment, disability or death
- Acute illness or injury resulting in acute severe pain until once made comfortable, they can have appropriate investigations or additional treatment before being directed to definitive care.

The Emergency Department does not provide services for:

- Minor non-urgent illnesses that can be better managed in a non time critical manner by other community or primary care services both in and out of hours
- Non acute exacerbations of chronic conditions that are under the management of specialist inpatient or outpatient services
- Non acute complications, enquiries or requests for advice following elective surgical procedures (including urology, orthopaedics, ENT, maxillofacial surgery, obstetrics and gynaecology etc).

The key role of the Emergency Department is to assess and treat quickly, and ensure that patients receive care in the most appropriate setting. Destinations from the Emergency Department will include home, home with community support which can be arranged directly from the Emergency Department, move to the Immediate Assessment Unit for a further assessment period, or admission to the Acute Receiving Unit.

8.4.3 Immediate Assessment Unit

GP referred patients will go directly to the Immediate Assessment Unit (IAU). The purpose of the unit is to provide rapid assessment of patients by senior decision makers.

The focus of the IAU will be to pursue appropriate alternatives to admission including: urgent out patient clinic appointments, rapid access to diagnostics, access to Comprehensive Geriatric Assessment by specialist multi disciplinary teams, initiating specialist care and opinion by the relevant specialty team and prioritising the timely admission of acute patients into the Acute Receiving Unit. Specific pathways will support patient management through this unit. Inter hospital transfers should not pass through Immediate Assessment Unit but should go directly to a specialty bed by agreement with the relevant specialty senior decision maker.

Care will be provided on a 24/7/365 basis. It is envisaged that the consultant input within the IAU for medicine will be predominantly from acute care physicians and the geriatric specialist team and will be supported by junior medical trainees and medical nurse practitioners.

The surgical model of care sees general surgery GP referrals, undiagnosed urology and undiagnosed vascular patients directed into the IAU.

The surgical receiving team under the control of the senior decision maker will provide opinion and admission or diagnostic decision making to the IAU 24 hours a day every day.

Orthopaedic, ENT and diagnosed vascular and urology patients should be directed from the Emergency Department for the relevant surgical specialist team to take the decision to discharge or admit to downstream wards or treatment facilities as appropriate.

It is proposed that all necessary imaging and diagnostic work is commenced in the IAU this should be available 24 hours a day 365 days a year; recognizing that these patients have the same diagnostic and imaging requirements as those within the ED.

8.4.4 Acute Receiving Unit

The Acute Receiving Unit (ARU) provides the initial period of acute management for patients assessed in the Emergency Department or Immediate Assessment Unit as requiring admission.

The ARU will enable senior decision makers to manage the patient's assessment with fast access to diagnostic tests and the ability to discharge home or for suitable patients for return to the emergency department outpatient department. The ability to care for patients in the ARU for periods over 24 hours will allow complex diagnostic investigations to be completed without the need to admit to a downstream ward. The aim is for all imaging of patients within the ARU to be completed whilst the patient is in ARU.

8.5 Principles and standards

8.5.1 For patients requiring attendance and or admission to hospital for emergency care the following principles and standards are proposed:

8.5.2 Principles

- Patients are managed in an area designated for their acuity of illness by a 'generalist' (this includes Emergency Department or Acute Care Physician, Care of the Elderly Physician, Intensive Care Medicine Physician or General Physician) with early input from a specialist where required to ensure the most effective treatment plans are put in place as quickly as possible
- Consistent standards of care are in place across the systems which maximise patient outcomes.
- Prompt commencement of time critical treatment.
- Prompt access to appropriate imaging (CT, U/S, plain radiography) to allow immediate diagnosis of life threatening conditions.
- Availability of appropriate critical care expertise and skills across the system.
- Early informed decision making regarding patient disposition.
- An extended presence of senior clinicians providing expert direct patient care, leadership and supervision.
- Timely, planned discharge to an appropriate setting and with appropriate support.

8.5.3 Process standards

- Emergency admissions should be seen promptly by someone who is appropriately trained to make an assessment of their care needs, and with prompt consultant input where required. The different needs of medical and surgical patients should be managed appropriately.
- The Assessment Unit approach is a core component of emergency care, providing protocolised periods of investigation, observation, and review for patients who would otherwise be admitted to scarce and expensive hospital beds or discharged potentially unsafely.

- Ambulatory care- care should be instigated in the Emergency Department / Immediate Assessment Unit / Acute Receiving Unit and continued in the community where clinically appropriate.
- A comprehensive 24-hour interventional radiology service should be available.
- To maximise patient outcomes, where specialist care is required, it should be provided by senior clinicians undertaking high volumes of cases/ operations in line with national guidelines.
- Emergency day case surgery should be available where clinically appropriate.
- Patients should be provided with any necessary care, treatment and support in the most appropriate setting and environment, compatible with the delivery of safe and effective care, including the community where appropriate.

8.5.4 Disease/condition specific standards

- Frail elderly patients should have early access to comprehensive geriatric assessment to support effective management.
- Appropriate and timeous access to mental health services should be in place for people with mental health needs.
- Patients suffering major trauma injuries should be taken directly to a major trauma centre.
- Patients suffering from chest pain should have timeous access to angiography services.
- Patients suffering from a stroke should be taken directly to a specialist centre (see figure 16)
- Acute hospitals providing care for patients with GI bleeding should meet the national recommendations and provide 7 days a week access to out-of-hours endoscopy services; within 1-2 hours of admission for severe bleeding and within 12 hours for moderate bleeding. Appropriate assessment systems should be in place in all sites, with appropriate care pathways in place to treat patients or to transfer patients to the appropriate site for definitive treatment.
- National guidelines should be met where available; for example in the care of patients with myocardial infarction, head injury, bleeding in early pregnancy, suicide prevention and child protection.

8.5.5 Diagnostics

- Underpinning the new models will be a heavy focus on access to diagnostics to support the assessment of patients. This will require changes to how the services are currently organised to support early investigation to support decision making without the need to admit patients to organise tests.

Illustration: for a patient, moving to the new model of care described might look like this:

Now: Present to A&E and is admitted to hospital

Future: assessed by a consultant, not acutely unwell requiring admission, sent home with an appointment for a diagnostic test the following day with an outpatient appointment. GP informed, community team informed where indicated. Patient has information on what to do if condition changes / warning signs to look for.

Figure 16: Example of future models: Stroke

- **Prevention:** Primary prevention and management of risk factors [Rapid assessment of high risk TIA patients within 1 day of referral. All GPs using rapid assessment service; cardiac and vascular services resourced to meet demand from stroke.

- **Hyper acute stroke service (HASS):** Scottish Ambulance Service take patients with FAST +ve suspected stroke directly to hospital with HASS beds; early specialist stroke team assessment; immediate imaging and investigations; treatment commenced (including thrombolysis where indicated); rehab commenced in HASS; 35% patients discharged home from HASS bed.

- **Integrated acute/rehab stroke unit:** transfer from HASS at average of 2.5 days post admission; 7 day stroke specialist Multi Disciplinary Team assessment and rehab (AHPs, nursing, medical); planning for discharge and support for carers; average length of stay in unit 21 days.

- **Early Supported Discharge within Community Stroke Team:** 6/7 day stroke specialist rehab; multiple visits per day to support early discharge from hospital; close links with re-ablement care services; time limited intervention with review/follow up.

- **Support in the Long Term:** local community and voluntary sector services with awareness of stroke; GP Enhanced Service for stroke.

8.6 Implementation challenges for this model

- How we can consistently support a model of the 'generalist' as first line approach supported by specialist rotas allowing timely intervention. It will also consider the implications of this model across Glasgow and Clyde in terms of:

    - Activity and patient flows
    - The staffing model of generalist and specialists required to support the model
    - Accommodation requirements to allow for the effective components of the models to manage patient flows as described.
    - Assessment / Decision Unit approach and availability of urgent outpatient service across GGC.
    - Contact system for GPs to discuss patients prior to referral to hospital.
    - Develop a more detailed position on key areas identified for a change in specialist approach:
        - Stroke
        - Angiography / angioplasty
        - GI bleeding
        - Vascular
    - Develop the major trauma centre in line with regional and national planning, considering the critical clinical adjacencies to support this.

9. PLANNED CARE

9.1 Key Components of the approach

9.1.1 Local provision of outpatient and ambulatory care facilities

It is proposed that wherever possible outpatients, investigations, day surgery and short stay surgery should be provided as locally as possible across NHS GGC. This would provide a full range of core clinical services locally to meet the majority of patient needs with patients travelling only where clinically required to other sites.

9.1.2 Outpatient model modernisation

Outpatient model of referral and attendance at outpatient clinic needs to be modernised to provide alternatives to clinic consultation. This should include telephone consultation, telephone advice services for GPs to manage patients without referral to hospital; direct to test approach where appropriate.

Return appointment models should be reviewed with the aim to reduce the return appointments where appropriate and to facilitate alternative follow-up arrangements where possible. This should include telephone follow up; discharge with patient driven return initiation. The recent cancer services group and the work on Quality Performance Indicators suggest that the follow up arrangements could be reduced. For chronic disease management, different approaches to ongoing management and follow-up are also being considered with both groups considering how community based follow –up and patient initiated follow up could be part of the future models.

9.1.3 Community based service provision

Care should be provided within the community wherever possible. This could include:

- Further development of local phlebotomy services and monitoring of patients in community.
- Nurse/AHP led clinical services in the community or in hospital where applicable. This would build on the currently available services such as the diabetes and respiratory services. Some of the areas currently proposed to be developed could include:
  - Lower urinary tract and incontinence service;
  - Raised PSA clinic – Nurse led triage clinic where TRUS biopsy is provided;
  - Chronic pain service.
- Specialist clinics in community settings, working with GPs and community teams to develop joint care plans for patients.

9.1.4 Consolidation of low volume/ high complexity care

The evidence suggests that there is a case for improving outcomes by providing complex investigations and treatments in only a few specialist centres. This applies in particular to cancer care, which is covered in the next section.

9.1.5 Maximisation of ambulatory care including day surgery and the development of short stay surgical models within Ambulatory Care Hospital type facilities

There is scope to improve the use of Greater Glasgow and Clyde's inpatient beds for planned care. This is in part by maximising day case surgery / day treatment but also by

managing the time patients spend in hospital after elective care, which can be quite variable across sites.
This variation is caused by a number of factors, including availability and the quality of home and community support as well as the surgical techniques used.

Programmes such as the Enhanced Recovery after Surgery (ERAS) should be in place to ensure that patients spend no longer than they need in hospital. These programmes also encourage active participation of patients in the care plan and recovery process. This type of approach should be encouraged across surgery. Similarly, less invasive techniques should be used where clinically appropriate to improve the patient experience and the speed of recovery.

Reducing length of stay, where clinically appropriate, will be important to improve the patient experience and to bring financial benefit to allow investment in other parts of the service.

9.1.6 Planned ‘urgent’ care clinics

Through the work of the Emergency Care work stream there are a number of areas being identified to develop a more planned approach to care to avoid emergency admissions. This was detailed in the earlier part of this report and requires the service to consider different approaches.

9.1.7 New service models

New service models to better support the management of patients are being considered such as the digestive diseases service combining gastroenterology and upper and lower GI surgery to provide a single coordinated service for GGC.

Illustration: for a patient, moving to the new model of care described might look like this:

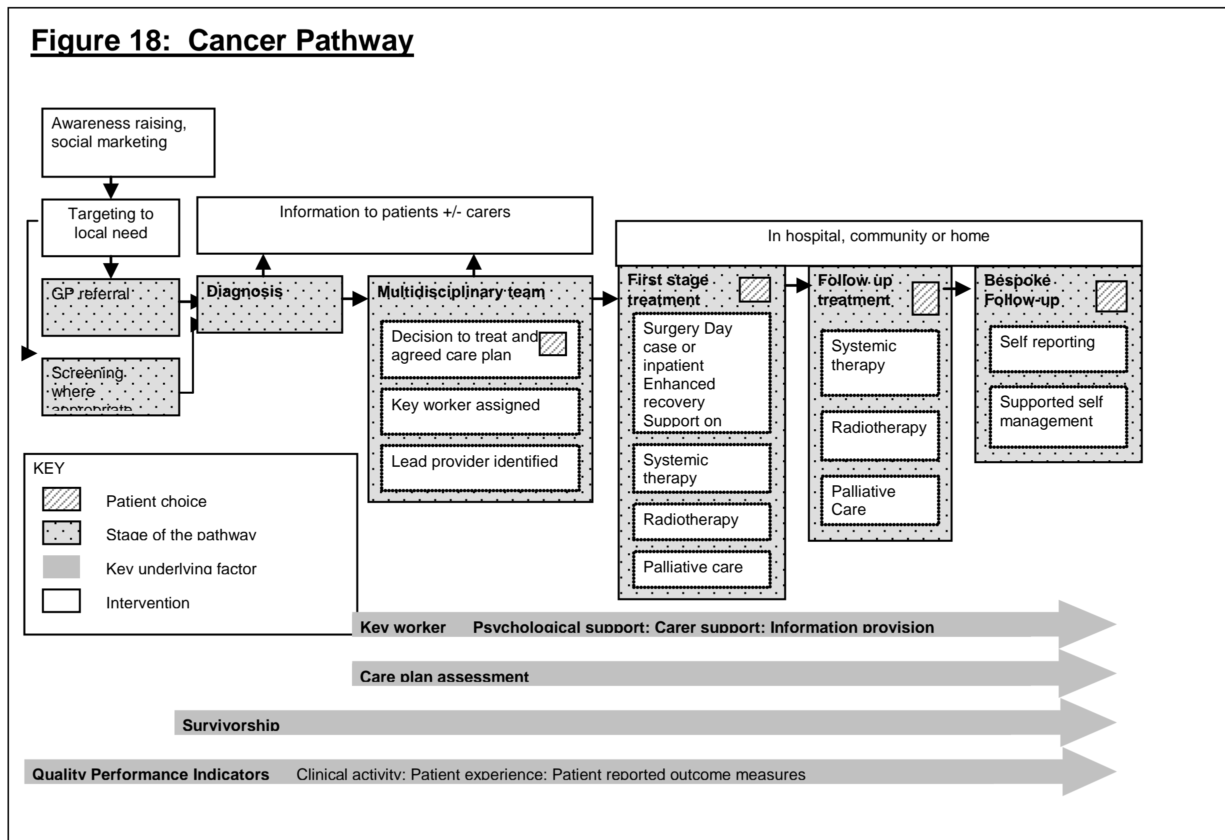
Patient Story
70 year old woman lives in Argyll and Bute, 4 hour travel time to services in Glasgow, main carer for husband. She attends outpatient clinic once a year for specialist follow up.

Now:
Sent an appointment for 9am, has to change to a time she can travel for
Makes arrangement for husband to be cared for
Travels all morning for rearranged early afternoon appointment
Has bloods taken and sees consultant for 5 minutes to be told everything is fine
Travels 4 hours home again – arriving late evening

Future:
Blood tests done locally, OP only arranged if indicated from results. Phone consultation or via telemedicine link for follow up where clinically appropriate.

10. CANCER

10.1 Key Components of Approach



The key aspects of the care pathway identified to enhance survival and quality of life are shown on figure 18 above. In general the cancer pathways are considered to be well established and working well. Some areas were identified as areas where further consideration and development is required which are discussed below. Clinical evidence suggests that common cancer care such as systemic anti cancer therapy and patient follow-up should be provided as locally as possible and where possible outside the hospital setting. The evidence also makes the case for improving outcomes by providing complex investigations and treatments in only a few specialist centres.

10.2 Cancer surgery

The number of site(s) providing cancer surgery should be based on numbers of patients and outcomes achieved. The proposed model of care recommends some further consolidation of surgical services for both common and rarer cancers. This will ensure that clinical teams and environments are in place to provide high quality care and improved outcomes for patients across Greater Glasgow and Clyde.

10.2.1 Impact for Common Cancer Surgery

- **Breast cancer surgery**

Breast cancer surgery can be delivered as a day case, with surgeons using less invasive techniques so that patients do not have to stay in hospital unnecessarily. Guidelines suggest that 60-70% of breast surgery should be day case.

To improve outcomes and experience, day case breast services should be available locally to all patients who require less complex surgery.

Patients undergoing more complex surgery should have the opportunity to discuss their breast reconstruction options and have immediate breast reconstruction if appropriate.

- **Colorectal surgery**

The number of patients being seen and patient outcomes from cancer audit results should determine the number of sites. Where clinically appropriate this should be delivered locally. Complex colorectal surgery with plastic surgical involvement should be delivered in a specialist unit.

10.2.2 Impact for rarer cancers

Over recent years NHS Greater Glasgow and Clyde has consolidated services into single sites for some rarer cancers such as upper gastrointestinal cancer. For a number of cancers this has also resulted in supporting other boards within the region to provide a tertiary level service such as ovarian cancer. However there are still some areas where we are providing care on a number of sites for relatively small numbers of cases. Consolidating services into fewer hospitals would create and maintain complete clinical environments that can enable the delivery of best practice providing improvements and benefits for patients by focusing experience in limited areas within services.

There are a number of rarer cancers where volumes mean that the service can only be provided from a single site.

- **Rarer urological cancers**

As with other small volume cancers urological cancers need to be provided from a specialist urology team. General urology services should be able to refer patients with complex needs to the specialist team. To ensure the best outcomes and experience, rarer urological services should have access to all of the requirements of a high quality service such as 24 hour access to interventional radiology, appropriate consultant cover and resident surgical juniors. NHS GGC needs to consider creating a centralised specialist team and unit to support the provision of complex urological cancer care. Currently there is ongoing work with other Boards within the region to realign small volume surgery into one service within NHS GGC.

10.3 Changes to Treatment

10.3.1 12.3.1 Systemic Anti-Cancer Therapy (SACT)

Guidelines recommend that to provide patient centred care the inpatient delivery of systemic anti-cancer therapy (SACT) should be minimised. Over recent year's local provision has developed in many areas linked to the central unit at the Beatson to provide more convenient treatment to patients where it is safe and clinically appropriate to do so. As therapies evolve with the development of oral preparations it will be important to develop the service to increase the care delivered locally and where possible and clinically appropriate out with the hospital setting.

10.3.2 Managing emergency care

For patients admitted as an emergency the guidelines indicate that arrangements should be in place to assess cancer patients immediately when they arrive at hospital to expedite care.

It is proposed to provide an acute oncology assessment unit (OAU) and 24 hour phone to provide a dedicated service for all adult oncology /haematology patients who are currently receiving /or have received treatment (chemotherapy /radiotherapy) in the past 6 weeks at the cancer centre, or are at risk from disease / treatment related immuno-suppression.

It will also support all patients attending the cancer centre who are identified to be at risk of developing malignant spinal cord compression (MSCC) as per the National Institute for Clinical Effectiveness (NICE) and the West of Scotland Cancer Network Guidelines.
It is expected that this will prevent unnecessary hospital admissions, and where hospital admission is required, ensure patients are seen /and or admitted to the right facility to support the care they require, improving patient outcomes and care.

10.3.3 Haematological cancers

The management of haematological (blood) cancers is increasingly dependent on the detection of particular genetic changes within the cancer cells. These require highly specialised molecular techniques and many new agents are being developed. These genetic changes are important for determining both prognosis and appropriateness of therapies, including the need for stem cell transplants. Molecular techniques can be used to monitor response to treatment.

Access to modern diagnostic techniques is critical to ensure appropriate use of therapies and to monitor effectiveness.

10.3.4 Follow up and Support

The follow-up of most cancer patients is done on a routine basis in hospital outpatient departments. Recent regional and national work through the Managed Clinical Networks (MCNs) indicates that there is a requirement to change the follow-up arrangements for many areas. This includes providing monitoring and follow–up within the community where possible including patient blood tests.

With changes to survivor rates it is recognised that the approach needs to be altered to offer more individualised aftercare services and more responsive to patient needs as some patients can become ill again between outpatient appointments and not feel able to see a specialist until their next scheduled visit. Changing the method of follow-up will improve outcomes and quality of life for patients and could free up specialists' time to continue to improve quality of care for all patients across GGC in other ways and could support a more person-centred interaction with the clinical team. To support this it will be important that patients are given the relevant information to make an informed choice on their preferred model of follow-up.

10.3.5 Supportive and palliative care

This is a key part of care, especially with the changes in survivor rates, and so needs to meet the needs of patients both living with cancer as well as to support advanced care planning for the end of life. Across NHS GGC the Gold Standard Framework has been

implemented as has the use of advanced care pathways. This has helped improve both palliative care and end of life care planning. See figure 13 on End of Life Care.

As future services are planned it is recognised that there is a need to ensure that holistic assessments are part of the patient pathway including assessment of psychological needs and the support requirements of carers with advanced care plans in place consistently across GGC to support patient care.

10.4 Implementation challenges for this model

- Modelling of the capacity required to meet the future predicted increase in cancer patient numbers.
- Consolidation of complex / low volume surgery / care – impact on patient activity changes / clinical team and infrastructure changes required.
- Front door model to support emergency care of patients with cancer.
- Provision of increased chemotherapy in the community – estimating the impact of chemotherapy changes and the community / local service capacity requirements or changes.
- Service requirements in primary care to support monitoring and follow up including links with the 3rd Sector to support patients and carers.
- Requirements to support palliative care and end of life care out with hospital with effective advanced care planning – this is linked to other work in relation to long term condition management and management of the frail elderly to consider alternatives to hospital care.

11. CHILDREN SERVICES

11.1 The emerging models from the Children's Services group in some respects mirror the developments in other work streams, such as emergency care and the management of patients with complex care needs, particularly in relation to the development of primary care, community services and better working at the interface. The specific drivers and proposed changes for children's services are set out in this section.

11.2 The Children's Group focused primarily on services provided to the NHSGGC population rather than on the wide range of regional and tertiary services provided by the Royal Hospital for Sick Children (RHSC). This acknowledges the national and regional planning fora which cover these more specialist areas, as well as the significant amount of work and redesign going into the planning for the new RHSC.

11.3 The work of the group focused on general paediatrics, long term conditions, links to the community and providing support in an emergency, as well as on effective transition between children's and adult services. These were the priority areas highlighted during the development of the Case for Change.

11.4 Core principles

- Care should be focused on the needs of children and families.
- Care should be provided in dedicated child friendly environments.
- The approach to care in settings should uphold the Rights of the Child
- There should be a focus on co-ordination of care and clear points of contact.
- There should be an appropriately trained, skilled and senior workforce: complying with relevant standards.
- Information should be shared and available across the system to inform care.

- There should be robust child protection systems in place.
- Emotional support has to be central.
- Clear transition arrangements should be in place when children move to adult services.
- Standards of care and access to range of children's services should apply equally across the whole of Greater Glasgow and Clyde.
- Care should be focused on reducing inequalities by ensuring access for the most disadvantaged and supporting children to have the best start in life.

11.5 Key components of approach

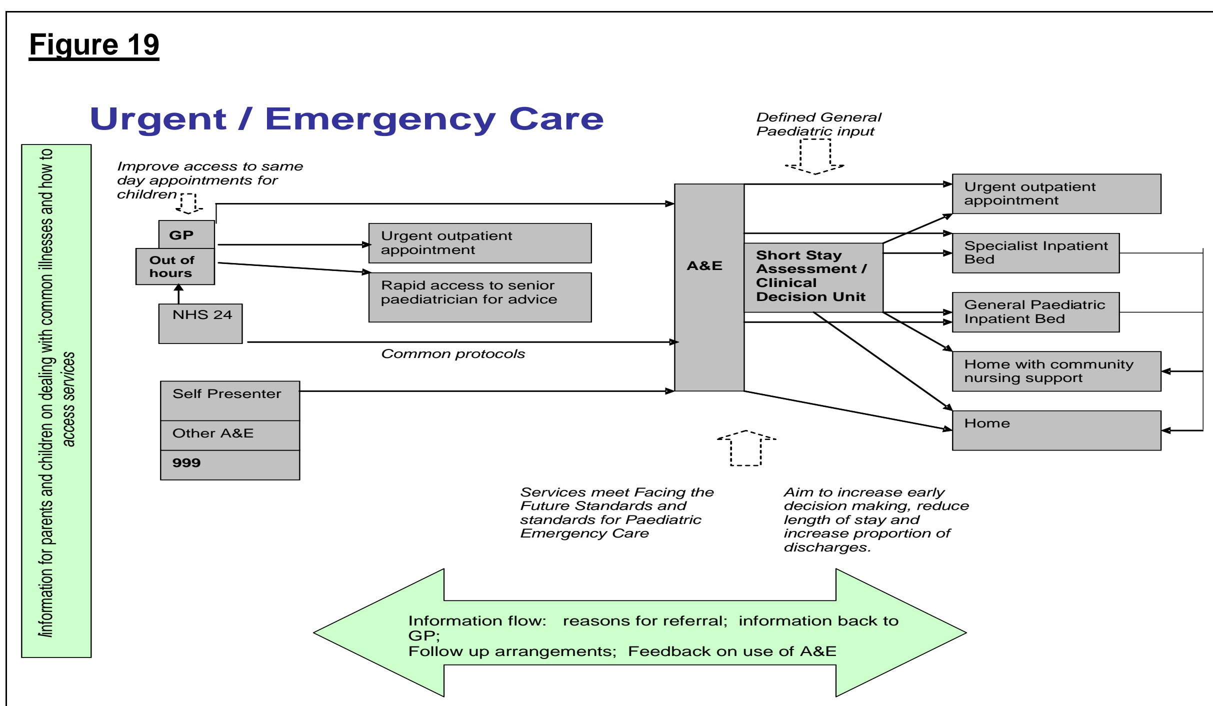
11.5.1 Emergency care

As with the model for adult emergency care there are a number of ideas being proposed to provide a range of alternatives to admission, which are accessible from the Emergency Department such as urgent outpatient appointment and community nursing support to enable earlier discharge.

This needs to be underpinned by the effective flow of information from the GP to the hospital and vice versa, supported by clear follow-up arrangements and feedback to practices on Emergency Department attendances and outcomes.

Where there are admissions for exacerbation of chronic disease this needs to prompt review of the care plan. The diagram below sets out the urgent / emergency care pathways.

Figure 19



This model requires a greater focus on the development of dedicated General Paediatric input as a focal point for the management of emergencies and alternatives to emergency admission. It also requires further development of nursing roles and closer working across acute and community services, facilitating earlier discharge and ensuring children can be supported at home were possible.

The 'Facing the Future' standard and Standards of Care for Paediatric Emergencies set out clear expectations for the skills, expertise and specialist opinion which should be available for children in all emergency settings. We need to ensure that we can provide this required range of specialist paediatric services to all children presenting as emergencies and those requiring inpatient care.

Key elements of this pathway will be implemented as part of the move to the new Royal Hospital for Sick Children on the South Glasgow Hospitals site. This move will enable all 'blue light' emergency cases for children in Glasgow to come to the dedicated paediatric unit which represents a gold standard in terms of access to the definitive place of care with specialist treatment, a dedicated child friendly environment and dedicated paediatric staff across a range of services and disciplines, including triple co-location between children's, adult and maternity services.

The changes described above will support that move and we need to consider further the pathways for 'blue light' emergencies and inpatient care, as well as minor injuries and self-presenters, across Greater Glasgow and Clyde to ensure that patients can access the right level of care as quickly as possible.

While this diagram focuses on access to urgent and emergency care from the community to hospital settings, we recognise that neonatal services also deal with a significant emergency workload with a pathway to urgent care from maternity units to neonatal units and that this is an additional route into emergency care. As such, it needs to be supported by clear criteria for identifying and transferring sick newborns both in maternity wards and in the early days following discharge home.

11.5.2 Planned care and long term conditions

The emerging service model seeks to establish local **Integrated Children's Centres.** This supports:

- Local provision of a range of services, enabling better joint management of patients across services and agencies, with locally accessible specialist care.
- Promote different way of working: not current hospital activity in a different place but rather a focus on effective joint care planning across primary care, community services and specialist paediatrics.
- Point of contact for families with long term conditions / complex disabilities, including being a focal point for transition.

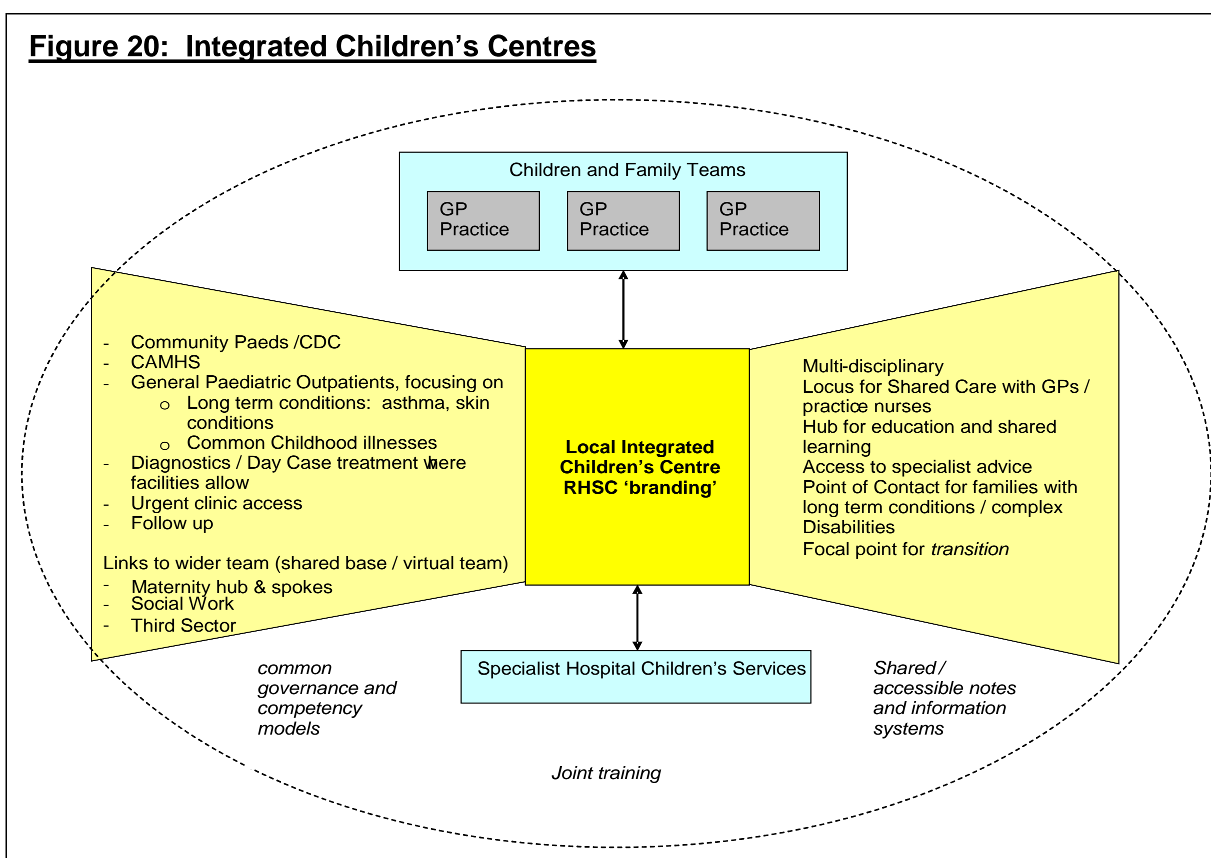
Core components of the **Integrated Children's Centres** would include:

- Community Paediatrics / Child Development Centres
- Child and Adolescent Mental Health Services
- General Paediatric Outpatients, focusing on
  - Long term conditions: asthma, skin conditions
  - Common childhood illnesses
- Diagnostics / Day case treatment where facilities allow
- Urgent clinic access
- Follow up
- Links to wider teams and services (shared base / virtual team)
  - Maternity hub and spokes
  - Social Work
  - Third Sector
- Link to localities / clusters of GP practices

- Locus for Shared Care with GPs / practice nurses
- Hub for education and shared learning
- Local point of access for specialist advice

This model will only work if it is seen as a very different way of doing things, rather than providing the same services in a different location. The real potential of integrated children's centres is to enable services and families to work together in a different way, across current service boundaries. The Royal College of Paediatrics and Child Health estimate that 50% of paediatric outpatients could be seen in a community setting, and that a greater community focus will lead to better long term conditions management and a more holistic social and behavioural approach. The centres also offer the opportunity to look at different ways of working to support children and families at home, and to set the foundations for effective chronic disease management for a lifetime. This includes using new technologies and making the most of opportunities for home monitoring and supported self care.

Figure 20: Integrated Children's Centres



11.5.3 Transition

Transition has been a recurring them of discussions with patients and professionals. The model described above will support effective transition through the integrated children's centres, enabling a clear point of contact and co-ordination for families, and by involving GPs at an earlier stage in the management of long term conditions and complex care packages for children which will give greater continuity into adulthood. In addition to this, good practice in the approach to transition has been identified as including the following components:

- Transition should be viewed as a process, not an event. Services need to view transition as a period of at least 2 years, which starts in early adolescence, and allows gradual, coordinated transfer of care to primary care and adult health services. The aim of the transition process is therefore to enable and empower young people and their families to confidently access adult services.

- A key worker should be identified to coordinate the transition from paediatric to adult health services.

- In order to develop workable transition care pathways, there should be good communication and cooperation between paediatric and adult services and GPs.

- Joint transition clinics for paediatric and adult health services would help support the transition of young people with more complex needs and/or those requiring ongoing active management. The future co-location of adult and paediatric hospital services at the South Glasgow Hospitals site might help to facilitate this joint working for some hospital-based teams.

- The collation and sharing of information between health professionals needs to be improved to ensure effective transfer of health information to adult services. This sharing of information may be facilitated by improved IT systems. The use of a patient-held health record should also be considered.

12. MATERNITY SERVICES

12.1 Principles

- Focus on providing safe, accessible and effective care which improves outcomes for women and babies and reduces inequalities.
- Care focused on the health and social needs of women and families.
- Promotion of normal childbirth and reduction of interventions.
- Appropriately trained, skilled and senior workforce: complying with national workforce recommendations.
- Strengthen communication and collaboration between services which include other key NHS services and local authorities.
- Women are able to make informed decisions about their care.
- Use women's experience of care to drive service improvements.

12.2 Key components of approach

The key components of the approach of the service model for maternity care are set out below:

- Pre-pregnancy advice and health promotion.
- Early booking.
- Comprehensive assessment as early as possible, informed by shared information.
- Early identification of red / green pathway: midwife led care where possible, with regular review and ability to move between pathways when required. Identification of risk and appropriate support is critical to successful outcomes, and to defining future service and workforce needs both for maternity and neonatal services.
- Early pregnancy assessment service available 7 days a week.

- Increased support for vulnerable women and families in pregnancy: identification of vulnerability based on broad assessment of individual family and social circumstances.
- Supporting access to wider services including financial inclusion, welfare advice, and family support.
- Health visitor involvement as early as required, especially for vulnerable families: co-ordination of care and handover between midwife and health visitor.
- Team based approach with a central role of midwives as autonomous practitioners of normal pregnancies, working as a team with obstetricians, anaesthetists and paediatricians, in the care of women with complex and complicated pregnancies.
- Delivery suites meet required staffing standards: Midwife, Obstetrician and Anaesthetic cover. Move to 24 hour consultant obstetrician presence. Increasingly this will require to be covered by dedicated Obstetricians, with the increasing specialisation of gynaecology.
- 'Timely' discharge from hospital: reducing length of stay.
- Neonatal units which comply with Neonatal Quality Framework standards, with clearly defined pathways to ensure that babies are identified in post-natal settings and transferred in a safe and timely manner.

13. UNDERPINNING SYSTEM CHANGE

13.1 As we move to develop implementation plans for this strategy there are a number of areas of work which need to underpin system change. These include:

- Diagnostics and diagnostic Systems
- Information and Information Systems
- Communications
- New Ways of Working - appointment systems / technology
- Ways we deliver care – person centred care. Equalities sensitive practice

13.2 There are also implications for Other NHS Organisations including the SAS, NHS 24 and other territorial health Boards.

14. PUBLIC AND PATIENT ENGAGEMENT

14.1 There has been extensive engagement through the development of this clinical services review which has been referenced throughout this document. Formal approval of the Clinical Strategy is a further opportunity for that wide engagement. As we develop specific change proposals engagement will continue to be fundamental.

14.2 The Scottish Health Council (SHC) have been involved in this process from the start, attending the ongoing engagement events with the patient reference groups and the third sector as well as attending the event at Hampden in April when the emerging service models work was shared with the wider clinical group. In addition they have met with Board Officers to discuss the programme and to share thinking on the approach being taken, feedback on their observations and to support planning for the ongoing engagement. As the planning to develop service change proposals follow this strategy this close engagement will be continued to ensure the approach taken is in line with SHC guidance in relation to engagement, pre consultation and consultation, where this is indicated. The fill SHC commentary on the review is attachment one to this paper.

15. CONCLUSION

15.1 The clinical service review has enable us to develop this clinical strategy to provide a basis for the development of detailed service change proposals working with Integration Joint Boards and with the emerging national approach to clinical strategy and delivering the 2020 Vision. We need to work together to deliver:

- Improving health and prevention of ill health; empowering patients and carers through the development of supported self care.
- Developing primary care and community service models; simplification of community models; focus on anticipatory care and risk stratification to prevent crisis.
- Improving the interface between the community and hospital to ensure care is provided at the right time in the right place; Community and primary care services inward facing and hospital services outward facing; focused on patient and carers needs.
- Developing the ambulatory approach to hospital care, with inpatient hospital care focused on those with greatest need ensuring equitable access to specialist care.
- Redesign of specialist pathways to establish a consistent service model delivering the agreed clinical standards and good practice guidelines.
- Developing the rehabilitation model based on need not age; working across the service within primary and secondary care and with partner organisations to provide rehabilitation in the home setting where clinically appropriate.
- Changing how care is delivered - patient centred care; shifting the paradigm to deliver care differently for patients particularly for patients who have multiple conditions; helping patients and the public to develop and understand the new approaches to care

[i] London Health Programmes: A framework for action, 2011.

[ii] Better cancer care: an action plan (2008). Edinburgh: Scottish Government.

Attachment 1

Board consideration of clinical services review

Clinical Services Review

21 February 2012	Board Meeting	Clinical Services Fit for the Future paper to the Board for agreement for agreement to progress
02 October 2012	Board Seminar	Briefing on Clinical Services Review
18 December 2012	Board Meeting	Case for Change to Board for Approval
07 May 2013	Board Seminar	Emerging Service Models (presentation)
07 August 2013	Board Seminar	Service Models (presentation)
20 August 2013	Board Meeting	Service Models Paper to Board for approval
6 December 2013	Board Away Day	Clinical Services Review Update (presentation)
17 December 2013	Board Meeting	Clinical Services Review Update - Development of the Renfrewshire Development Programme for approval
14 February 2014	Board Away Day	Clinical Services Review Update (presentation)
21 October 2014	Board Meeting	Clinical Services Review Renfrewshire Development Programme update paper to Board
09 December 2014	Board Away Day	Clinical Services Review Update (presentation)

9th

Attachment 2

scottish health council

making sure your voice counts

Ms Catriona Renfrew
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Date: August 2013

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Dear Catriona

Clinical Services Review Fit for the Future

The Scottish Health Council has welcomed the exchange of information that's taken place between ourselves and board officers over the past 18 months. We consider that this has been helpful in enabling us to have a dialogue to ensure that the process, as it develops, observes the principles of openness and transparency, contained within national guidance.

As well as providing comment on the board's early process of engagement and information, we have also used these meetings to provide feedback on our observations from the meetings hosted by the board and share the findings of our recent survey on participants' experience of involvement.

Scottish Health Council staff attended most of the Patient Reference Group sessions held during the period March 2012 to April 2013; Third Sector events held in January and June 2013; the Combined Clinical Group workshop in April 2013; and the Combined Patient Reference Group meeting held in June 2013.

We also note that there was patient and public representation on each Clinical Steering Group and that an Overarching Patient Reference Group met several times throughout the process. In addition we are aware that NHS Greater Glasgow and Clyde officers took the opportunity to discuss this review process with Public Partnership Forums and some community groups across the Board area.

For each meeting between the Scottish Health Council and board officers we prepared a "feedback paper" to inform our discussions. Our most recent meeting was held on 25th July 2013. The feedback on the board's review process for June and an extract from the May feedback is provided as an appendix to this letter.

Some of the key themes from the engagement so far have included:

- Participants appear to support the general direction of travel (anticipatory care and early intervention) and some acknowledge that difficult decisions may be needed in order to deliver new models of care.
- Some people have expressed concerns around the interface between acute services and primary care (including access to and capacity of GPs), discharge planning and community support.
- Some participants at the Patient Reference Group sessions have whether there are sufficient links with local authorities, other public agencies and the Third Sector to support multi-agency pathways of care.
- Challenges have been identified around how some of the aspirations can be implemented eg staff training, finance and resources.
- Some participants at the Combined Patient Reference Group session in June 2013 noted that it was difficult, at this stage to see anything coherent within the draft service model discussion paper and referred to the challenge of articulating the emerging models of care, with the inclusion of the proposed 'interface services'.
- Consideration should be given to continued discussion and engagement with neighbouring Boards

and their patients/public involvement structures in any proposed service development and change. As part of the Scottish Health Council's survey to capture participants' experience of involvement to date, we issued130 questionnaires (70 by hand, 47 by post and 13 by email) and received 36 completed questionnaires giving a response rate of 28%. Responses included:

- 29 people (81% of respondents) felt they'd been able to contribute to the emerging models and 24 people (73%) felt that the models reflected previous group discussions.
- 25 people (69% of respondents) felt they'd been able to influence the process
- 32 people (89%) indicated that they intend to continue their involvement in the process

In response to some of the issues raised, the Scottish Health Council would encourage NHS Greater Glasgow and Clyde to:

- Consider how patients, carers, the public and voluntary sector may continue to be meaningfully involved in further engagement.
- Ensure that information is accessible for a wide range of people and that acronyms and technical language is kept to a minimum. Information and communications should be developed with patients, carers and public representatives to ensure that the language and content supports peoples' understanding of any proposals.
- Seek to address the issues and concerns that have been raised by patient and public representatives and staff during this early phase of engagement to inform the next steps.
- As the detail of the review emerges, demonstrate the 'contrasts' between existing and proposed new services. The paper makes reference to "support to maintain people at home, when clinically appropriate", "need to do more to stop people being admitted to hospital" and "help people leave hospital more quickly". However it may not be clear to people whether this drive is to maintain existing structures and services or may result in disinvestment or changes to service configurations. The use of case studies may also help people to appreciate the impact of change.
- Work in partnership with special and neighbouring NHS boards, public agencies, the Third Sector and others as more detail around service models emerges.
- Continue to develop the equality impact assessment, with additional elements from health inequalities.
- Evaluate its process and structure of engagement (March 2012 – June 2013) to identify any learning and areas for improvement.

At our meeting on 25th July, representatives from the board acknowledged that the service models developed do not currently contain the necessary detail required for public consultation. We agreed that the timescales in the draft discussion paper did not reflect the further work required to develop specific models/proposals in order for or a wider group of people to then be engaged. T This should include option development and appraisal which should assist in identifying any preferred options. Where the proposal, or elements of th his, may be considered 'major' the guidance "Informing, Engaging and Consulting People in D Developing Health and Community Care Service" (CEL 4 (2010)) indicates that the board should not move to consultation until they have confirmation from the Scottish Health Council on the public c involvement process to date. Finally, we would like to acknowledge t e the scope of involvement work conducted to d date and encourage this to be carried forward as the process develops. We would be happy too continue our dialogue with NHS Greater Glasgow and Clyde as planning is progressed and look f forward to hearing from you in due course.

Yours sincerely

Louise Wheeler
Service Change Adviser

Appendix

Extract from Feedback on process for Clinical Services 'Fit for the Future' May 2013

Emerging themes from PRGs from discussions

- Numbers have remained consistent at each of the workshop sessions (suggesting that people have stayed involved in the process)
- Participants at the PRGs have questioned the 'links' with local authorities, public agencies and the Third Sector to support multi-agency pathways of care
- Participants have had the opportunity to respond to the issues/themes raised from earlier PRG sessions. Clarity was sought on shared understanding at the start of each session.
- At several of the workshops, participants have questioned buy-in to the review from GPs and the primary sector
- Concerns around how some of the aspirations can be implemented eg staff training, finance/resource (Unplanned care/Chronic Disease)

Information

- Note that information from the first two PRGs is available on the Board's website.
- Information and presentations do not appear to be shared consistently with participants in advance of meetings
- The presence of a clinician has enabled participants to ask, and get immediate response, to some probing and specific questions.
- To date, lay participants appear to be content with the review process and their involvement with some representatives speaking supportively of it at sessions.
- Some people noted that there were too many acronyms in some of the presentations (Planned care, Cancer). Where possible the use of these should be eliminated or reduced.
- In Mental Health, some participants found the papers difficult to understand. The content, detail and format of these should be considered for future participation.
- Participants raised an impression that there may be reluctance by NHS staff to refer to third sector services. This point was agreed upon as something requiring further investigation by the Board officer present.

Next steps

- Participants have suggested that it would be helpful to bring all the public representatives together for the next round of discussions, given the cross-over/ entire patient pathways
- With patient flows between services across neighbouring Boards – have discussions taken place to engage these Boards and their patients/public involvement structures?
- The Scottish Health Council welcomes the development of the EQIA for the review process – we would encourage the Board to consider how people with protected characteristics may be involved in considering service models and engagement and consultation processes.

- Gauge impact re specialist tertiary care – have other Boards and patients been involved in this work? Board officer stated that the Tertiary Care Clinical Group has been informed from discussions of other PRGs and the service models will be shared at event in June – will relevant Boards/ patients/ public representatives be invited to this session?
- Discussion around the Scottish Health Council's survey questionnaire (June 2013).

Feedback on process for Clinical Services 'Fit for the Future' July 2013

The comments below come from the Scottish Health Council's attendance at the Third Sector event on 24th June, the Combined Patient Reference Group session on 26th June, the Scottish Health Council's feedback survey and consideration of the Clinical Services Review discussion paper. It is also informed by reviewing footage of interviews conducted by NHS Greater Glasgow and Clyde with six members of the Overarching Patient Reference Group.

Information

- The Scottish Health Council welcomes the ongoing exchange of information and communication that's taken place with board staff and the Scottish Health Council and their response to feedback.
- Three people in NHS Greater Glasgow and Clyde's interviews advocated the use of plain language, without acronyms, to support understanding.
- From the Scottish Health Council's survey, 29 people (85% of respondents) said they'd received enough information and 32 (91% of respondents) said that information had been shared in a timely manner.
- The events in June were planned to share the emerging service models with patient and public representatives and the Third Sector. Although Board officers presented an overview there was little detailed discussion or interrogation of the discussion paper that was sent in advance of the meeting
- At the Combined PRG session, some people felt that there was too much information to take in and that it was difficult to see how this had evolved from PRG involvement.
- Some participants highlighted that they felt the presentations were comprehensive and provided a good overview.
- Some participants noted that it was difficult to see anything coherent within the discussion paper and that it was difficult to articulate the emerging models of care, with the inclusion of the proposed 'interface services'.
- One group at the Combined PRG session noted that there was not enough information for people to understand what the models mean. The Scottish Health Council notes that public representatives sit on the Clinical Groups as well as the Patient Reference Groups.
- Two respondents to the Scottish Health Council survey suggested that more detail would be needed to engage with the public.

Implementation and themes

- It was suggested that there may be challenges to collaboration within the Third Sector as each organisation seeks to:
- o Preserve their own identity and empowered budget
- o Successfully compete for the same pot of money
- Most participants at both events appeared to support the general direction of travel (anticipatory care and early intervention) and recognised that some difficult decisions would be needed around disinvestment in acute care.
- Some people are concerned around GP interface, discharge planning and community support.
- Three people (through the Overarching PRG interviews and Scottish Health Council survey) commented that work to date appears to have been mainly led by medical professionals – participants suggested that the Board extend involvement to other staff groups
- Participants suggested that further engagement is needed with social work, education etc.

Process

- Some participants at the Combined PRG session noted that they had welcomed the Board's openness and opportunities for discussion
- The Scottish Health Council notes that there were fewer people at the Third Sector event in June (around 35) compared with that held in January (around 100).
- • Responses to the Scottish Health Council survey indicated:
- o 32 people (89%) intend to continue their involvement in the process (note that Board advised that the PRG work has now drawn to a close).
- o 29 people (81% of respondents) felt they'd been able to contribute to the emerging model and 24 people (73%) felt that the models reflected previous group discussions.
- o 25 people (69% of respondents) felt they'd been able to influence the process
- • Some additional comments from the Scottish Health Council survey (not covered elsewhere):
- o Exciting and ambitious project
- o Continue to engage with service users and the public
- o Aim to recruit more young people/identify gaps in representation

Scottish Health Council's Survey Responses

The Scottish Health Council issued 130 questionnaires (70 by hand, 47 by post and 13 by email) and received 36 completed questionnaires giving a response rate of 28%.

Half of the respondents indicated which workstream they were involved in – but all workstreams had a response from at least one representative (highest was Older People with six responses).

Most people indicated that they were representing a group or structure eg Public Partnership Forum (12), community/voluntary group (12), Third Sector (11). Note that the Third Sector is also involved through a separate process.

Clinical Services Review Discussion Paper

- The Scottish Health Council is unaware of any discussions with lay representatives around the detail and content of the board's discussion paper though there has been lay representation in the development of service models through the Clinical Groups. We acknowledge that people have indicated general support for the direction of travel for the process to date. However, some people have commented on the lack of detail about what is being proposed.
- We acknowledge the scale of the Clinical Services Review project and the board's attempts to provide a comprehensive overview – and this is reflected in the length of the discussion paper. However, this may be to the detriment of making the paper accessible to lay participants. Consideration should be given to some of the terms used such as polypharmacy and co-morbidity and whether a glossary would assist with this.
- We welcome the Board's production and distribution of a more succinct four page summary. It may be helpful if this format is used as the process progresses and the details emerge.
- As the detail of this review work emerges it would be helpful to demonstrate the 'contrasts' between existing and proposed new services. The paper makes references to "support to maintain people at home, when clinically appropriate", "need to do more to stop people being admitted to hospital" and "help people leave hospital more quickly" however it may not be clear to people whether this drive is to maintain the existing structures or may result in disinvestment or changes to service configurations.

Next steps

- The Scottish Health Council notes that the service change models are still at a high level and give a general direction of travel. The paper and Board officers have acknowledged that more work involving stakeholders is needed to develop these further.
- The Scottish Health Council would suggest that in future information should aim to communicate the impact of change perhaps through the use of case studies or 'contrasts' (comparing existing service with the new service). Information and communication should be developed with patients, service users and carers to ensure that the language and content supports people's understanding.
- Consider how existing patient representatives may be further involved in the engagement process.
- It will be helpful to clarify what stage NHS Greater Glasgow and Clyde has reached in their review process in terms of the Informing, Engaging and Consulting guidance, CEL 4 (2010)and discuss expectations and next steps.

In particular we note the timescale outlined in section 13 of the board's discussion paper. The timescales do not appear to indicate further work may be required to develop more robust models/proposals that a wider group of people can then be engaged. This engagement should include option development and appraisal in order to identify any preferred options. This review process, or elements of this may be considered 'major' change. In such cases, the guidance indicates that the board should not move to consultation until they have confirmation from the Scottish Health Council on the public involvement process to date.