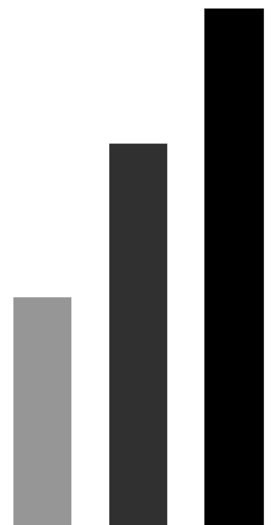
INVERCLYDE HSCP
Health and Social Care Partnership

Agenda 2016

Inverclyde Integration Joint Board

For meeting on:

18	August	2016



INVERCLYDE
HSCP
Health and Social Care Partnership

Municipal Buildings, Greenock PA15 1LY

Ref: SL/AI

PLEASE NOTE VENUE OF MEETING

Date: 5 August 2016

A meeting of the Inverclyde Integration Joint Board will be held on Thursday 18 August 2016 at 3pm within the Scott Walker Room, Holiday Inn Express, Cartsburn West, Greenock PA15 1AE.

Gerard Malone
Head of Legal and Property Services

BUSINESS

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1.	**Apologies, Substitutions and Declarations of Interest**	**Page**
2.	**Inverclyde New Ways of Working** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership **NB:** There will also be a presentation on this item	**p**
3.	**Minute of Meeting of Inverclyde Integration Joint Board of 20 June 2016**	**p**
4.	**Directions from Integration Joint Board to Inverclyde Council and NHS Greater Glasgow and Clyde** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
5.	**Freedom of Information Arrangements** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
6.	**Freedom of Information** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
7. **	**Period 3 Financial Report** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	

8.	**Health Board Financial Allocation 2016/17** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
9.	**Performance Exceptions Report** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
10.	**HSCP Complaints Annual Report 2015/16** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
11.	**Delayed Discharge Performance** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
12.	**Risk Management Policy and Strategy** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
13.	**Imatter Update** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
14.	**GP Health and Care Experience Survey 2015/16** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
15.	**Strategic Service Planning** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
16.	**Chief Officer's Report** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
The documentation relative to the following items have 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 the paragraphs of Part I of Schedule 7(A) of the Act as are set opposite the heading to each item		
17.	**Living Wage** **Paras 9 & 12** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership on the implications of implementing the Living Wage in relation to the provision of Adult Care	**p**
18	**Governance of HSCP Commissioned External Organisations** **Para 6** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership on matters relating to the HSCP governance process for externally commissioned Social Care Services	**p**

19.	**Report on Care Home** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership on issues relating to a particular care home	**Para 6**	**p**

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

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 2

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/51/2016/BC**
Contact Officer:	**Beth Culshaw Head of Health and Community Care**	**Contact No:**	**01475 715283**
Subject:	**INVERCLYDE NEW WAYS OF WORKING**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board of the range of work underway across Inverclyde in relation to the New Ways of Working pilot.

2.0 SUMMARY

2.1 General Practice is under considerable pressure as a result of increasing workload and workforce shortages. It is recognised that one of the major concerns in the health and social care system at present is that few of the professionals involved are truly working at the 'top of their licence', i.e. many are engaged in a significant proportion of tasks/activity that could be more effectively done by others.

2.2 The role of the General Practitioner and other professionals in Primary Care in future must be able to make best use of the unique experience and skills of each.

2.3 In order to improve outcomes, GPs need to be freed up from activities that do not require GP involvement and other health and social care professionals require to become more accessible.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the range of work in progress, and consider the potential future delivery of Primary Care and consequential resource implications.

Brian Moore
Corporate Director
(Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 In September 2015, Inverclyde HSCP was approached to consider the opportunity to work in partnership with NHS Greater Glasgow and Clyde, the Scottish Government and the British Medical Association (BMA) to explore new ways of working and inform the development of the new GP contract.

4.2 An unprecedented combination of pressures has resulted in the continued delivery of Primary Care in its current format no longer being tenable. Pressures driving change include demographic changes; increasingly complex health care needs; workforce shortages; financial demands and public expectations.

4.3 By changing the role of GPs, it is expected that we will improve recruitment and retention and strengthen the crucial role of General Practice and Primary Care within the wider health and social care system.

4.4 The revised role of the GP is envisaged to be that of a senior clinical decision-maker in the community who will focus upon:-

- Complex Care in the Community
- Undifferentiated Presentations
- Whole System Quality Improvement and Clinical Leadership

Complex Care in the Community

GPs will spend a greater proportion of their time delivering care to patients with multiple co-morbidity, general frailty associated with age, and those with requirements for complex care, e.g. children or adults with multiple conditions including mental health problems or significant disabilities. The system will be focused on knowing its population and assessing where there is potential to achieve better outcomes. Each Practice would therefore need to be supported with adequate information to proactively identify this cohort of patients, and to then work with others to devise an appropriate care plan to ensure that these patients receive the optimum care and support.

One of the main aims of this change in approach/focus is to reduce the avoidable time spent in hospital by patients with complex needs, where this is appropriate. It is broadly agreed that where care at home is desirable and adequately supported, it is better for patients. GPs spending more time on patients with complex needs would help to ensure that admission to Acute care should only be to achieve a specific outcome, or for an assessment or treatment that could only be provided in a hospital setting.

GPs will also be involved in establishing protocols for community teams on how to manage patients with complex needs and develop anticipatory care plans for these patients in order that they can be cared for in their own homes for as long as possible. As the expert generalist in the community, GPs will also support these community teams when any expert GP input is required.

Undifferentiated Presentations

Seeing patients who are unwell, or believe themselves to be unwell, has to remain a core part of General Practice as it is the basis for learning the clinical skills required of a generalist and is expected by patients. However, GPs are a limited resource and their capacity to see patients is finite. There will, therefore, need to be a balance found between access to GP appointments, access to other health professionals where that is more appropriate, and encouraging patients to seek self-care where appropriate.

The new model of care, with everyone working to the top of their licence, will require

other health professionals to be more involved in meeting immediate patient needs. Working alongside GPs they need to be able to efficiently assess and treat patients, within their clinical competence. It will be essential that they are able to complete episodes of care without recourse to the GP on a significant number of occasions. Yet, GPs must retain oversight of the service and must maintain longitudinal patient contact to develop and maintain the skills that are required to manage complex care.

Practices should act as a "patient gateway" to ensure that patients are being adequately streamed to the most appropriate service. Patients should experience contacting the Practice, either in person or remotely, as a way to obtain advice on how best to have their needs met most efficiently by the service. GPs should oversee and manage the process to ensure it is effective and that streaming of patients is clinically appropriate.

Whole System Quality Improvement and Clinical Leadership

GPs must have regular protected time to be able to develop as clinical leaders, with the intended outcome that they become fully involved in assessing and developing services intended to meet the needs of their patients and local communities.

As senior clinical decision-makers, GPs will assess the overall performance of their own Practice, Practices within their cluster and the wider community team, with a clear focus on outcomes of relevance to patients leading to suggestions for improvement that will, in turn, be evaluated by them and others. This will require GPs to have influence to direct change within the wider health and social care organisations. Indeed, it is doubtful that health and social care organisations can be successful without the significant involvement and engagement of GPs in this meaningful way.

Whilst it is recognised that many GPs may not currently see themselves attracted to broader leadership roles and responsibilities, each will need to be involved in improvement activity in both their Practice and the wider system, as any significant improvement in patient outcomes is only likely to be achieved if every senior clinician is engaged in these activities at some level.

5.0 CURRENT POSITION

5.1 Following initial engagement sessions led by the Partnership, NHS Greater Glasgow and Clyde, the Scottish Government and the BMA, all 16 Practices in Inverclyde signed up to participate in the pilot.

5.2 Feedback from these sessions, complemented by a wider multi-disciplinary session (including Practice Managers (PM), Practice Nurses (PN), Pharmacy, District Nurses (DN), Allied Health Professionals (AHP), Public Representatives, Third Sector and Housing colleagues), clarified areas to address into 3 broad categories:-

- Communication
- Operational
- Transformational

Communication and Operational

From the sessions it became apparent that there was not widespread or consistent awareness of the full range of services available within Inverclyde or, indeed, how to access these. There was also frustration at some issues in operational systems which were resulting in delays and inefficiencies in day to day working. Work has been ongoing in these areas to fully identify the issues and explore how to address these whilst also communicating across teams to improve understanding and up to date knowledge of all services within Inverclyde.

Transformational

Transformational work has focused upon a number of Tests of Change, identified by the Primary Care workforce as areas where realignment of activity could achieve the aim of releasing GP capacity:-

- To develop a reliable and responsive Community Phlebotomy Service; implementation of a pre-bookable service that would run in parallel with the existing service. Five local GP Practices are involved in this pilot to evaluate the impact on GPs and Practice Nurses in terms of releasing capacity. The impact would also be measured for existing community phlebotomy, treatment rooms and district nursing services.

- Addressing early intervention and prevention for people with long-term conditions. Implementation of Activity of Daily Living (ADL) smartcare system to increase self-management of non-acute conditions, direct patient access to some items of aids to daily living, timely access to Occupational Therapy (OT) for those patients at high risk and reduce dependence on GP Practice services. We envisage that 6 local Practices will be involved in this Test of Change.

- To provide first point of contact for assessment, diagnosis and initial management of Musculoskeletal (MSK) conditions in a GP Practice setting. This test will take place in 3 GP Practices in the hope that patients requiring early interventions in acute MSK conditions will access the right person at the right time. It is envisaged that this model will reduce the patient journey, reduce GP referrals to MSK, reduce the need for longer courses of physio treatment and use Secondary Care services effectively.

- Exploring opportunities for working differently to maximise the nursing potential within Practice and Community setting. Test the role of Advanced Nurse Practitioner (ANP) based on learning from other areas. This test is in preparatory stages working with local PNs and Community Nurses to determine current roles and opportunities for working at an advanced level. Work is also underway to develop local Health Care Assistants and determine the way forward with this role in Practices.

- Manage home visits more effectively by testing implementation of telephone triage. One GP Practice will be involved in this test, with support from one of our experienced PNs, as will other key professionals. This test will then focus on responses to home visit requests to determine which patients could be safely managed by other members of the Primary Care team.

5.3 Other Areas

- Pharmacy – each Practice has been allocated additional support to shift the balance of pharmacy workload from GPs to Pharmacists. This will take shape in various formats depending on Practice need; examples are: acute/special prescriptions, clinics, medication advice and medication reviews.

- Older People – developing how older people are assessed and supported within Acute and the community is underway, including the introduction of early Comprehensive Geriatric Assessment in Inverclyde Royal Hospital and consideration of how Community Geriatrician support can enhance care for older people in the community. This supports New Ways by providing access to the right person/support at the right time in the right place.

5.4 Complementary Workstreams

In addition to the tests of change, the work is underpinned by a number of

complementary workstreams, all within direct GP involvement:-

- Patient and Carer Involvement – recognising that to move workload from GPs to a range of other professionals, a key element is to inform the public of the need for change, utilise their input to understand how and why they access services and to begin to redirect to other services, we are working closely with Your Voice to engage with patients and carers.

- Education and Communication – in redesigning services locally, we have researched to understand how some of the issues we are facing have been addressed elsewhere, rather than perhaps trying to reinvent the wheel from scratch. The existing Continuing Professional Development Group is using this to programme this year's work, through formal Protected Learning Time events and more informal network communication.

- Data and Outcomes – clearly in utilising the methodology of Tests of Change, to understand the impact upon activity, we not only need to know what activity changes but also what activity was happening as a baseline. We are endeavouring to build this in at the outset of each piece of work, supported by the expertise of colleagues in Public Health and Information Services Division. This is an area of particular challenge as, unlike activity in Secondary Care, much of Primary Care activity historically has not been vigorously recorded.

- Quality and Leadership – given the pivotal change to embed a qualitative approach to Primary Care, a range of initiatives are underway. Facilitated sessions for GPs, PMs and PNs have commenced in 4 locations, sharing basic tools and techniques for Quality Improvement and using the time to identify common themes/areas for improvement. In addition, access to Quality Improvement Workshops at a Board level has been provided for some key individuals, with local workshops planned for PMs, PNs and any other interested parties. Over the course of the next 12 months, 5 groups will commence working together following a national facilitated programme, Collaborative Leadership in Practice. This will be delivered locally in 4 geographic clusters and with the fifth supporting the work to improve pathways for older people between Primary and Secondary Care. The Collaborative Leadership work is key to widening the New Ways work beyond purely healthcare staff, and will include Social Workers and Homecare Team Leads in particular, with the key aim of improving understanding of how roles impact upon each other and can change to meet the needs of our population more effectively.

6.0 PROPOSALS

6.1 The challenges leading to the development of the New Ways of Working project are complex and multifactorial. Careful monitoring is underway to monitor the impact of change and, in particular, the ability to move activity between services and/or professionals encouraging all to work to the top of their licence. Inverclyde is not unique in testing models of change, with some of the initiatives already tried in other areas and, indeed, we have learned from this. However the scale of change, across professions, with all Practices involved is not replicated elsewhere, giving us a unique opportunity to progress a longer-term strategy of transformational change. To assist in reviewing the impact and overview of the project, researchers from the Scottish School of Primary Care at Glasgow University have been commissioned by the Scottish Government to evaluate progress.

6.2 Of particular note to date has been the level of engagement and willingness to participate we have secured from the local GP community, against the backdrop of the whole purpose of the project, i.e. increasing demand for their services.

6.3 Going forward, a key issue will be finance. To date, the money supporting the project has been on a one-off and non-recurring basis. Support secured, both directly financially and support in kind, such as the Collaborative Leadership Programme, has been considerably in excess of what we would have secured on a solely population base. However, if we demonstrate the benefits of moving activity, inevitably the need for recurring resources will arise and the IJB should consider this in the light of any available monies for allocation.

7.0 IMPLICATIONS

FINANCE

7.1 **Financial Implications**:

Funding in the region of £385,000 on a non-recurring basis has been allocated.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
Health and Community Care	New Ways	2015-17			

Annually Recurring Costs/ (Savings)

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

LEGAL

7.2 There are no legal issues within this report.

HUMAN RESOURCES

7.3 There are no human resources issues within this report.

EQUALITIES

7.4 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.

8.0 CONSULTATION

8.1 There has been ongoing discussion with the Staff Partnership Forum.

9.0 LIST OF BACKGROUND PAPERS

9.1 None.

Inverclyde Integration Joint Board

Monday 20 June 2016 at 3pm

Present: Councillors V Jones, J Clocherty (for S McCabe), J McIlwee and L Rebecchi, Mr A Macleod, Mr B Moore, Ms L Aird, Ms C Watt (for Ms R Garcha), Ms D McCrone, Ms M Telfer, Mr I Bruce, Ms C Boyd and Ms S McLeod.

Chair: Councillor McIlwee presided.

In attendance: Ms B Culshaw, Head of Health & Community Care, Ms H Watson, Head of Health Improvement & Commissioning, Ms A McCrea (for Head of Children's Services & Criminal Justice), Chief Financial Officer, Ms V Pollock (for Head of Legal & Property Services) and Ms S Lang (Legal & Property Services).

48 Apologies, Substitutions and Declarations of Interest 48

Apologies for absence were intimated on behalf of Councillor S McCabe, with Councillor J Clocherty acting as proxy, Mr S Carr, Dr D Lyons, Mr R Finnie, Ms R Garcha, with Ms C Watt acting as proxy, Dr H MacDonald and Ms C Roarty.

No declarations of interest were intimated.

49 Minute of Meeting of Inverclyde Integration Joint Board of 10 May 2016 49

There was submitted minute of the Inverclyde Integration Joint Board of 10 May 2016.
Decided: that the minute be agreed.

50 IJB Audit Arrangements 50

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (1) recommending the establishment of an Audit Committee for the Inverclyde Integration Joint Board (IJB) and (2) setting out proposed terms of reference, membership and meeting arrangements for the Committee.
Decided:
(1) that agreement be given to the establishment of an Audit Committee as a standing committee of the Integration Joint Board and the remit and powers as set out in Appendix 1;
(2) that the Board appoint six Members to serve on the IJB Audit Committee, having due regard to the requirements set out in paragraph 4 of the report, as follows:
Voting Members
NHS Greater Glasgow & Clyde – Mr A Macleod and Mr S Carr
Inverclyde Council – Councillor S McCabe and Councillor L Rebecchi
Non-Voting Members
Mr I Bruce and Ms R Garcha
(3) that having due regard to the requirements set out in paragraph 4.4 of the report, Mr A Macleod be appointed as Chair and Councillor S McCabe be appointed as Vice-Chair of the IJB Audit Committee;

(4) that the IJB Audit Committee meet at 1.30pm on the following dates, within the agreed cycle of meetings:
18 August 2016
24 January 2017
14 March 2017; and
(5) that approval be given to the proposed audit arrangements set out in section 5 of the report and the Chief Officer be directed to develop and implement a Service Level Agreement with Inverclyde Council's Chief Internal Auditor in relation to the internal audit arrangements for the Integration Joint Board.

51 2015/16 Draft Annual Accounts 51

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (1) setting out a proposed approach for the Inverclyde Integration Joint Board to comply with its statutory requirements in respect of its annual accounts and (2) outlining the main aspects to be contained in the draft 2015/16 accounts which require to be submitted to the External Auditor.
Decided:
(1) that the Board approve the proposed approach to complying with the Local Authority Accounts (Scotland) Regulations 2014;
(2) that the Board note the ongoing work in relation to the unaudited accounts for the Inverclyde Integration Joint Board for 2015/16; and
(3) that it be agreed that the unaudited accounts for 2015/16 be submitted to the Auditor.

52 Interim Budget 2016/17 52

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership proposing the setting of an interim budget for the Inverclyde Integration Joint Board for 2016/17, to be spent in line with the Strategic Plan.
Decided:
(1) that the contents of the report be noted;
(2) that the Board agree an interim net budget of £50.084m to Inverclyde Council and direct that this funding is spent in line with the Strategic Plan;
(3) that it be noted that the Health Board budget is not yet approved and that only an indicative budget is available at this time which includes an unidentified savings target;
(4) that the Board agree an interim budget of £73.073m which excludes the "set aside" budget to NHS Greater Glasgow & Clyde and directs that this funding is spent in line with the Strategic Plan; and
(5) that it be noted that a further report on the budget and due diligence process will be required in August 2016 when a finalised contribution from the Health Board will have been confirmed.

53 Insurance Arrangements 53

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership seeking approval to submit an application to become a member of the Clinical Negligence and Other Risks Scheme (CNORIS).
Decided: that it be agreed to make an application to join the CNORIS Scheme.

It was agreed in terms of Section 50(A)(4) of the Local Government (Scotland) Act 1973 as amended, that the public and press be excluded from the meeting during consideration of the following item on the grounds that the business involved the likely disclosure of exempt information as defined in paragraph 6 of Part I of Schedule 7(A) of the Act.

54 Appendix to Minute of Meeting of Inverclyde Integration Joint Board of 10 May 2016 54

There was submitted appendix to the minute of the Inverclyde Integration Joint Board of 10 May 2016.
Decided: that the appendix to the minute be agreed.

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 4

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore, Corporate Director (Chief Officer), Inverclyde Health and Social Care Partnership**	**Report No:**	**VP/LP/093/16**
Contact Officer:	**Brian Moore**	**Contact No:**	**01475 712722**
Subject:	**Directions from Integration Joint Board to Inverclyde Council and NHS Greater Glasgow and Clyde**		

1.0 PURPOSE

1.1 The purpose of this report is to seek approval from the Inverclyde Integration Joint Board (IJB) to issue directions to Inverclyde Council and Greater Glasgow & Clyde NHS Board (the Health Board) in respect of the delivery of the functions delegated to the IJB under the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act).

2.0 SUMMARY

2.1 The Act places a duty on the IJB to develop and publish a Strategic Plan for integrated functions and budgets under its control. The IJB approved its Strategic Plan at its meeting on 15 March 2016 which was thereafter published on the HSCP website. Responsibilities for services and functions were then fully delegated from Inverclyde Council and the Health Board to the IJB as from 1 April 2016.

2.2 The Act also places a duty on the IJB to set out its mechanism for implementing the Strategic Plan and this is to take the form of Directions from the IJB to Inverclyde Council and the Health Board.

2.3 This report sets out the proposed Directions to both Inverclyde Council and the Health Board relating to those functions and services which have been delegated by both parties to the IJB.

3.0 RECOMMENDATION

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

(1) approves the Directions to Inverclyde Council and Greater Glasgow & Clyde NHS Board in respect of the delivery of the functions delegated to the Inverclyde Integration Joint Board as set out in Appendix 1 of this report;

(2) delegates authority to the Chief Officer to issue the Directions to the Chief Executives of Inverclyde Council and Greater Glasgow & Clyde NHS Board; and

(3) agrees that both sets of Directions are reviewed by the Inverclyde Integration Joint Board as and when updates are required and at a minimum on an annual basis in respect of the following financial year.

Brian Moore
Corporate Director
(Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) places a duty on the IJB to develop and publish a Strategic Plan for integrated functions and budgets under its control. The IJB approved its Strategic Plan at its meeting on 15 March 2016 which was thereafter published on the HSCP website. Responsibilities for services and functions were then fully delegated from Inverclyde Council and the Health Board to the IJB as from 1 April 2016.

4.2 The Act also places a duty on the IJB to set out its mechanism for implementing the Strategic Plan. The IJB's mechanism to implement the Strategic Plan is set out in Sections 26 to 28 of the Act. This mechanism takes the form of binding written directions from the IJB to one or both of Inverclyde Council or the Health Board. A direction must be issued in respect of every function which has been delegated to the IJB and must set out how each function is to be delivered and the budget associated with that. One direction can cover more than one function.

5.0 CONTENT OF DIRECTIONS

5.1 Directions should set out a clear framework for operational delivery of the functions that have been delegated to the IJB. A function can be described in terms of delivery of services, achievement of outcomes, and/or by reference to the Strategic Plan. The direction may also specify what the Health Board or Council is to do in relation to carrying out a particular function and so there is scope to include detailed operational instructions in relation to particular functions (and associated services).

5.2 Directions must include detailed information on the financial resources that are available for carrying out the functions that are the subject of the Directions, including the allocated budget and how that budget (whether it is a payment, or an amount made available) is to be used.

5.3 No standard template or format for Directions have been prescribed. The Scottish Government has produced only a good practice note – which is not statutory guidance – for IJBs in relation to Directions. The format of Directions is therefore a matter for each IJB, taking into account the legislative requirements of Sections 26 to 28 of the Act. The draft Directions attached at Appendix 1 are therefore framed within the context of the IJB's Strategic Plan and existing operational arrangements.

6.0 ISSUE AND REVISAL OF DIRECTIONS

6.1 A Direction does not have a fixed timescale and will remain in place until it is varied, revoked or superseded by a later Direction issued by the IJB in respect of the same function.

6.2 It would be good practice to review the Directions on a regular basis and particularly when there are any developments – such as changes to strategic and/or operational plans or when action is needed to balance budgets.

6.3 The mechanism of Directions has flexibility to ensure that delivery of integrated health and social care functions is consistent with the Strategic Plan, and takes account of any changes in local circumstances.

7.0 IMPLICATIONS

Finance

7.1 The Directions include the budget allocation made available to Inverclyde Council and the Health Board to deliver the relevant functions as agreed by the IJB at its meeting of 20 June 2016.

One Off Costs

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

			Report		
N/A					

Annually Recurring Costs/(Savings)

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

Legal

7.2 The IJB is, in terms of Sections 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014 required to direct Inverclyde Council and Greater Glasgow & Clyde NHS Board to deliver services to support the delivery of the Strategic Plan.

Human Resources

7.3 There are no HR implications arising from this report.

Equalities

7.4 There are no equalities implications arising from this report.

8.0 CONSULTATIONS

8.1 The Corporate Director (Chief Officer) and the Chief Financial Officer of the Inverclyde Health & Social Care Partnership, and the Head of Board Administration of Greater Glasgow and Clyde NHS Board have been consulted in the preparation of this report.

9.0 CONCLUSIONS

9.1 The IJB is required to issue Directions for the delivery of integrated health and social care services as from 1 April 2016.

10.0 BACKGROUND PAPERS

10.1 Link to Integration Scheme:

https://www.inverclyde.gov.uk/meetings/committees/57

APPENDIX

INVERCLYDE INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

THE INVERCLYDE COUNCIL is hereby directed to deliver for the Inverclyde Integration Joint Board (the IJB), the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the IJB's Strategic Plan and existing operational arrangements pending future directions from the IJB.

Services: All services listed in Annex 2, Part 2 of the Inverclyde Health and Social Care Partnership Integration Scheme.

Functions: All functions listed in Annex 2, Part 1 of the Inverclyde Health and Social Care Partnership Integration Scheme.

Associated Budget:

SUBJECTIVE ANALYSIS	Budget 2016/17 £000
SOCIAL WORK	
Employee Costs	25,724
Property costs	1,170
Supplies and Services	728
Transport and Plant	338
Administration Costs	658
Payments to Other Bodies	35,404
Income	(13,938)
SOCIAL WORK NET EXPENDITURE	**50,084**

OBJECTIVE ANALYSIS	Budget 2016/17 £000
SOCIAL WORK	
Planning, Health Improvement & Commissioning	1,731
Older Persons	22,778
Learning Disabilities	6,327
Mental Health	1,117
Children & Families	10,689
Physical & Sensory	2,062
Addiction / Substance Misuse	1,038
Business Support	2,005
Assessment & Care Management	1,563
Criminal Justice / Scottish Prison Service	0
Homelessness	774
SOCIAL WORK NET EXPENDITURE	**50,084**

This direction is effective from 1 April 2016.

INVERCLYDE HSCP Health and Social Care Partnership

INVERCLYDE INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

GREATER GLASGOW & CLYDE NHS BOARD is hereby directed to deliver for the Inverclyde Integration Joint Board (the IJB), the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the IJB's Strategic Plan and existing operational arrangements pending future directions from the IJB.

Services: All services listed in Annex 1, Part 2 of the Inverclyde Health and Social Care Partnership Integration Scheme.

Functions: All functions listed in Annex 1, Part 1 of the Inverclyde Health and Social Care Partnership Integration Scheme.

Associated Budget:

SUBJECTIVE ANALYSIS	Budget 2016/17 £000
HEALTH	
Employee Costs	21,317
Property	499
Supplies & Services	5,039
Family Health Services (net)	20,833
Prescribing (net)	17,422
Resource Transfer	9,203
Unidentified Savings	(587)
Income	(1,240)
HEALTH NET EXPENDITURE	**72,486**

OBJECTIVE ANALYSIS	Budget 2016/17 £000
HEALTH	
Children & Families	2,744
Health & Community Care	4,233
Management & Admin	2,653
Learning Disabilities	558
Addictions	1,827
Mental Health - Communities	3,314
Mental Health - Inpatient Services	7,935
Planning & Health Improvement	836
Change Fund	1,504
Family Health Services	20,844
Prescribing	17,422
Unidentified savings	(587)
Resource Transfer	9,203
HEALTH NET EXPENDITURE	**72,486**

An additional £17.704 million is set aside for large hospital services.

This direction is effective from 1 April 2016.

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 5

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore, Corporate Director (Chief Officer), Inverclyde Health and Social Care Partnership**	**Report No:**	**VP/LP/092/16**
Contact Officer:	**Vicky Pollock**	**Contact No:**	**01475 712180**
Subject:	**Freedom of Information Arrangements**		

1.0 PURPOSE

1.1 The purpose of this report is to seek approval for the adoption of a draft publication scheme for the Inverclyde Integration Joint Board (IJB), as required by the Freedom of Information (Scotland) Act 2002 (FOISA).

2.0 SUMMARY

2.1 The IJB is designated as a public authority for the purposes of FOISA. This means that it is subject to obligations under FOISA and will need to respond to requests for information which it holds within the statutory timescales and have its own publication scheme.

2.2 This report advises the IJB of the proposed arrangements for meeting the legislative requirements placed on it in terms of FOISA relating to how the IJB holds and processes information.

3.0 RECOMMENDATION

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

(1) approves the adoption of the Publication Scheme as detailed in Appendix 1 of this report and agrees to its submission to the Scottish Information Commissioner for approval;

(2) delegates authority to the Chief Officer to complete the preparation of the Guide to Information as detailed in Appendix 2 of this report;

(3) delegates authority to the Chief Officer to prepare, complete and publish policies and procedures, an internal review/appeals process and leaflet to staff and the public detailing the Inverclyde Integration Joint Board's arrangements for dealing with requests for information in terms of the Freedom of Information (Scotland) Act; and

(4) delegates authority to the Chief Officer to review and amend as necessary the Publication Scheme, Guide to Information, policies and procedures, internal review/appeals process and draft leaflet to staff/the public in response to legislative changes, best practice and operational requirements.

Brian Moore
Corporate Director
(Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Freedom of Information (Scotland) Act 2002 (FOISA) – and the related Environmental Information (Scotland) Regulations 2004 (EIRs) – provide any applicant with the right to request – and be provided with – any recorded information held by Scotland's public authorities. If an authority considers that information should not be released it is required to justify its decisions by applying one or more defined exemptions (or under the EIRs – exceptions).

4.2 The IJB has been designated as a "public authority" for the purposes of FOISA. This means that it is subject to both FOISA and the EIRs and must put in place the necessary arrangements for properly responding to requests for information.

4.3 The IJB's responsibilities under FOISA and the EIRs are supplemented by Codes of Practice issued by the Scottish Government and compliance with the legislation is monitored by the Scottish Information Commissioner, who provides advice and guidance on the operation of the legislation

4.4 The IJB is required to have the following:-

i. A Publication Scheme – Section 23 of FOISA imposes a specific duty on all Scottish public authorities to adopt and maintain a scheme that relates to the publication of information by the authority (a "Publication Scheme"). A Publication Scheme sets out the types of information that a public authority routinely makes available. The IJB will need to put in place a Publication Scheme, along with a guide setting out which information it will make available. The Publication Scheme at Appendix 1 follows the model approved by the Scottish Information Commissioner and it is proposed that this Publication Scheme is adopted by the IJB. Once a public authority has agreed to adopt the scheme, the Scottish Information Commissioner must be notified of its adoption.

ii. A guide to information, a draft of which is attached at Appendix 2.

iii. Policies and procedures in place on how the IJB responds to requests for information.

iv. An internal review/appeals process to consider cases where an applicant is dissatisfied with a response to a request for information, or there has been a failure to respond.

v. Arrangements in place to make staff and the public aware of the procedures to follow and to distinguish appropriately between requests that should be processed by Inverclyde Council or Greater Glasgow and Clyde NHS Board rather than the IJB. The determining factor is who holds the information.

The information needed for iii to v is being developed and authority is sought to prepare, complete and publish these documents on the relevant website.

4.5 It is likely that the IJB will only hold a very limited amount of information to begin with and the Publication Scheme and Guide to Information reflect that position. It is also important to note that the IJB must respond to requests made directly to the IJB for information which it holds. The IJB cannot simply refer requests on to the Council or Health Board to deal with – unless the information requested is held by those parties rather than the IJB. The Council and Health Board will continue to be responsible for requests relating to information they hold about the delivery of health and social care services under their own existing freedom of information policies and procedures.

4.6 In order to comply with its duties under FOISA and the EIRs, the IJB will be supported by officers from both Inverclyde Council and Greater Glasgow and Clyde Health Board with relevant experience in dealing with freedom of information matters.

5.0 IMPLICATIONS

Finance

5.1 The IJB is entitled to charge fees for certain types of requests for information and the IJB's charging policy is set out in the Guide to Information.

One Off Costs

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

Annually Recurring Costs/(Savings)

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

Legal

5.2 The IJB is required under the Freedom of Information (Scotland) Act 2002 to respond to requests for information and have a Publication Scheme in place.

Human Resources

5.3 There are no HR implications arising from this report.

Equalities

5.4 The relevant legislation requires that equality issues are taken into account in responding to requests for information.

6.0 CONSULTATIONS

6.1 The Corporate Director (Chief Officer) and the Chief Financial Officer of the Inverclyde Health & Social Care Partnership, and the Head of Board Administration of Greater Glasgow and Clyde NHS Board have been consulted in the preparation of this report.

7.0 CONCLUSIONS

7.1 The IJB requires to adopt a Publication Scheme and have in place suitable arrangements to deal with freedom of information requests.

Model Publication Scheme

Produced and approved by the Scottish Information Commissioner on 29 March 2016

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Cross-referenced VC documents (for internal use)

VC No	VC name
69812	Model Publication Scheme: Guide for Scottish Public Authorities
69676	Model Publication Scheme: Notification Form
69815	Model Publication Scheme: Self-assessment checklist

Introduction

1. The Freedom of Information (Scotland) Act 2002 (the Act) requires Scottish public authorities to adopt and maintain a publication scheme. Authorities are under a legal obligation to:

   (i) publish the classes of information that they make routinely available

   (ii) tell the public how to access the information they publish and whether information is available free of charge or on payment.

2. The Act also allows for the development of model publication schemes which can be adopted by more than one authority. **The Commissioner's Model Publication Scheme was approved on 29 March 2016.**

3. The Commissioner has issued a Guide for Scottish Public Authorities to accompany the model scheme. This is **essential reading** for authorities adopting the model scheme as it explains the requirements of the scheme in detail and provides lists of types of information the Commissioner expects authorities to publish.

Definition of "published" information

4. For the purposes of this Model Publication Scheme, to be "published", information must be:

   (i) already produced and prepared and

   (ii) available to anyone to access easily without having to make a request for it

5. Research and information services which involve the commissioning of new information are **not** "publications".

Adopting this model scheme

6. It is expected that the model scheme will be adopted by any authority which is subject to the Freedom of Information (Scotland) Act 2002. For more information about which bodies this applies to, please visit http://www.itspublicknowledge.info/YourRights/WhocanIask.aspx

7. Adoption commits an authority to:

   (i) adopting the model scheme, and any updates to it, without amendment

   (ii) publishing the information, including environmental information, that it holds and which falls within the classes of information below.

   (iii) ensuring that the way it publishes its information meets the Model Publication Scheme Principles.

   (iv) producing a Guide to Information which sets out the information the authority publishes through the model scheme, how to access it, whether there is a charge for it and how to get help to access information.

   (v) notifying the Scottish Information Commissioner that it has adopted the model scheme.

8. Where an authority fails to meet the above commitments, it cannot be considered to have adopted the Commissioner's model scheme and may be failing with the duty to adopt and maintain a publication scheme in line with section 23(1) of the Act.

Notifying the Commissioner

9. Authorities adopting the model publication scheme for the first time must notify the Commissioner that they have done so. Thereafter no further notification is required unless the Commissioner has revoked approval (because the authority is not complying with the scheme).

10. The Commissioner will regularly review the model scheme and will consult authorities before making any substantive changes. The Commissioner will notify authorities of any changes.

11. The Commissioner will continue to monitor the effectiveness of authorities' application of the model publication scheme. As required, she may contact individual authorities about practice issues, in line with her Enforcement Policy.

Model Publication Scheme principles

Principle One: Availability and formats

12. Information published through this model scheme should, wherever possible, be made available on the authority's website.

13. There must be an alternative arrangement for people who do not wish to, or who cannot, access the information either online or by inspection at the authority's premises. An authority may e.g., arrange to send out information in paper copy on request (although there may be a charge for doing so).

Principle Two: Exempt information

14. If information described by the classes cannot be published and is exempt under Scotland's freedom of information laws e.g., sensitive personal data or a trade secret, the authority may withhold the information or provide a redacted version for publication, but it must explain why it has done so.

Principle Three: Copyright and re-use

15. The authority's Guide to Information must include a copyright statement which is consistent with the fair dealing provisions of the Copyright, Designs and Patents Act 1988. Where the authority does not hold the copyright in information it publishes, this should be made clear.

16. Any conditions applied to the re-use of published information must be consistent with the Re-Use of Public Sector Information Regulations 2015.

17. The Commissioner recommends that authorities adopt the Open Government Licence and/or the non-commercial Government Licence, produced by The National Archives for their published information.

Principle Four: Charges

18. The Guide to Information must contain a charging schedule, explaining any charges and how they will be calculated.

19. No charge may be made to view information on the authority's website or at its premises, except where there is a fee set by other legislation e.g., for access to some registers.

20. The authority may charge for computer discs, photocopying, postage and packing and other costs associated with supplying information. The charge must be no more than these elements actually cost the authority e.g. cost per photocopy or postage. There may be no further charges for information in Classes 1 – 7 below. An exception is made for commercial publications (see Class 8 below) where pricing may be based on market value.

Principle Five: Contact details

21. The authority must provide contact details for enquiries about any aspect of the adoption of the model scheme, the authority's Guide to Information and to ask for copies of the authority's published information.

22. The Act requires authorities[1] to provide reasonable advice and assistance to anyone who wants to request information which is not published. The authority's Guide to Information must provide contact details to access this help.

Principle Six: Duration

23. Once published through the Guide to Information, the information should be available for the current and previous two financial years. Where information has been updated or superseded, only the current version need be available (previous versions may be requested from the authority).

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[1] Section 15 of the Freedom of Information (Scotland) Act 2002 and regulation 9 of the Environmental Information (Scotland) Regulations 2004

The Classes of Information

	Class	Description
1	About the authority	Information about the authority, who we are, where to find us, how to contact us, how we are managed and our external relations
2	How we deliver our functions and services	Information about our work, our strategies and policies for delivering functions and services and information for our service users
3	How we take decisions and what we have decided	Information about the decisions we take, how we make decisions and how we involve others
4	What we spend and how we spend it	Information about our strategy for, and management of, financial resources (in sufficient detail to explain how we plan to spend public money and what has actually been spent)
5	How we manage our human, physical and information resources	Information about how we manage the human, physical and information resources of the authority.
6	How we procure goods and services from external providers	Information about how we procure goods and services and our contracts with external providers
7	How we are performing	Information about how we perform as an organisation and how well we deliver our functions and services
8	Our commercial publications	Information packaged and made available for sale on a commercial basis and sold at market value through a retail outlet e.g., bookshop, museum or research journal.
9	Our open data	Open data made available by the authority as described by the Scottish Government's Open Data Strategy and Resource Pack, available under an open licence.

Document control sheet

Document Information	
Full name of current version: Class, Title, Version No and Status. *E.g. C5 Key Documents Handbook v01 CURRENT ISSUE*	C2 Model Publication Scheme v01 CURRENT ISSUE
VC FileId	69809
Type	Briefing
Approver	SMT
Responsible Manager	HOPI
Date of next planned review	31 March 2017
Approval & Publication	
Approval Date (major version)	29 March 2016
For publication *(Y/N)*	Y
Date published	14 April 2016
Name of document in website file library	ModelPublicationScheme
Corrections / Unplanned or Ad hoc reviews (see Summary of changes below for details)	
Date of last update	

Summary of changes to document				
Date	**Action by** *(initials)*	**Version updated** *(e.g. v01.25-36)*	**New version number** *(e.g. v01.27, or 02.03)*	**Brief description** (*e.g. updated paras 1-8, updated HOPI to HOOM, reviewed whole section on PI test, whole document updated, corrected typos, reformatted to new branding*)
05/04/16	JAW	01.00	01.01	New document created
05/04/16	JAW	01.01	01.02	Addition of VC FileID
14/04/16	JAW	01.02	01.03	Correction to cross references to VC documents
14/04/16	KB	01.03	01.04	DCS updated
14/04/16	KB	01.04	01.05	DCS updated, published on website

Scottish Information Commissioner
Kinburn Castle
Doubledykes Road
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enquiries@itspublicknowledge.info

www.itspublicknowledge.info

APPENDIX 2

Inverclyde Integration Joint Board

GUIDE TO INFORMATION AVAILABLE UNDER THE MODEL PUBLICATION SCHEME 2016

Contents

SECTION 1: Introduction to the Integration Joint Board – Guide to Information

SECTION 2: About Inverclyde Integration Joint Board

SECTION 3: Accessing Information under the Guide

SECTION 4: Information that we may withhold

SECTION 5: Our Charging Policy

SECTION 6: Our Copyright Policy

SECTION 7: Records Management Policy

SECTION 8: Contact details for enquiries, feedback and complaints

SECTION 9: How to access information which is not available in the Guide to Information

SECTION 10: Classes of Information

Class 1: About Inverclyde Integration Joint Board
Class 2: How we deliver our functions and services
Class 3: How we take decisions and what we have decided
Class 4: What we spend and how we spend it
Class 5: How we manage our human, physical and information resources
Class 6: How we procure goods and services from external providers
Class 7: How we are performing
Class 8: Commercial publications
Class 9: Open Data

Section 1: Introduction

The Freedom of Information (Scotland) Act 2002 (the Act) requires Scottish public authorities to adopt and maintain a publication scheme which has the approval of the Scottish Information Commissioner, and publish information in accordance with that scheme. The publication scheme must:

- publish the classes of information that the authority makes routinely available; and
- tell the public how to access the information and whether information is available free of charge or on payment

Inverclyde Integration Joint Board has adopted the **Model Publication Scheme 2016** which has been produced and approved by the Scottish Information Commissioner.

You can see this scheme on our website at: https://www.inverclyde.gov.uk/health-and-social-care

You can also contact us at the address below if you prefer a copy of the Model Publication Scheme 2016, or this Guide to Information, to be provided in a different format.

The purpose of this Guide to Information is to:

- allow you to see what information is available (and what is not available) for the Inverclyde Integration Joint Board in relation to each class in the Model Publication Scheme 2016;
- state what charges may be applied;
- explain how you can find the information easily;
- provide contact details for enquiries and to get help with accessing the information; and
- explain how to request information we hold that has not been published.

Alongside the Act, the Environmental Information (Scotland) Regulations 2004 (the EIRs) provide a separate right of access to the environmental information that we hold. This guide to information also contains details of the environmental information that we routinely make available.

Section 2: About Inverclyde Integration Joint Board

The Inverclyde Integration Joint Board (the Board) was established on 27 June 2015 as a corporate body under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014. It is one of 29 Integration Joint Boards each created covering one or more areas coterminous with that of local authorities. The function of the Board which contains representatives of Inverclyde Council, Greater Glasgow and Clyde NHS Board and a number of professional and stakeholder representatives, is to provide arrangements for the development of the integration of health and social care. This integration will improve the outcome for patients, service users, carers and their families. The Board has delegated to it, in terms of the Act and an Integration Scheme approved by the Scottish Ministers, functions and resources of Inverclyde Council and Greater Glasgow and Clyde NHS Board.

The Board is commonly referred to as the Inverclyde Health and Social Care Partnership. This is the public facing aspect of the Board and comprises the organisation drawing staff from the Council and the Health Board which supports the Board in delivering its objectives.

Introducing the Inverclyde Integration Joint Board

The Board has its principal offices at Hector McNeil House
7-8 Clyde Square
Greenock
PA15 1NB

Telephone 01475 715365 Fax [ ] e-mail HSCP.Communications@ggc.scot.nhs.uk
The Chief Officer of the Board is Brian Moore.

We cover the area of Inverclyde Council.

We work in co-operation with other Integration Joint Boards, Inverclyde Council and Greater Glasgow and Clyde NHS Board and other agencies in planning and commissioning health and social care services.

The governing body is the Integration Joint Board, which comprises 8 voting members – 4 members appointed from Councillors on Inverclyde Council; 4 members from the Non-Executive Board Members of Greater Glasgow and Clyde NHS Board. Additionally there are non-voting stakeholder members and professional members. For more information on the Board see Section 10 – Classes of Information – Class 1.

Section 3: Accessing Information under the Scheme

Availability and formats

The information we publish through this Guide to Information is, wherever possible, available on our website. We offer alternative arrangements for people who do not want to, or cannot, access the information online or by inspection at our premises. For example, we can usually arrange to send information to you in paper copy (although there may be a charge for this – see Section 5: Our Charging Policy).

Information in our Guide to Information will normally be available through the routes described below. Section 10 – Classes of Information provides more details on the information available under the Guide, along with additional guidance on how the information falling within each class may be accessed.

Online:
Most information listed in our Guide to Information is available to download from our website. In many cases a link within Section 10: Classes of Information will direct you to the relevant page or document. If you are having trouble finding any document listed in our guide, then for further assistance please contact:

Head of Administration & Business Support (Freedom of Information)
Hector McNeil House
7-8 Clyde Square
Greenock
PA15 1NB

Telephone: 01475 715365
Email: HSCP.Communications@ggc.scot.nhs.uk
Website: https://www.inverclyde.gov.uk/health-and-social-care

By email:
If the information you seek is listed in our Guide to Information but is not published on our website, we can send it to you by email, wherever possible. When requesting information from us, please provide a telephone number so that we can telephone you to clarify details, if necessary.

By phone:

All information in the guide will be available in hard copy form for example, paper copies. Hard copies of information can be requested from us over the telephone. Please call us to request information available under this scheme.

By post:
You can also request hard copies of any information in the Guide by post. Please address your request to:

Head of Administration & Business Support (Freedom of Information)
Hector McNeil House
7-8 Clyde Square
Greenock
PA15 1NB

When writing to us to request information, please include your name and address, full details of the information or documents you would like to receive, and any fee applicable (see Section 5: Our Charging Policy for further information on fees). Please also include a telephone number so we can telephone you to clarify any details, if necessary.

Personal visits:
If you prefer to visit us to inspect the information you may do so during our normal office hours of 9.00 am to 5.00pm Monday to Thursday and to 4.00pm on a Friday. It may avoid delay if you notify us in advance that you intend to visit. In a limited number of cases you may be required to make an appointment to view the information. In such cases, this will be set out within Section 10 – Classes of Information, and contact details will be provided within the relevant class.

Advice and assistance:
If you have any difficulty identifying the information you want to access, then please contact us to help you.

Exempt information
We will publish all the information we hold that falls within the classes of information in the Model Publication Scheme 2016. We publish this information in Section 10 of this guide. If a document contains information that is exempt under Scotland's freedom of information laws (for example sensitive personal information or a trade secret), we may remove or redact the information before publication but we will explain why.

Section 4: Information that we may withhold

All information covered by our Guide to Information can either be accessed through our website, or will be provided promptly following our receipt of your request. Our aim in adopting the Commissioner's Model Publication Scheme 2016 and in maintaining this Guide to Information is to be as open as possible. You should note, however, that there may be limited circumstances where information will be withheld from one of the classes of information listed in "Section 10 – Classes of Information". Information will only be withheld, however, where the Act (or, in the case of environmental information, the EIRs) expressly permits it. Information may be withheld, for example, where its disclosure would breach the law of confidentiality, harm an organisation's commercial interests, or endanger the protection of the environment.

Information may also be withheld if it is another person's personal information, and its release would breach data protection legislation.

Whenever information is withheld we will inform you of this, and will set out why that information cannot be released. Even where information is withheld it will, in many cases, be possible to provide copies with the withheld information edited out. If you wish to complain about any information which

has been withheld from you, please refer to Section 8 – Contact details for enquiries, feedback and complaints.

Section 5: Our Charging Policy

This section explains when we may make a charge for our publications and how any charge will be calculated.
There is no charge to view information on our website, at our premises (except where there is a statutory fee, for example to access registers), or where it can be sent to you electronically by email.

We may charge you for providing information to you, for example photocopying and postage, but we will charge you no more than it actually costs us to do so. We will always tell you what the cost is before providing the information to you.
Our photocopying charges per sheet of paper are shown in the table below:

Black and white photocopying

Size of paper	Pence per sheet of paper
A1	Not available
A2	Not available
A3	20p
A4	10p
A5	10p

Colour photocopying

Size of paper	Pence per sheet of paper
A1	Not available
A2	Not available
A3	60p
A4	30p
A5	30p

Information provided on CD-Rom will be charged at £1.00 per computer disc.

Postage costs will be recharged at the rate we pay to send the information to you. Our charge is based on sending information by Royal Mail First Class.

When providing copies of pre-printed publications, we will charge no more than the cost per copy of the total print run.

We do not pass any other costs on to you in relation to our published information.

Details of any individual charges which differ from the above charging policy are provided within Section 10 – Classes of Information.

Section 6: Copyright

Inverclyde Integration Joint Board holds the copyright for the vast majority of information in this Publication Scheme. All of this information can be copied or reproduced without our formal permission, provided it is copied or reproduced accurately, is not used in a misleading context, is not used for profit, and provided that the source of the material is acknowledged.

Providing access to information does not mean that copyright has been waived, nor does it give the recipient the right to re-use information for commercial purposes. If you intend to re-use information obtained from the Scheme, and you are unsure whether you have the right to do so, please make a request to re-use the information to:
Head of Administration & Business Support (Freedom of Information)
Inverclyde Integration Joint Board
Hector McNeil House
7-8 Clyde Square
Greenock
PA15 1NB

Telephone: 01475 715365
Email: HSCP.Communications@ggc.scot.nhs.uk

Your request will be considered under the Re-use of Public Sector Information Regulations 2015, which may provide the right to impose a charge. In the event that a charge is payable you will be advised what this is and how it is calculated. If you require more information on the re-use of information go to http://www.nationalarchives.gov.uk/information-management/re-using-public-sector-information/ or contact the Head of Administration & Business Support.

The Publication Scheme may contain information where the copyright holder is not the Integration Joint Board. In most cases, the copyright holder will be obvious from the documents. In cases where the copyright is unclear it is the responsibility of the person accessing the information to locate and seek the permission of the copyright holder before reproducing the material or in any other way breaching the rights of the copyright holder. This includes, for example, Ordnance Survey Maps, which are Crown Copyright.

Section 7: Records Management Policy

Inverclyde Integration Joint Board regards its records as a major asset of the organisation. It confirms that its records are one of the essential resources, which support management in the efficient and effective fulfilment of its governance, business and legal responsibilities. The Board will over coming months develop records management and retention policies which will be applied to the management of information held by the Board.

Section 8: Contact details for enquiries, feedback and complaints

The Act requires that we review our publication scheme from time to time. As we have adopted the Model Publication Scheme 2016, this means we will review our Guide to Information from time to time. As a result, we welcome feedback on how we can develop our guide further. If you would like to comment on any aspect of this Guide to Information, or comment or complain that information is not included then please contact us via.

Head of Administration & Business Support (Freedom of Information)
Hector McNeil House
7-8 Clyde Square
Greenock
PA15 1NB

Telephone: 01475 715365
Email: HSCP.Communications@ggc.scot.nhs.uk
Website: https://www.inverclyde.gov.uk/health-and-social-care

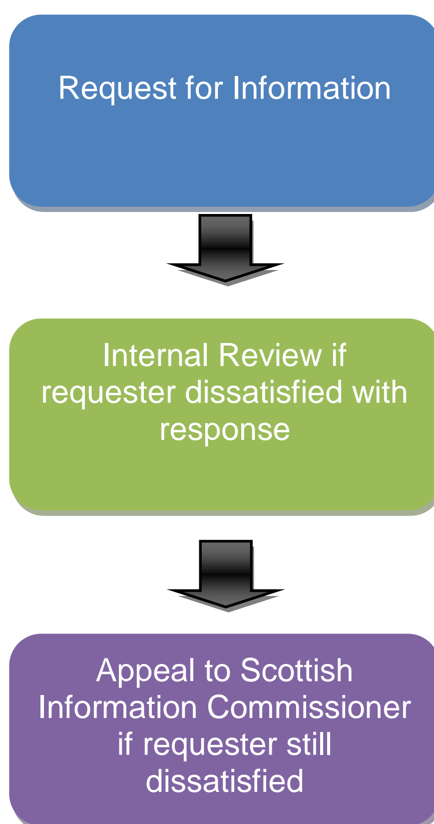
You may, for example wish to tell us about:

• other information that you would like to see included in the guide;
• whether you found the guide easy to use;
• whether you found the guide to information useful;
• whether our staff were helpful;
• other ways in which our guide to information can be improved.

Our aim is to make our guide to information as user-friendly as possible, and we hope that you can access all the information we publish with ease. If you do wish to complain about any aspect of the Guide then please contact us and we will try and resolve your complaint as quickly as possible.

Any complaint will be acknowledged within three working days of receipt and we will respond in full within twenty working days.

You have legal rights to access information under the Model Publication Scheme 2016 (as described in this Guide to Information) and a right of appeal to the Scottish Information Commissioner if you are dissatisfied with our response. These rights apply only to information requests made in writing[1] or another recordable format. If you are unhappy with our response to your request you can ask us to review it and if you are still unhappy, you can make an appeal to the Scottish Information Commissioner



The Commissioner's website has a guide to this three step process, and she operates an enquiry service on Monday to Friday from 9:00am to 5:00pm.

Her office can be contacted as follows:

Scottish Information Commissioner
Kinburn Castle
Doubledykes Road
St Andrews
Fife KY16 9DS

[1] Verbal requests for environmental information carry similar rights

Tel: 01334 464610
Email: enquiries@itspublicknowledge.info
Website: www.itspublicknowledge.info/YourRights

Section 9: How to Access Information which is not available in the Guide to Information

If the information you are seeking is not available through the Model Publication Scheme 2016 (as described in this Guide) then you may wish to request it from us. The Act provides you with a right of access to the information we hold, subject to certain exemptions. The EIRs separately provide a right of access to the environmental information we hold, while the Data Protection Act 1998 (DPA) provides a right of access to any personal information about you that we hold.

Again, these rights are subject to certain exceptions or exemptions. Should you wish to request a copy of any information that we hold that is not available under the Model Publication Scheme 2016 (and described in this Guide), please write to:

For requests under Freedom of Information and the EIRs please contact:

Head of Administration & Business Support (Freedom of Information)
Inverclyde Integration Joint Board
Hector McNeil House
7-8 Clyde Square
Greenock
PA15 1NB

Telephone: 01475 715365
Email: HSCP.Communications@ggc.scot.nhs.uk

For requests under the Data Protection Act please contact:
Head of Administration & Business Support (Data Protection)
Inverclyde Integration Joint Board
Hector McNeil House
7-8 Clyde Square
Greenock
PA15 1NB

Telephone: 01475 715365
Email: HSCP.Communications@ggc.scot.nhs.uk

Charges for information that is not available under the scheme:

The charges for information that is available under this Guide to Information are set out under Section 5 – Our Charging Policy.
If you submit a request to us for information that is not available in this Guide the charges will be based on the following calculations:

General information requests:
• There will be no charge for information requests that cost us £100 or less to process.

• Where information costs between £100 and £600 to provide you may be asked to pay 10% of the cost in excess of £100. That is, if you were to ask for information that cost us £600 to provide, you would be asked to pay £50 calculated on the basis of a waiver for the first £100 and 10% of the remaining £500 being chargeable.

• We are not obliged to provide information in response to requests which will cost us over £600 to process.

• In calculating any fee, staff time will be calculated at actual cost per staff member hourly salary rate to a maximum of £15 per person per hour.

• We do not charge for the time to determine whether we hold the information requested, or for the time it takes to decide whether the information can be released. Charges may be made for locating, retrieving and providing information to you.

• In the event that we decide to impose a charge we will issue you with notification of the charge (a fees notice) and how it has been calculated. You will have three months from the date of issue of the fees notice in which to decide whether to pay the charge. The information will be provided to you on payment of the charge. If you decide not to proceed with the request there will be no charge to you.

Charges for environmental information:
Environmental information is provided under the EIRs rather than the Act. The rules for charging for environmental information are slightly different. We do not charge for the time to determine whether we hold the environmental information requested, or deciding whether the information can be released. Charges may be made for locating, retrieving and providing information to you, for example photocopying and postage. In the event that we decide to impose a charge we will issue you with notification of the charge and how it has been calculated. The information will be provided to you on payment of the charge. If you decide not to proceed with the request there will be no charge to you.

Charges are calculated on the basis of the actual cost to the IJB of providing the information without any disregard for the first £100 and without any discount on the elements above £100.

- Photocopying is charged at 10p per A4 sheet for black and white copying, 30p per A4 sheet for colour copying.

- Postage is charged at actual rate for Royal Mail First Class.

- Staff time is calculated at actual cost per staff member hourly salary rate.

The IJB may elect to waive the fee:-

- if satisfied that there is a widespread public interest in the publication of the information in question. This is unlikely to be the case where a request appears to be driven by commercial interests or is highly specific in terms of focus or geographical area;

- if satisfied that it would be uneconomical to issue a fees notice and process payment. The IJB may elect to waive the fee where information is requested which consists of a mixture of environmental and non-environmental information, and the non-environmental information would not be subject to a fee in terms of the FOI legislation.

The IJB may elect to apply a disregard of the first £100 of any fee and charge only 10% of the marginal costs between £100 and £550 if it has processed an environmental information request as a mainstream FOI request. This should not be taken as an indication that the same disregard will be applied to any similar requests in future.

Charge for request for your own personal data:
The minimum cost is £10 rising to a maximum of £50 depending on the volume and type of information requested, plus reproduction and postage costs (both on the same basis as for FOI requests).

Section 10 – Classes of Information

CLASS 1: ABOUT INVERCLYDE INTEGRATION JOINT BOARD

Class description:
Information about Inverclyde Integration Joint Board, who we are, where to find us, how to contact us, how we are managed and our external relations.

The information we publish under this class

CLASS 2: HOW WE DELIVER OUR FUNCTIONS AND SERVICES

Class description:
Information about our work, our strategy and policies for delivering functions and services and information for our service users.

The information we publish under this class

CLASS 3: HOW WE TAKE DECISIONS AND WHAT WE HAVE DECIDED

Class description:
Information about the decisions we take, how we make decisions and how we involve others.

The information we publish under this class

CLASS 4: WHAT WE SPEND AND HOW WE SPEND IT

Class description:
Information about our strategy for, and management of, financial resources (in sufficient detail to explain how we plan to spend public money and what has actually been spent).

The information we publish under this class

CLASS 5: HOW WE MANAGE OUR HUMAN, PHYSICAL AND INFORMATION RESOURCES

Class description:
Information about how we manage the human, physical and information resources of Inverclyde Integration Joint Board

The information we publish under this class

Human Resources

Physical Resources

Information Resources

Data Protection; Policy for the Retention and Disposal of Documents and Records Paper and Electronic; Environmental Information Regulations; Freedom of Information; Re-use of Public Sector Information.

CLASS 6: HOW WE PROCURE GOODS AND SERVICES FROM EXTERNAL PROVIDERS

Class description:
Information about how we procure goods and services, and our contracts with external providers.

The information we publish under this class

CLASS 7: HOW WE ARE PERFORMING

Class description:
Information about how we perform as an organisation, and how well we deliver our functions and services.

The information we publish under this class

CLASS 8: OUR COMMERCIAL PUBLICATIONS

Class description:
Information packaged and made available for sale on a commercial basis and sold at market value through a retail outlet e.g. bookshop, museum or research journal.

We do not publish any information in this class

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 6

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18th August 2016**
Report By:	**Brian Moore** **Corporate Director, (Chief Officer)** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/38/2016/HW**
Contact Officer:	**Helen Watson** **Head of Service** **Planning, Health Improvement & Commissioning**	**Contact No:**	**715285**
Subject:	**FREEDOM OF INFORMATION**		

1.0 PURPOSE

1.1 The purpose of this report is to inform Integration Joint Board Members of the number, themes and sources of Freedom of Information requests from July 2015 to June 2016, and our performance with regard to response timescales.

2.0 SUMMARY

2.1 The Freedom of Information (Scotland) Act 2002 (FOISA) came into force on 1st January 2005. The Act provides a statutory right of access to information held by Scottish public bodies and requires us to respond appropriately to requests for information made under the terms of the Act. Responses should normally be completed and issued within 20 working days of receipt of the request. Information is available through the Council and NHS Board's Publication Schemes, located at www.inverclyde.gov.uk and www.nhsggc.org.uk . Requests for access to information can be made by anyone, whether resident in the UK or not, and can be made for information held prior to enactment of the Act. The right of access to information is subject to a number of exemptions within FOISA.

2.2 During the year from 1st July 2015 to 30th June 2016, we received **166** requests under the terms of the Act, and of these **148 (94%)** were responded to within 20 working days. There are currently 8 still outstanding, within the 20 day timescale for response. There were 10 completed outwith the 20 working days.

We seek to respond to all requests within 20 working days however there are times when the 20 working day turnaround presents challenges where there are complex cases.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the Annual Report on the operation of the Freedom of Information (Scotland) Act 2002 in Inverclyde Health and Social Care Partnership in period 1 July 2015 to 30 June 2016

Brian Moore
Corporate Director (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Freedom of Information (Scotland) Act 2002 ("the Act") imposes a number of obligations on Scottish public authorities, including NHS Greater Glasgow and Clyde (NHSGG&C) and Inverclyde Council. The Act gives a general right of access to recorded information held by public authorities, subject to certain exemptions. The Act also imposes additional responsibilities:-

(a) to produce a Publication Scheme which is subject to approval by the Scottish Information Commissioner. Publication schemes are high level, strategic documents in which a public authority makes binding commitments to make information available to the general public. Such schemes:-

- provide clear evidence to the public that an authority is meeting its obligations under the Act to be accessible, open & transparent;

- enable the public to see what information is already published, and to access it without having to make a formal request for information;

- give employees clear guidance about the information that they can and should give out to the public so they can respond to information requests efficiently;

- help reinforce leadership messages about openness and accountability to staff at all levels in the organisation;

- are to be easily accessible and designed to be easy to understand and to use by everyone (including those with no internet access).

(b) to respond to requests (which must be in writing or some other permanent form) made by anyone for information held by the authority within set timescales (normally 20 working days) regardless of when it was created, by whom, or the format in which it is now recorded.

(c) to advise an applicant if information is not held.

(d) to specify within the terms of exemptions set out in the Act if the authority refuses to release the requested information.

(e) to charge for the provision of information only in accordance with regulations made under the Act and to decline to provide information if the cost of doing so exceeds a specified level.

(f) to make applicants aware of their right to seek a review of any decision on a request for information and of the right to pursue an appeal to the Scottish Information Commissioner if dissatisfied with the decision of the authority.

4.2 Given that the HSCP is part of both Inverclyde Council and NHSGGC, there are two different processes in place. We have worked to streamline the system in that we receive FOIs through a central office and comply with the correct organisational procedure which in turn gives an overall picture of FOIs received. It is important to note that while there are slight variations in the detail of organisational processes, the legislation that covers both parent organisations is the same, as are the response timescale requirements.

5.0 REQUESTS RECEIVED

5.1 During the specified time-frame there were **166** FOI requests. Table 1 below outlines

our performance in relation to timescales.

Quarter	***Total FOI Requests***	***Completed within Timeframe***	***Timeframe not met***
Jul - Sep 2015	38	34	4
Oct - Dec 2015	39	35	4
Jan - Mar 2016	61	59	2
Apr - Jun 2016	28	20*	0
Total	**166**	**148**	**10**

Table 1 – Performance in respect of timescales

* 8 Requests currently active

All of the above have come through the Council FOI system. This does not include local health FOI requests. Health requests are centrally co-ordinated at the Health Board, and generally relate to the whole Board area, rather than Inverclyde specifically.

5.2 Table 2 and Figure 1 provide a breakdown of the source of requests for information in respect of Freedom of Information. This shows the majority of requests come from individuals (38%), followed by requests from journalist/ media organisations (20%).

Indicative source of request	**July 2015 – June 2016**	**July 2014 - June 2015**
Charity/Campaign/Voluntary organisations	10 (6%)	12 (7%)
Commercial organisations	27 (16%)	35 (21%)
Education/research	3 (2%)	7 (4%)
Journalist/Media organisation	33 (20%)	33 (19%)
Legal Organisations	3 (2%)	5 (3%)
Individuals	63 (38%)	58 (34%)
MSP/Scottish Parliament/other elected official	25 (15%)	18 (11%)
Other Public Body	1 (0.5%)	0 (0%)
Trade Union/Professional Representative body	1 (0.5%)	2 (1%)
Total	**166**	**170**

Table 2 – Source of requests

Fig 1 – the chart below shows indicative source of requests from July 2015 – June 2016 alongside comparator data from 2014/15

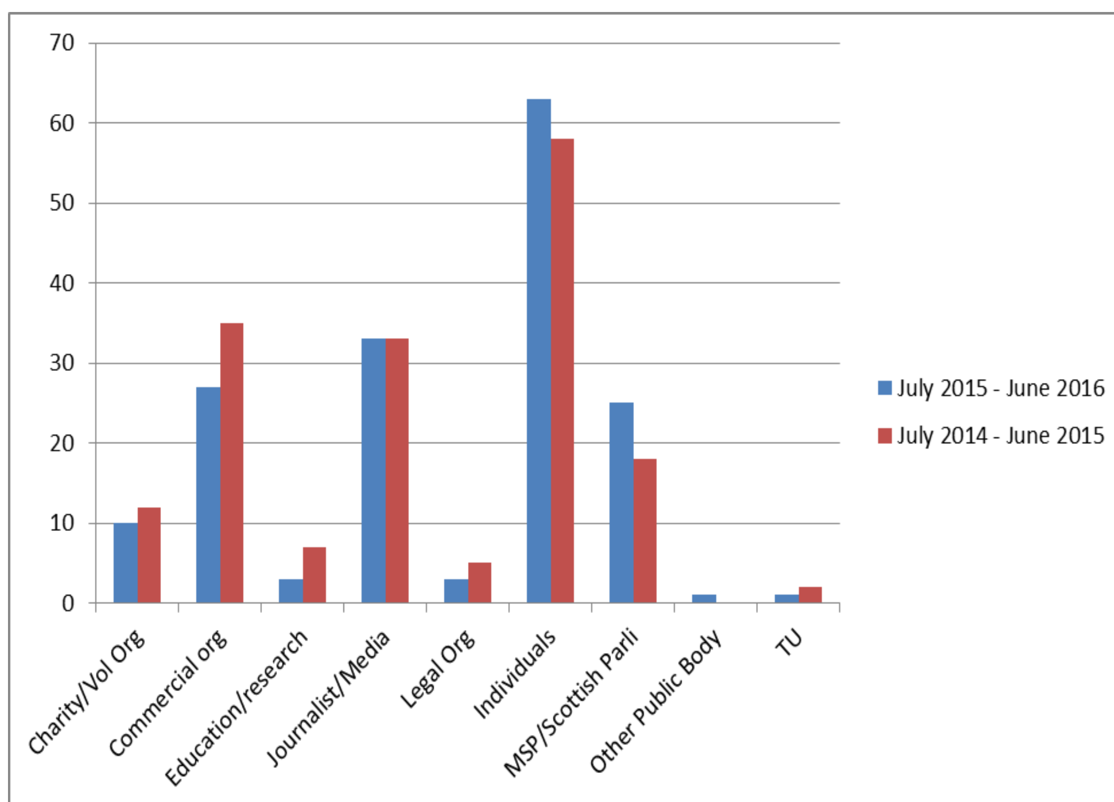


Figure 1 – Source of requests

5.3 The information shows a slight decrease in the number of FOIs received since 14/15. Going from 170 in 2014/15 to 166 in 2015/16. The decrease is most notable in the amount of requests received from Charity and Voluntary Organisations and Commercial Organisations, however there is an increase in requests from Individuals and MSP/Scottish Parliament.

6.0 TYPE OF INFORMATION REQUESTED

6.1 A number of recurring themes were identified in the subject matter of requests for information. These are listed below together with a flavour of the detail of what was asked in relation to each key theme.

Themes	July 2015 - June 2016	July 2014 - June 2015
Finance	29	12
Social Work Staffing	23	21
Adult Services – *Social Care Fees/ Care Home Info.*	40	42
Learning Disability Services	9	5
SDS Personalisation	8	12
Children & Families	45	47

Carers & Respite Services	0	2
The Travelling Community	2	2
Housing & Homelessness	26	6
Criminal Justice	5	8
Mental Health & Addictions	5	8
Corporate Policies & Reports/ Complaints	3	12
Welfare/ Financial Advice Service	5	3

Table 3 – Themes of requests

Fig 2 – Themes are shown below between July 2015 – June 2016 along with comparator data from 2014/15, with detailed analysis showing an increase in FOI requests around finance and housing and homelessness, with a slight reduction noted in respect of children and families and adult social care.

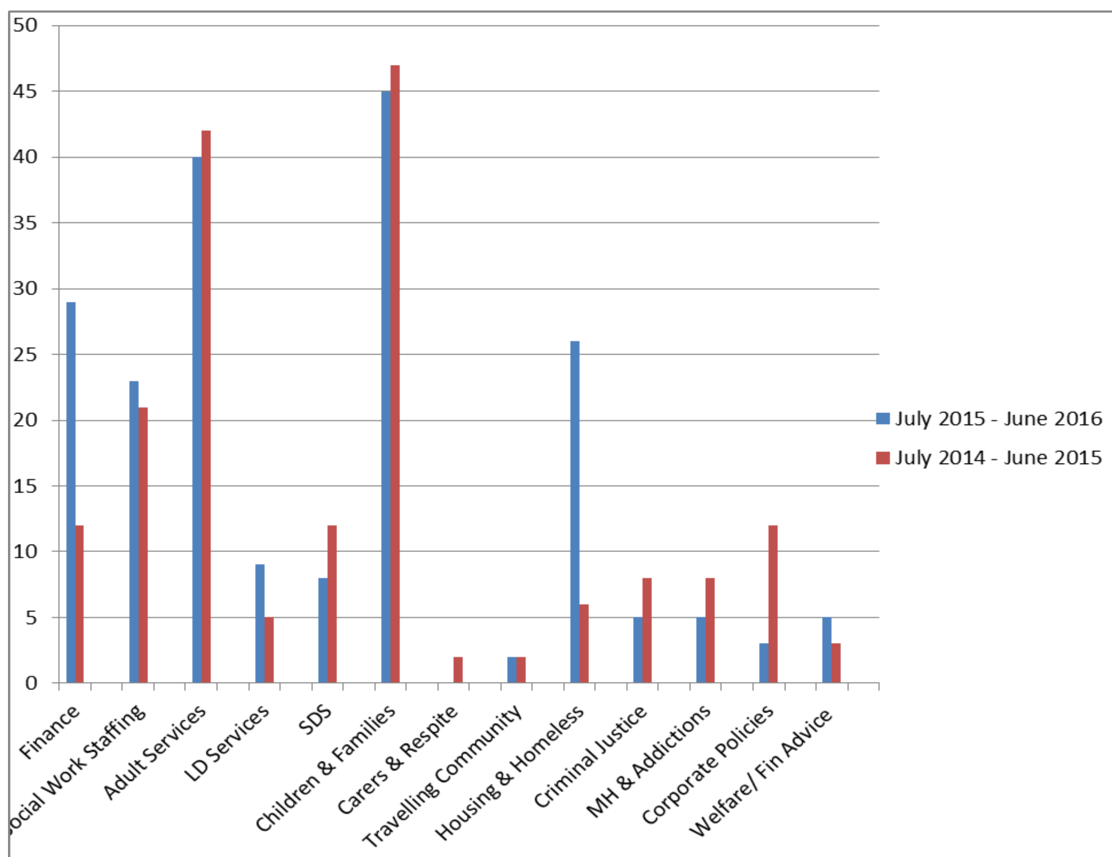


Figure 3 – Themes of requests

6.2 The biggest increases in relation to the themes are noted around information requests about housing and homelessness, finance and learning disability services. We will review the information on the Publication Scheme relating to these aspects to see if it can be improved, to reduce the need for future FOI requests and responses.

7.0 CONCLUSION

7.1 Whilst we embrace the spirit of the Act, it should be noted that there is significant demand on staff with 166 requests from July 2015 to June 2016. We have issued 11 exemption notices during this period, both in respect of time and financial limits as this would have involved an excessive amount of staffing resource including front line practitioner resource to gather and return the information. To date no applicant has responded to the 11 exemption notices, therefore no charge for information has been issued by Inverclyde HSCP.

7.2 The majority of requests to Inverclyde HSCP came from individuals, journalists and commercial organisations, which we seek to address by working with the corporate functions of the Council to further develop the Scheme of Publication to help interested members of the public, and to reduce the amount of time required to respond to requests.

7.3 The Council has developed a Freedom of Information Working Group, which:-

- Oversees the implementation of local guidance based on the Scottish Ministers Code of Practice on the discharge of functions by public authorities under the Freedom of Information (Scotland) Act 2002.
- Reviews current arrangements and makes suggestions for better working and streamlining processes and consistency across the Council.
- Provides a forum for all staff with FOI remit to come together to share knowledge and expertise.
- Discusses the volume and types of requests received by the council, and amends the publication scheme as indicated.
- Monitors significant changes in access legislation and updates group members on developments in the law.
- Makes recommendations relating to the legislation when necessary and/or appropriate.
- Discusses performance of FOIs.
- Reports to the Information Governance Steering Group on progress.

7.4 Members are asked to note this updated report on the operation of the Freedom of Information (Scotland) Act 2002 within Inverclyde HSCP and give any comments or views on the format of the report or on any area with regard to the Act.

8.0 IMPLICATIONS

FINANCE

8.1 Financial Implications:

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

8.2 There are no legal issues within this report.

HUMAN RESOURCES

8.3 There are no human resources issues within this report.

EQUALITIES

8.4 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.

9.0 CONSULTATION

9.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP)

10.0 BACKGROUND PAPERS

10.1 None.

INVERCLYDE
HSCP
Health and Social Care Partnership

AGENDA ITEM NO: 8

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/43/2016/LA**
Contact Officer:	**Lesley Aird**	**Contact No:**	**01475 712744**
Subject:	**HEALTH BOARD FINANCIAL ALLOCATION 2016/17**		

1.0 PURPOSE

1.1 The purpose of this report is to provide the Board with an update on the financial allocation agreed for Inverclyde Integration Joint Board (IJB) by the Health Board for 2016/17.

2.0 SUMMARY

2.1 The IJB agreed an interim Health budget on 20 June 2016. This interim budget was based on assumed Health Board funding to the IJB of £76.935m (including £4.449m for Social Care) for 2016/17.

2.2 The Health Board budget for 2016/17 was subsequently agreed on 28 June 2016. The Chief Executive of the Health Board wrote to the Chief Officer on 5 July 2016 confirming an Inverclyde financial allocation for the year of £76.313m, £0.622m less than previously anticipated. A copy of that letter is enclosed at Appendix A.

2.3 The main movement relates to an additional £0.587m savings target applied to Inverclyde as part of the Board wide Partnership savings target of £20m. Half of the £20m was identified through system wide projects, the remainder has been shared across Partnerships on a pro-rata basis

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board notes the contents of this report.

Brian Moore
Corporate Director (Chief Officer)

Lesley Aird
Chief Financial Officer

4.0 BACKGROUND

4.1 The Health Board approved the 2016/17 Financial Plan for NHS Greater Glasgow and Clyde on 28 June 2016. As part of that Financial Plan assumed savings of £20m had been applied to Health and Social Care Partnerships. Of this £20m, less than half had already been identified through whole system projects. The Health Board has split the remaining balance across Partnerships on a pro rata basis as an additional savings target. The Inverclyde IJB financial allocation for 2016/17 has been confirmed as £76.313m, £0.622m less than previously anticipated. A copy of the funding letter from the Health Board Chief Executive is enclosed at Appendix A.

5.0 BUDGET IMPACT 2016/17

5.1 The Health Board has recognised that Partnerships may not be able to release the full value of their targeted savings in 2016/17 and the enclosed letter confirms that limited non-recurring relief is available to offset the full year effect of savings delivered in year. No funding is being released to Partnerships to cover this at this stage.

5.2 Partnerships had an unachieved savings balance from 2015/16 of £7.8m. The Health Board has advised that it will endeavour to cover this from non-recurring sources.

5.3 The Health Board budget had a further balance of £10m of Board wide savings still to be identified for 2016/17. We have been advised that further savings schemes may need to be identified as part of the Board's overall plan should the national programme of work fail to identify sufficient savings to cover this gap.

5.4 **Inverclyde Savings Target**
The Inverclyde share of the unidentified Partnership savings balance has been calculated by the Health Board at an additional £0.587m of savings to be delivered in 2016/17, bringing the total savings target to £0.911m, or around 2% of influenceable spend. Influencable spend for the purpose of this exercise is everything excluding the Prescribing, Change Fund and Resource Transfer budgets. The full savings are to be identified and agreed by January 2017. It is not known what portion of the further £10m savings (outlined in 5.3 above) might be apportioned against Inverclyde.

5.5 The detail of the calculation methodology splitting the savings target between Partnerships has been requested but not yet received.

5.6 The movement in anticipated funding allocation from the interim budget at 20 June till now is £0.622m. This is comprised of:

- Additional savings target applied to Inverclyde £0.587m
- Other budget minor adjustments and realignments totalling £0.035m

5.7 **Inverclyde Savings Proposals**

Of the total £0.911m savings for Inverclyde, the Partnership had already identified savings of £0.324m which are in the process of being delivered. These are:

Saving	Saving released in 2016/17 £000	Full Year Saving £000
Workforce savings through removal of vacancies and other initiatives	80	200
Savings within the Alcohol & Drug Partnership as part of GG&C wide initiative	40	75
Health Visiting as part of GG&C wide initiative	21	21
Public Health – removal of 0.5 WTE vacant post	28	28
TOTAL	**169**	**324**

5.8 Savings options for 2016/17 to address the £0.587m balance of the £0.911m are being developed by officers and will be brought to the IJB for approval later in the year. The allocation letter from confirms that the Health Board has some limited non-recurring relief available in year to offset the full year effect of savings delivered in year.

5.9 Work is also underway to identify options for savings for 2017/18. While actual savings targets for 2017/18 have not been confirmed at this time officers are working out scenarios based on initial advice from the Health Board Finance team.

6.0 IMPLICATIONS

6.1 Finance

Additional savings of £0.587m need to be identified from within Health Budgets in 2016/17.

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

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

Human Resources

6.3 There are no specific human resources implications arising from this report.

Equalities

6.4 There are no equality issues within this report.

7.0 CONSULTATION

7.1 The Chief Officer, the Council's Chief Financial Officer and Director of Finance NHSGGC have been consulted.

8.0 BACKGROUND PAPERS

8.1 None.

APPENDIX

Greater Glasgow and Clyde NHS Board

JB Russell House
Gartnavel Royal Hospital
1055 Great Western Road
GLASGOW
G12 0XH
Tel. 0141-201-4444
Fax. 0141-201-4601
Textphone: 0141-201-4479
www.nhsggc.org.uk

Brian Moore
Chief Officer
Inverclyde Health and Social Care
Partnership
10 Clyde Street
Greenock
PA15 1LY

Date: 5th July 2016
Our Ref: RC/BOB

Enquiries to: Robert Calderwood
Direct Line: 0141-201-4614
E-mail: mailto:robert.calderwood@ggc.scot.nhs.uk

Dear Brian

2016/17 Financial Allocation to Inverclyde Health & Social Care Partnership

The Board approved the 2016/17 Financial Plan for NHS Greater Glasgow and Clyde on 28 June 2016.

The attached paper outlines the main assumptions as they apply to HSCPs and Appendix I gives specific details for your partnership including some recently agreed adjustments to Facilities budgets. Some further adjustments are required for telecoms, property maintenance and rates budgets. The prescribing out-turn figures for 2015/16 which form the basis for setting the current year budget have only recently become available and therefore the net uplift to your current prescribing budget will be applied during July.

The adjustments in the attached schedule will be processed in the Health Board ledger in time for the closure of the June reporting period and should be reflected in the out-turn you report to your HSCP Board for the first quarter of 2016/17.

Yours sincerely

Robert Calderwood
Chief Executive

NHS Greater Glasgow and Clyde

FINANCIAL PLAN 2016/2017
UPLIFTS TO PARTNERSHIPS

Summary

The Board's Financial Plan was approved by the Board on 28 June 2016.

This paper provides details of uplifts for pays, non-pays and prescribing growth in 2016/17. This will form the basis for updating budgets for 2016/17.

Salaries Inflation

(1) Agenda for Change

A provision has been made for an increase of 1.0%. In addition, a provision has been made for a flat rate increase of £400 for staff earning less than £22,000.

(2) Medical & Dental

A provision has been made for a general increase of 1.0%.

(3) Other Staff Groups

A provision has been made for a general increase of 1.0%.

(4) Employers' National Insurance

A provision has been made for the abolition of the contracted out rebate of 3.4% in employers' national insurance contributions in respect of staff who are members of the superannuation scheme.

For paragraphs (1) to (4), this gives a composite uplift of 2.98% with the following recurring uplift:

Salaries Inflation	£9,583,168

(5) Incremental Pay Progression – AfC

The experience of monitoring Agenda for Change (AfC) related pay trends has helped the Board develop a detailed understanding of the effect of incremental pay progression. This has enabled us to carry out a detailed forecast of pay growth for 2016/17, using current staff turnover ratios by staff category. The pay modelling has indicated incremental pay progression will not be a cost pressure in 2016/17, so no provision has been made for additional costs.

(6) Incremental Pay Progression – Consultants

The pay modelling has indicated incremental pay progression will not be a cost pressure in 2016/17, so no provision has been made for additional costs.

(7) Auto-enrolment to Superannuation

A provision has been made for the estimated cost of additional staff remaining within the Superannuation scheme following automatic re-enrolment on 1 April 2016. This will be applied to budgets as the actual costs are confirmed.

(8) Discretionary Points

A provision has been made for the on-going impact of funding additional discretionary points. This gives the following recurring uplift:

Discretionary Points	£100,000

Supplies Inflation

(1) PPP and similar costs

Provision has been made for the following recurring uplift:

PPP Inflation	£209,813

(2) General non pay uplifts – a provision of 1.0% has been made for other supplies, excluding drugs which will be separately funded. This gives the following recurring uplift:

Supplies Inflation	£603,142

Capital Charges

It is not possible to establish allocations for capital charges costs at this stage until the effects of the revaluation are assessed and capital charge forecasts are finalised. When this is complete the funding allocations for 2016/17 will be confirmed. It has been agreed that capital charges budgets will be removed from partnerships during 2016/17 and managed on a whole system basis.

Prescribing Growth – Primary Care

The prescribing cost growth projection for 2016/17 is based on information from the Board's Prescribing Advisers. It includes provision for likely growth in volume / prices, based on current trends, related to drug treatments prescribed within Primary Care.

The recurring uplift for 2016/17 is:

Partnerships	
Increase in Volume	£12,200,000
New Drugs	£8,500,000
Targeted Cost Savings	(£5,000,000)
Prescribing Growth	£15,700,000

NHS Greater Glasgow and Clyde

FINANCIAL PLAN 2016/2017
UPLIFTS TO PARTNERSHIPS

Allocations to individual partnerships are currently being finalised and will be applied to budgets prior to closure of the June reporting period. The Board will continue to operate the risk sharing arrangement for prescribing costs during 2016/17.

Resource Transfer

A provision of 1.7% has been made for uplifts to resource transfers. This gives the following recurring uplift:

Resource Transfer	£2,207,688

Cost Savings

Local Cost Savings plans for 2016/17 have not yet been fully developed and quantified. An interim recurring amount of £10.4m has been identified for 2016/17 reflecting the collective cost savings programme to achieve £69.0m.

Chief Officers were advised by the Chief Executive on 14 March 2016 that further recurring local savings will be required during 2016/17 to meet the overall partnerships savings requirement of £20.0m. The allocation of the overall savings requirement is shown in appendix I.

Cost Savings	(£20,000,000)

It is recognised that Partnerships may not be able to release the full £20.0m in 2016/17. Non recurring relief is limited but availability of non-recurring relief to offset the full year effect will be subject to further discussion during the year, so no funding will be released at this stage.

The Board will endeavour to cover 2015/16 unachieved savings of £7.8m from non recurring sources, however further savings schemes may need to be identified as part of the contribution to the £10m of unidentified savings in the Board's financial plan should the national programme of work fail to identify sufficient savings to cover this gap.

Service Commitments

Provision has been made to fund service commitments arising from specific funding allocations. This gives the following recurring uplifts:

Integrated Care Fund	£59,354,000

Funding for other service commitments will be dealt with separately.

NHS Greater Glasgow and Clyde

FINANCIAL PLAN 2016/2017
UPLIFTS TO PARTNERSHIPS

Appendix I

Details of the specific uplifts and other adjustments are detailed in the table below.

Partnership Budgets	Inverclyde £k
Rollover Budgets	*71,253.0*
Uplifts Applied	
Pay incl low pay allowance	233.0
National Insurance rebate withdrawn	364.9
Auto Enrolment (NR - Amounts to M2 only)	40.8
RT Uplift incl addictions RT	156.5
Non Pay Uplift	24.0
PPP	4.0
Net Prescribing adjustment tbc	
Social Care funding	4,449.0
Facilities Budget withdrawn	
Depreciation Budget Withdrawn	-295.0
Savings	
Savings Targets Applied (Month 2)	-324.0
Outstanding Savings Targets to be applied (Month 3)	-587.0
2016.17 Opening Budget	**75,319.1**
Anticipated Funding & Minor adjustments	994.1
2016.17 budget as at 30.06.16	**76,313.2**

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 9

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore** **Corporate Director (Chief Officer)** **Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/41/2016/HW**
Contact Officer:	**Helen Watson** **Head of Service** **Planning, Health Improvement & Commissioning**	**Contact No:**	**01475 715285**
Subject:	**PERFORMANCE EXCEPTIONS REPORT**		

1.0 PURPOSE

1.1 The purpose of this report is to present a sample of key performance exceptions data to the Integration Joint Board which reflects a balanced view of performance across the four Heads of Service areas of the HSCP as well as providing a picture of how people in Inverclyde experience Health and Social Care Services.

2.0 SUMMARY

2.1 The measures have been carefully selected from our on-going Quarterly Service Review (QSR) arrangements, to evidence areas of positive and negative performance and to highlight the remedial actions we plan to put in place in order to improve performance in those areas. The measures consist of health and social care delivery and span the Nurturing Inverclyde model of wellbeing categories which includes: safe, healthy, achieving, nurtured, active, respected and responsible and included.

2.2 Our previous performance report was presented to the former CHCP Sub-Committee on 23rd April 2015. This report re-commences the twice yearly performance exceptions reporting that has been put in place since formal establishment of the HSCP and IJB structures.

3.0 RECOMMENDATIONS

3.1 Members are asked to note performance within the report along with the remedial actions suggested where performance is below the standard that we would expect, and to provide any relevant comments to assist in ongoing performance improvement and reporting of such to the Integration Joint Board (IJB).

Brian Moore
Corporate Director (Chief Officer)
Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

4.1 The Integration Joint Board has a central function in respect of reviewing performance and scrutinising achievement of key outcomes. This report structure ensures that our efforts are focused on improving performance in line with our key commitments, as outlined in our Strategic Plan 2016 – 2019, and approved by the IJB in April 2016.

4.2 Our fully integrated system and process for the management of performance in the form of Quarterly Services Reviews (QSR) arrangements are now well embedded into our performance reporting framework and have already proven to be successful in assisting the service with the demands of all our local and national reporting requirements.

5.0 PROPOSALS

5.1 None, however Members are asked to note performance within the report along with the remedial actions suggested, and to provide any relevant comments to assist in ongoing performance improvement and reporting.

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 There are no equalities implications in respect of this report.

7.0 CONSULTATIONS

7.1 None.

8.0 LIST OF BACKGROUND PAPERS

8.1 HSCP Integrated Performance Exceptions Report: Period to July 2016.

Performance Exceptions Report

June 2016

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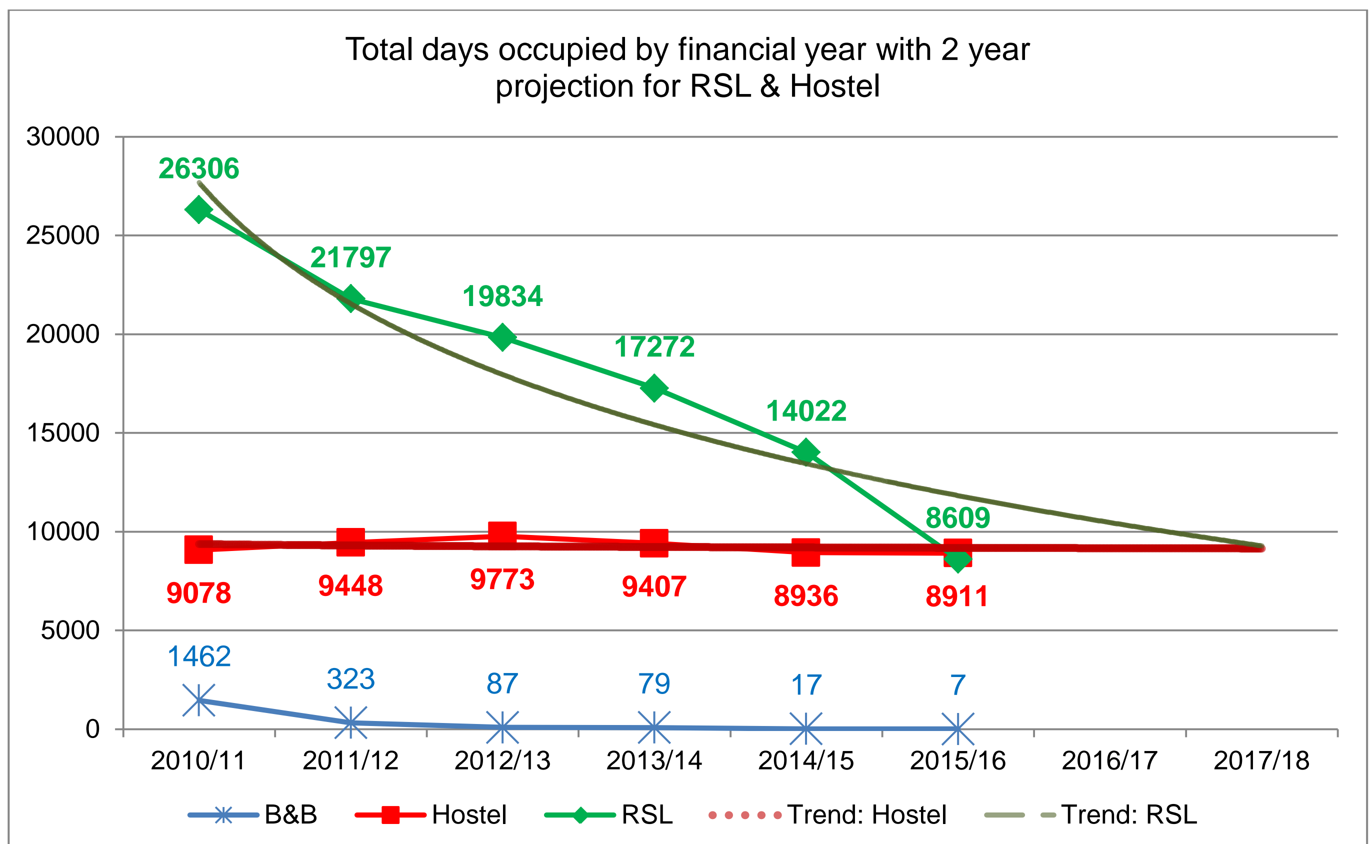
Service Area	Exceptions Measure	National Health and Wellbeing Outcome	Page
MHAH	Homelessness Temporary Accommodation	(5) Health and social care services contribute to reducing health inequalities.	3
MHAH	Referral to Treatment, Inverclyde Integrated Drugs Service	(1) People are able to look after and improve their own health and wellbeing and live in good health for longer.	5
MHAH	Dementia and Post Diagnostic Support	(4) Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	7
HCCPC	Delayed Discharges	(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.	9
HCCPC	Self-Directed Support	(1) People are able to look after and improve their own health and wellbeing and live in good health for longer.	11
HCCPC	Step-Up Beds	(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.	13
PHIC	Smoking Cessation	(1) People are able to look after and improve their own health and wellbeing and live in good health for longer.	14
PHIC	Complaints	(3) People who use health and social care services have positive experiences of those services, and have their dignity respected.	16
PHIC	Absence	(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.	18
CFCJ	MMR vaccination	(9) Resources are used effectively in the provision of health and social care.	20
CFCJ	Smoking in Pregnancy	(5) Health and social care services contribute to reducing health inequalities.	21
CFCJ	Community Payback Orders (CPO)	(5) Health and social care services contribute to reducing health inequalities.	23

MHAH: Homelessness Temporary Accommodation

Objective	Reduce reliance upon temporary accommodation by ensuring that people are housed into secure tenancies.
Outcome	(5) Health and social care services contribute to reducing health inequalities.
Measure	Length of time in temporary accommodation
Current Performance	2015/16 – 17527 days occupied

Number of days temporary accommodation occupied by financial year.

	Accommodation Type			
Year	**Bed and Breakfast**	**Hostel**	**RSL dwelling**	**Grand Total**
2010/11	1462	9078	26306	36846
2011/12	323	9448	21797	31568
2012/13	87	9773	19834	29694
2013/14	79	9407	17272	26758
2014/15	17	8936	14022	22975
2015/16	7	8911	8609	17527



Commentary
The use of Bed & Breakfast has significantly reduced as a result of increased capacity within the Registered Social Landlord (RSL) accommodation. The RSL temporary accommodation usage has dropped significantly year on year and this trend is likely to continue. This can be attributed to a number of factors including prevention work, link with Advice Services and easier access for securing a tenancy.

Homelessness presentations nationally and locally have been reducing year on year. This is mainly attributable to the increased activity around prevention work, housing options and the work of the Housing Options Hubs initiated by the Scottish Government.

However, the recent implementation of Choice Based Lettings by all the RSLs has resulted in a similar number of homeless applicants accessing housing by this method as those accessing housing by their Section 5 referral. This is resulting in homeless people receiving an offer of housing earlier and spending shorter period of time in temporary accommodation.

The number of temporary days occupied in a hostel has remained static due to the client group that are normally accommodated by this service. The provision of emergency accommodation, out of hours services and specific health support on site provide an essential service to the homeless people of Inverclyde.

Actions

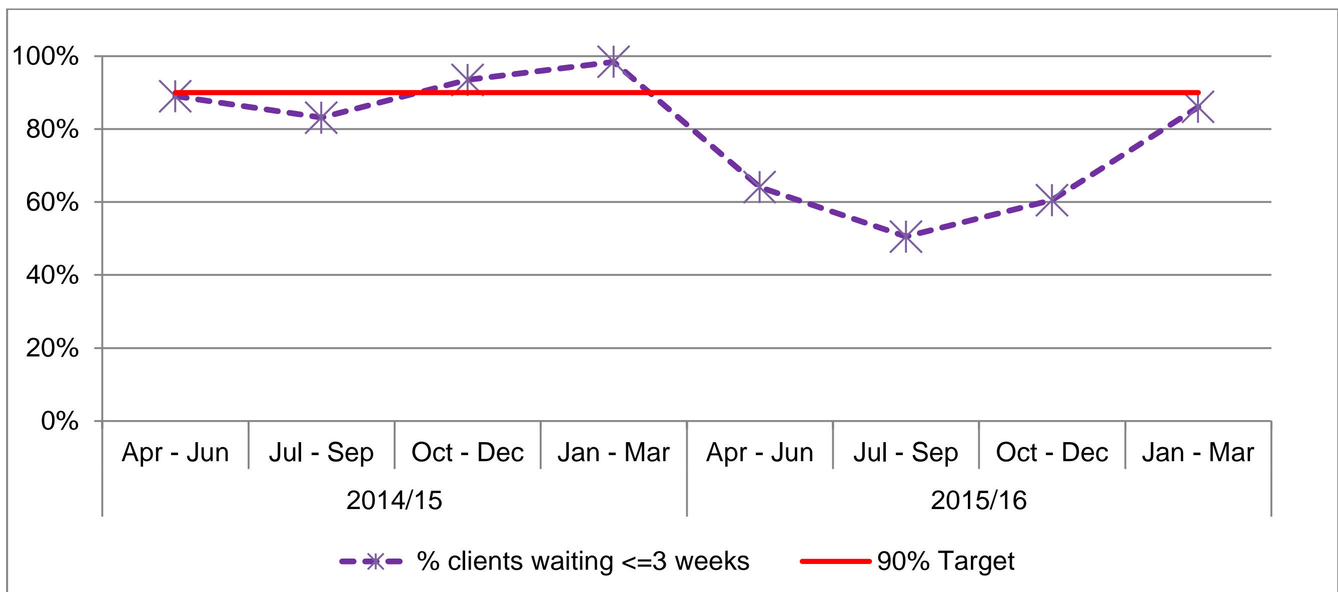
The Homelessness Service will continue to monitor this performance on a quarterly basis through the Mental Health, Addictions and Homelessness Quarterly Service Review (QSR).

The Homelessness Service continues to work with the Registered Social Landlords (RSLs) to access permanent accommodation for those in need via the Section 5 process.

MHAH: Referral to Treatment - Inverclyde Integrated Drugs Service (IIDS)

Objective	At least 90% of all IIDS Service Users will receive a 1st treatment appointment within 3 weeks of assessment
Outcome	(1) People are able to look after and improve their own health and wellbeing and live in good health for longer.
Measure	Referral to 1st Treatment Drug Services: % of services users seen within 3 weeks
Current Performance	Jan16 to Mar16: 60.53%

	2014/15				**2015/16**			
	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar
Total Clients	66	71	61	63	89	97	76	43
Clients waiting <=3 weeks	59	59	57	62	57	49	46	37
% clients waiting <=3 weeks	89.00%	83.10%	93.44%	98.41%	64.04%	50.52%	60.53%	86.05%
Clients waiting >3 weeks	7	12	4	1	32	48	30	6



Commentary

The Scottish Government set a target that by June 2013, 90% of people who need help with their drug problem will wait no longer than three weeks for treatment that supports their recovery. This was one of the national Health Improvement, Efficiency, Access, Treatment (HEAT) targets and has now become a Local Delivery Plan (LDP) standard.

Between March and July 2015 the performance against the 90% target dropped due to various issues, this in addition to an increase in the number of referrals.

In order to reduce the negative impact of this, cases were prioritised; people with child care responsibilities and those injecting were seen promptly, while some other cases were signposted to more appropriate services.

By taking a more targeted and focused approach, the graph above demonstrates that performance against waiting times is improving again, and at March 2016 was close to the target of 90% starting treatment within 3 weeks.

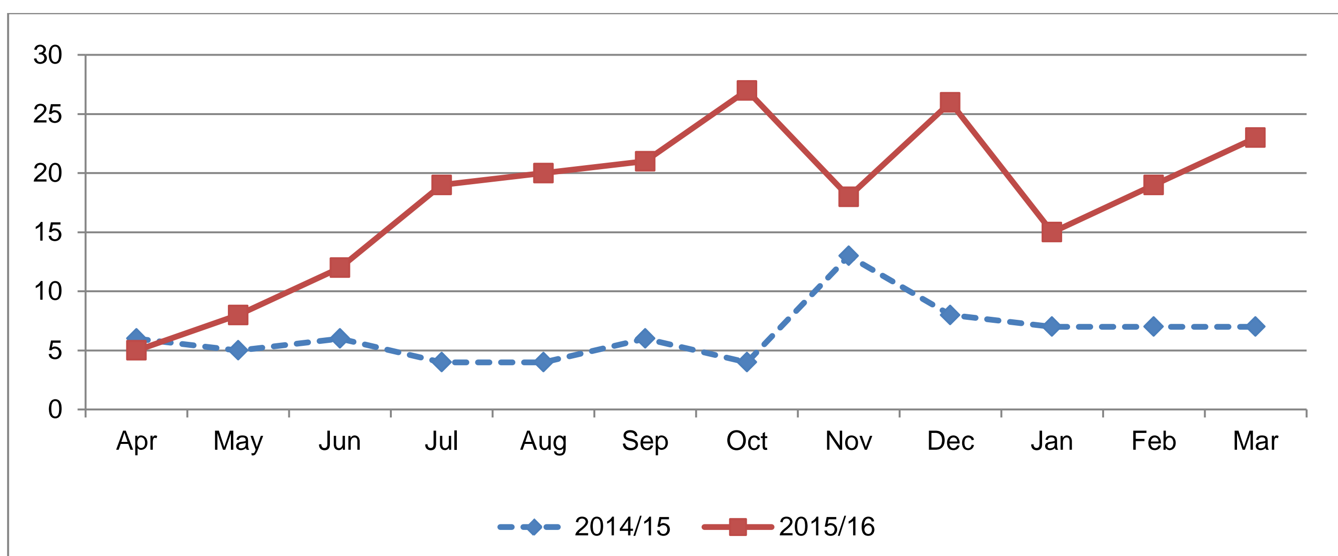
Actions

- Performance against this target will continue to be monitored in the Mental Health, Addictions and Homelessness Quarterly Service Review (QSR).
- We have negotiated alternative destinations for non-urgent cases; e.g. cannabis users who do not require medical intervention [these would have been low priority and waited beyond 3 weeks].
- We are prioritising cases (people with child care responsibilities and those injecting are seen quickly).

MHAH: Dementia – Post Diagnostic Support (PDS)

Objective	All people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.
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.
Measure	New referrals to Post Diagnostic Support Service
Current Performance	57 new referrals in the quarter Jan 2016 to Mar 2016 (up from 21 in the same period last year)

	Dementia Post Diagnostic Support (PDS) new referrals											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	6	5	6	4	4	6	5	13	8	7	7	7
2015/16	5	8	12	19	20	21	27	18	26	15	19	23



Commentary
We have seen a notable increase in people being referred to the PDS service. Total referrals for the financial year 2014/15 were 78 and for 2015/16 were 213, a 173% increase. This represents a challenging increase in demand for the PDS service. To respond to the increase in referrals, since April 2015 an additional post has been funded but despite this we still have an increasing waiting list for PDS. Whilst the increasing number of referrals shows positive access and is a clear indication of the need for the service, the average wait from the date of diagnosis to being seen by the service is now 12 weeks. Some people have been referred within the 12 months post diagnostic period and have received support, whilst others are offered support from the Alzheimer Scotland Dementia Advisor and/or referred for other support services as appropriate. The picture over the year indicates that the diagnostic rate in Inverclyde is much higher than the figures for the previous year would suggest.

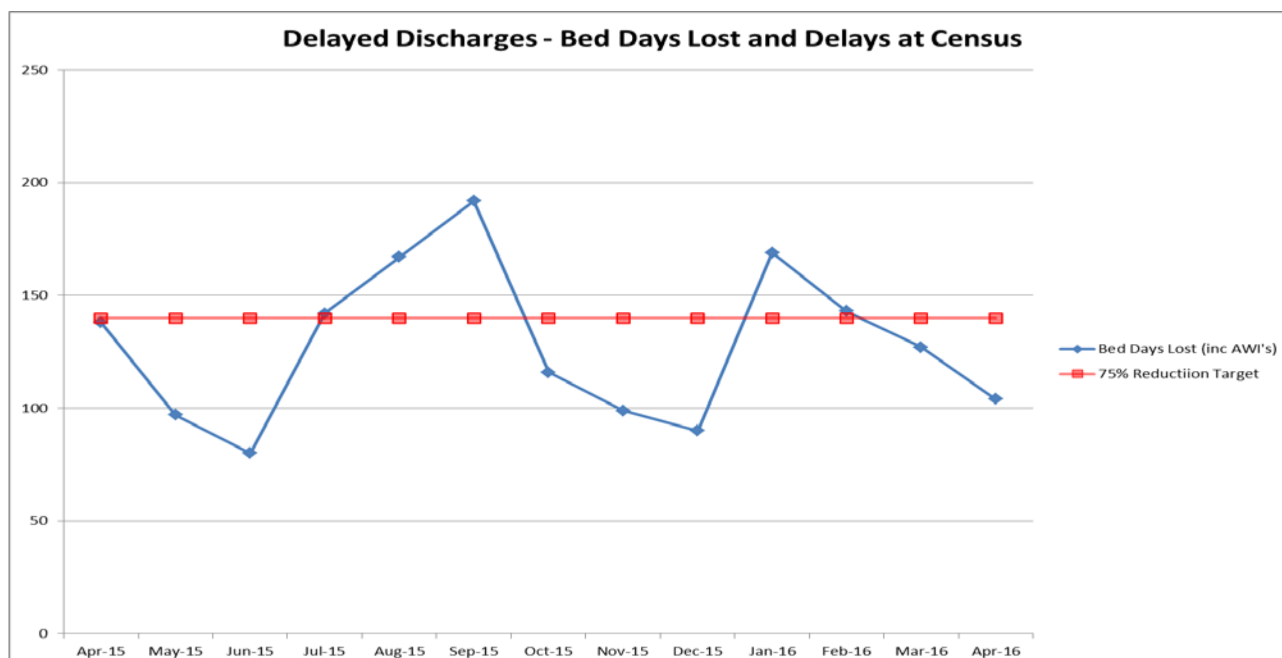
Actions

- Performance against this indicator will continue to be monitored in the Mental Health, Addictions and Homelessness Quarterly Service Review (QSR).
- Continue to review Argyll Unit service to improve the Post Diagnostic Support for people in Inverclyde.

HCCPC: Delayed Discharges

Objective	Ensure people are not in hospital longer than they need to be
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.
Measure	Acute Bed Days Lost to Delayed Discharge
Current Performance	104 bed days lost in January 2016

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Number of acute bed days lost to delayed discharges (65+)	138	97	80	142	167	192	116	99	90	169	143	127	104



Commentary
From April 2015 the target for Delayed Discharge 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; this provides a more complete picture of the impact of hospital delays. We continue to maintain positive performance in relation to the 14 day Delayed Discharge target. We have consistently achieved zero delays over 2 weeks since April 2015 up to and including May 2016. Despite an increase in delays and bed days lost during the winter period (in Inverclyde as well as the rest of GG&C) we are achieving the overall target of reducing bed days so far this financial year. Across the year (April 15 to March 16), we reached a 76.8% reduction on Bed Days Lost against the 2009/10 baseline; 1.8% better than the target set for us. Our total Bed Days Lost for this period was 1,560, which works out on average at 130 lost days per month. The monthly target is 140, so we exceeded the target on average by ten days each month.

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.

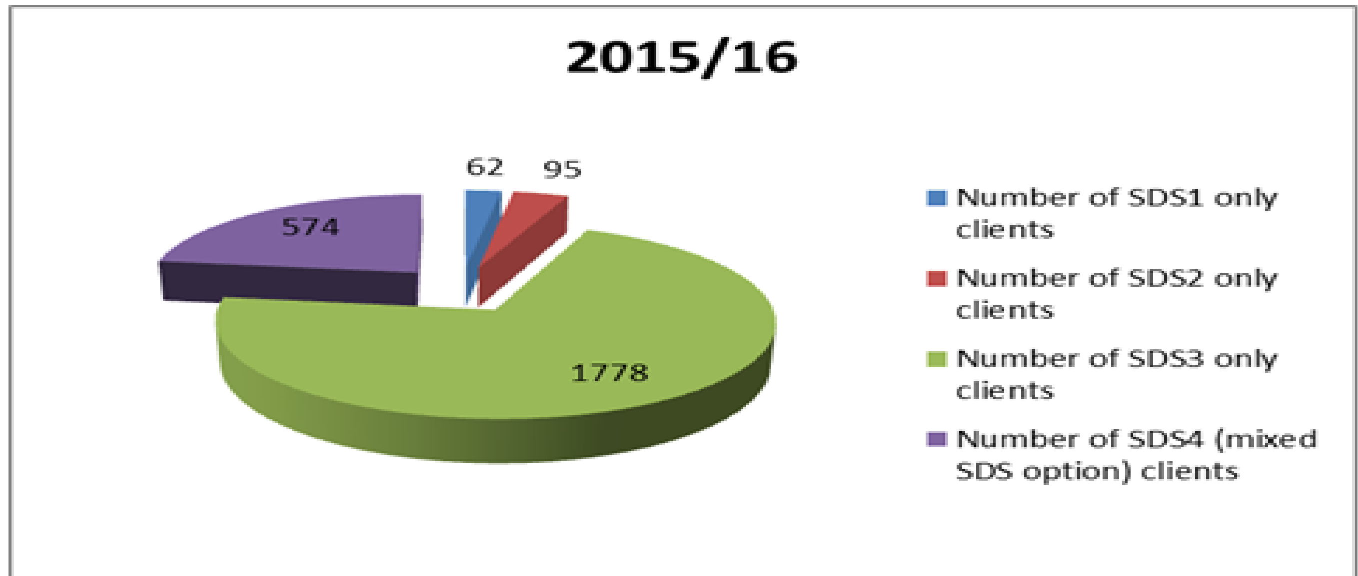
Actions

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

There is a continued focus to develop integrated and joint improvements to continually improve the hospital journey and discharge processes. This covers intermediate care (step up beds) and comprehensive geriatric assessment.

HCCPC: Self Directed Support (SDS)

Objective	To give options to the supported person ensuring that they are provided with the information and tools to make an informed choice about the available services and funds to best help them meet their outcomes.
Outcome	(1) People are able to look after and improve their own health and wellbeing and live in good health for longer.
Measure	Increase in Number of unique and mixed options chosen over the last 3 years.
Current Performance	2509 SDS clients in 15/16 – increase of 1068 clients from 14/15



SDS Unique Client Summary	2014/15	2015/16	Increased No. of clients
Total Number of SDS clients	1441	2509	1068
Number of SDS1 only clients	53	62	9
Number of SDS2 only clients	51	95	44
Number of SDS3 only clients	1316	1778	462
Number of SDS4 (mixed SDS option) clients	21	574	553

Commentary

Since the 1st of April 2014, Scottish councils have a legislative duty to offer the 4 SDS options to all service users assessed as requiring social care support. Collating the information to evidence the choices being made and the shift in services has been a major challenge. Since January 2016 we have put in place an individual support plan that is able to record the SDS option chosen by service users and link to service provided.

For 2015 all 2,509 service users assessed or reviewed were offered a choice of the 4 SDS options and the graph illustrates the number of individual service users who chose each option. 574 individuals chose a mix of the options offered which demonstrates the exercise of real choice and control by these individuals and the flexibility of service provision within Inverclyde.

There is a slight but gradual increase in number of SDS Option 1 (Direct Payment) which appears to be in line with other local authority areas but still below the average uptake. The more marked increase is in

Option 2 (individual service fund) and is related to changes in service provider following the implementation of the Homecare contract, choice around an independent day care provider for older people and re-coding services such as short breaks from option 3 (HSCP arranged service) to option 2.

Actions

Revision of the SDS Implementation Plan which will cover 4 themes.

- People
- Processes and Procedures
- Positioning the Social Care Market
- ICT

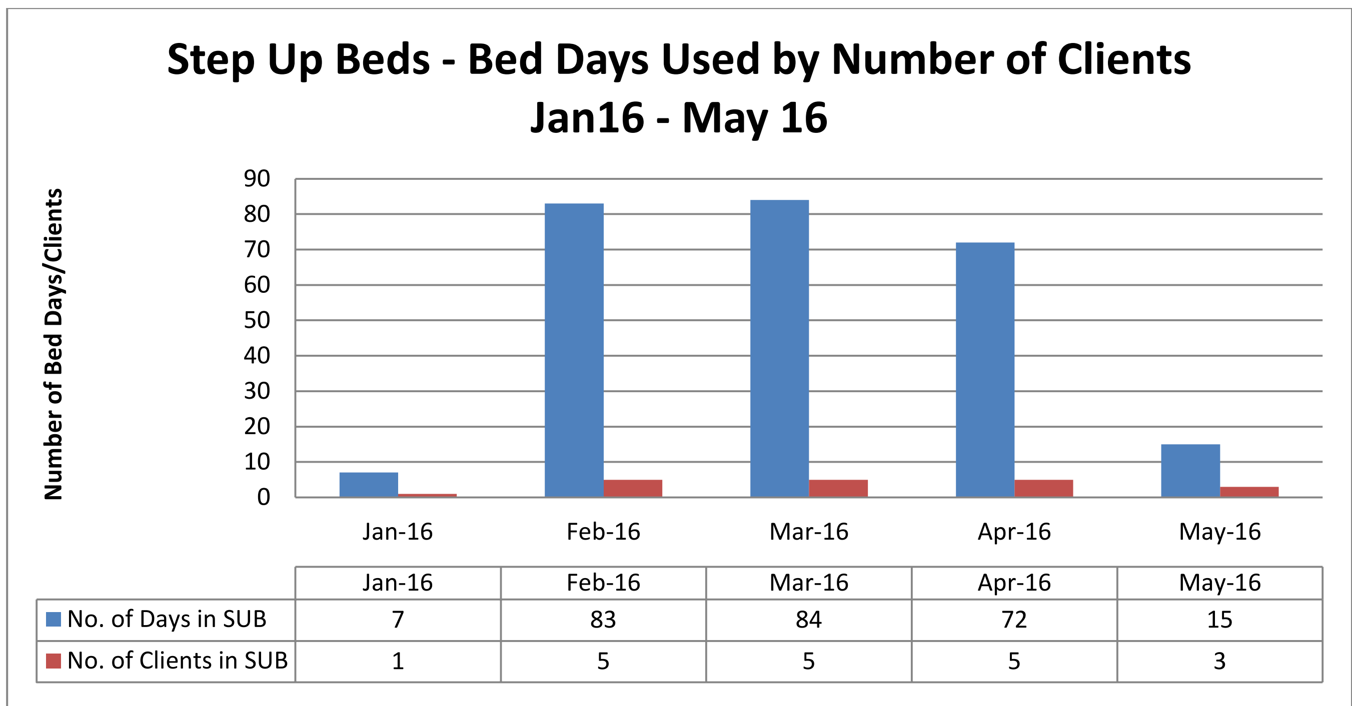
Key areas for action this year include;

- Governance Structure around SDS Implementation
- Review of the current Resource Allocation System (RAS)
- Finalise Procedures and Practice Guidance – including Service Agreements for Option 1 & 2.
- Training matrix for Staff
- Public Information including Employer Handbook
- Community Connectors and Inverclyde Life Portal
- Communication
- Support to strategic commissioning
- Continuation of SDS project team staff temporary posts

To deliver on the *Creating a Confident Workforce* element of the SDS legislation we are developing a Training Plan for staff covering awareness of outcome focused work and assessment and support planning.

HCCPC: Step Up Beds (Intermediate Care)

Objective	To avoid unnecessary hospital admission and to provide rehabilitation within an alternative community environment.
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.
Measure	Bed days provided within step up beds (intermediate care) rather than acute hospital.
Current Performance	261 days provided at 27 May 2016



	Jan-16	Feb-16	Mar-16	Apr-16	May-16
No. of Days in SUB	7	83	84	72	15
No. of Clients in SUB	1	5	5	5	3

Commentary

There have been 35 referrals to step up beds since 11th January 2016 with 11 admissions to the end of May 2016. We are confident that these individuals would otherwise have been admitted to hospital but instead were cared for in a community setting saving 261 days of acute bed usage. Of the 11 people who were admitted to Step Up Beds, one person subsequently required long term care and the other 10 were able to return to their own homes.

Actions

Complete full review of pilot so far to inform commissioning process. Health & Community Care Management team to determine way forward and meet with providers at the end of August 2016.

PHIC: Smoking Cessation

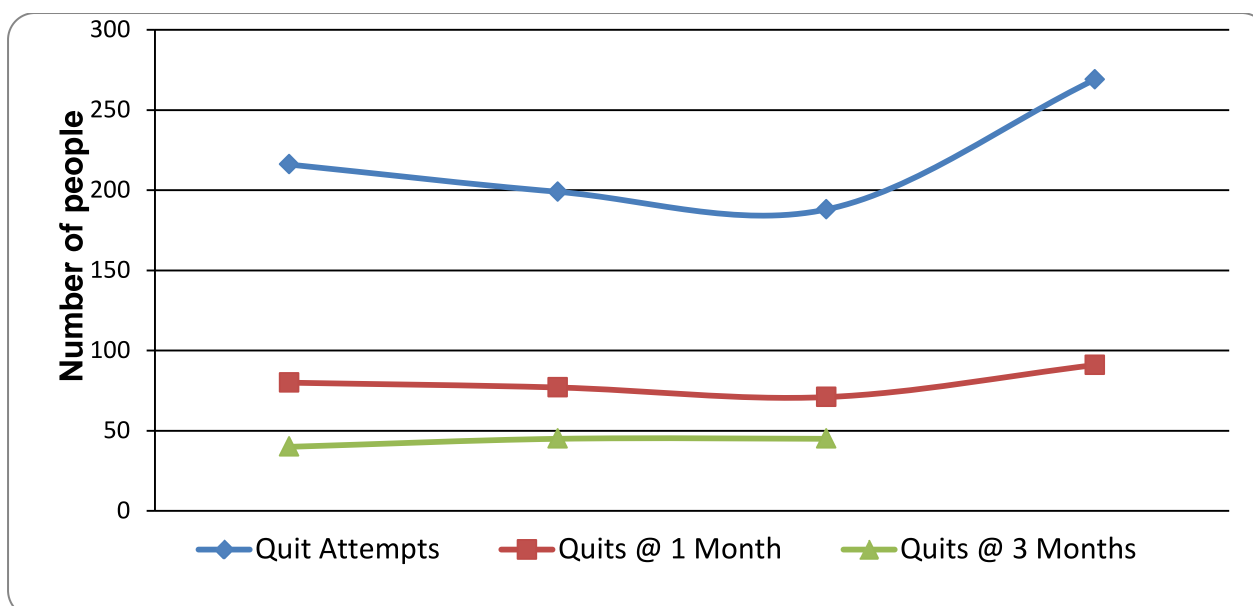
Objective	**To sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas**
Outcome	(1) People are able to look after and improve their own health and wellbeing and live in good health for longer.
Measure	The 2015/16 target for Inverclyde is 94 quits, 12 week post quit date from the 40% most deprived from all Inverclyde stop smoking services (community, pharmacy, acute, pregnancy).
Current Performance	Currently 130 have quit, 12 weeks post quit date from the 40% most deprived, which is 38% above the target. The data is incomplete for this reporting period, therefore it is anticipated to be higher.

Estimated smoking prevalence of adults (16+) in Inverclyde is 27.6% (source = Health & Wellbeing Survey 2013) which equates to 18,510 people.

Quarter	Quit Attempts	Quits @ 1 Month	Quits @ 3 Months
Apr15 - Jun15	216	80	40
Jul15 - Sep15	199	77	45
Oct15 - Dec15	188	71	45
Jan16 - Mar16	269	91*	
TOTAL	872	319*	130*

* only partial data available for the period of Jan16 to Mar16.

% Quits @ 1 Month	% Quits @ 3 Months
37%	19%
39%	23%
38%	26%
34%	



Commentary
A comprehensive stop smoking service is delivered across Inverclyde, within community, hospital, pregnancy and pharmacy settings. All services contribute towards the target with the pharmacy

service having the greatest footfall.

Over the preceding 3 years, there has been a gradual reduction in the number of people accessing stop smoking services across Inverclyde and further afield. As a result a piece of research was carried out with smokers from SIMD areas, including Inverclyde, to ascertain reasons for this reduction. Reasons included poor awareness of services and support available and the increased role of e-cigarettes. A review, re-branding and redesign of community stop smoking services was carried out and improvements implemented, early indications are that there has been an increase in uptake of services and improved performance.

The first Tobacco Strategy for Inverclyde was ratified in January this year through our Community Planning Partnership. It is anticipated, with support from our Inverclyde Alliance partners, that a comprehensive tobacco control strategy will be implemented which in turn will increase awareness of local services and further reduce the smoking prevalence within Inverclyde.

Actions

There is a further proposed 2016/17 Local Delivery Plan target for Inverclyde, which has the same focus on 12 week successful quits from the 40% most deprived communities. The proposal sees the target potentially increasing to 167 across all Inverclyde stop smoking services. NHSGGC has still to formally commission this level of delivery.

Continue to increase local awareness of the stop smoking services with local community, alcohol and drug services, family centres, GP practices, health and social care staff.

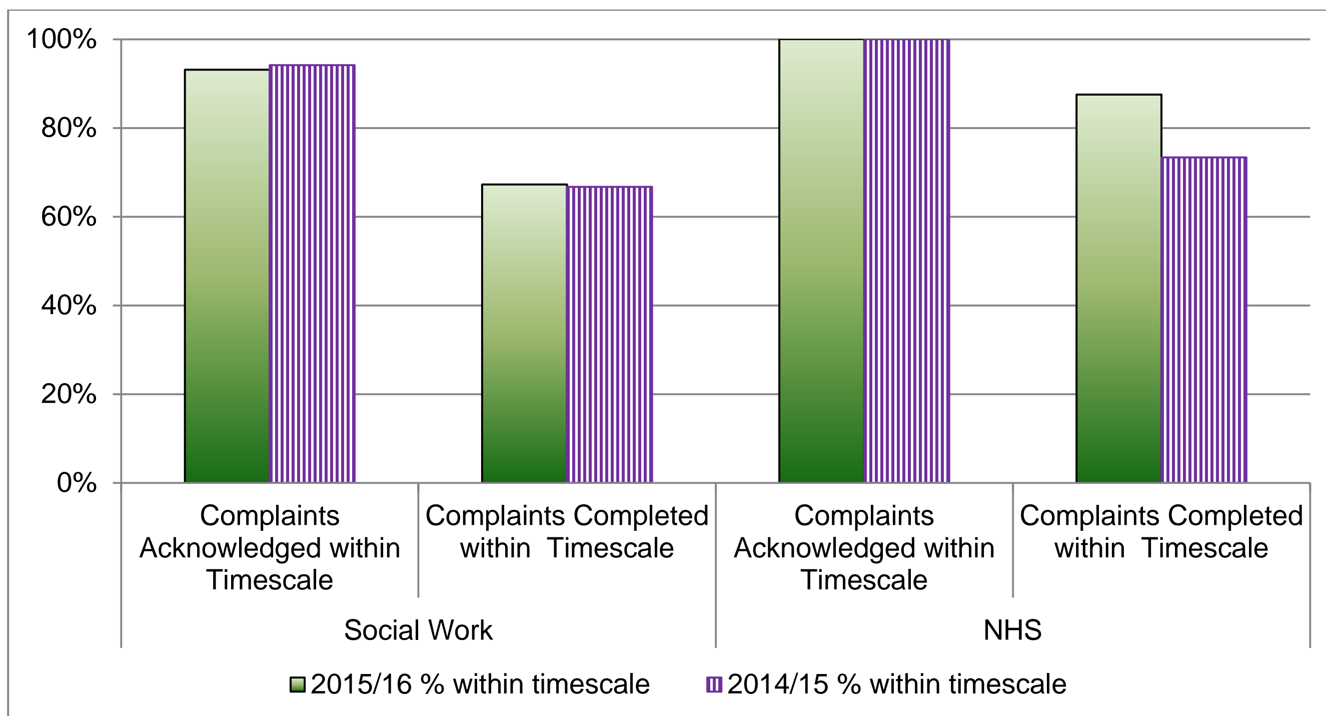
Increasing links with local pharmacy services across Inverclyde.

Increase support and activity of the Inverclyde Tobacco Strategy Local Implementation Group.

PHIC: Complaints

Objective	We use complaints as a valuable feedback to improve service standards
Outcome	(3) People who use health and social care services have positive experiences of those services, and have their dignity respected.
Measure	% of complaints received & investigated within timescales
Current Performance	100% March 2016

		2015/16* All Complaints			**2014/15^ Investigated Complaints**		
	Complaints	Met	Not Met	% within timescale	Met	Not Met	% within timescale
Social Work	Acknowledged within Timescale	54	4	93.1%	48	3	94.1%
	Completed within Timescale	39	19	67.2%	34	17	66.7%
NHS	Acknowledged within Timescale	8	0	100%	15	0	100%
	Completed within Timescale	7	1	87.5%	11	4	73.3%



Commentary
The Health and Social Care Partnership Integrated Complaints Procedure was implemented in 2015 which combined the requirements of the NHS and Social Work response target into an agreed formal process based on the Scottish Public Service Ombudsman Model Complaints Handling Process.

In house training supported by the SPSO took place in 2015 to support managers and teams in effective complaints handling and investigation skills.

Only Investigated Complaints were previously reported. As we seek to improve our learning from complaints resolved at the frontline, these have been included in the figures for future analysis and reporting.

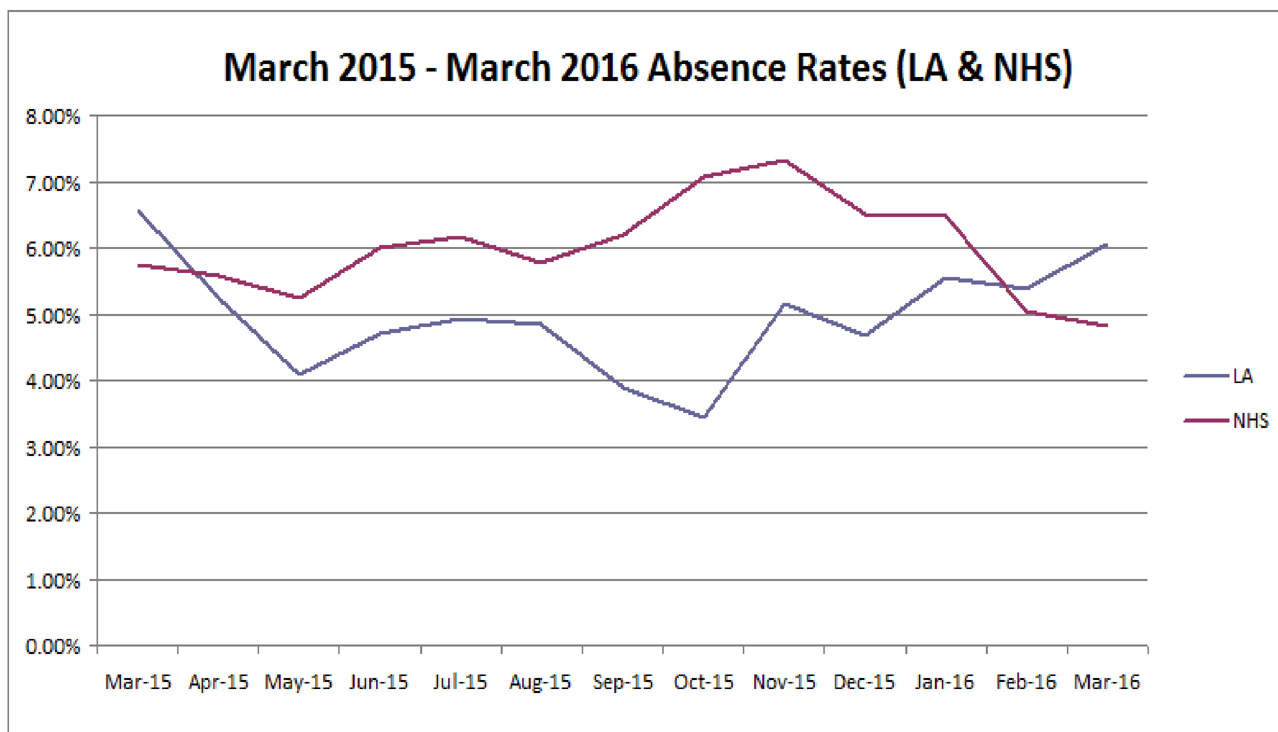
Resolving complaints within the agreed timescales is an important measure of performance. However the complex, multifactorial nature of some complaints needs consideration to ensure a comprehensive, accurate and meaningful response.

Actions

- Action plans with key themes for learning are identified by managers on conclusion of complaints.
- Performance for complaints is routinely monitored and scrutinised at quarterly performance management information reviews (QSR) within all service areas within Head of Service Meetings and at Clinical and Care Governance Group.
- The Annual Complaints Report for April 2015 – March 2016 has been compiled for presentation to the IJB during August 2016.
- The Quality and Complaints Officer will provide a focus for developing a quality assurance process around complaints.
- The Public Services Reform (Social Work Complaints Procedure) (Scotland) Order 2016 abolishes the existing social work complaints process and gives SPSO authority to undertake the review procedure for Social Work Services Complaints. This is due to become operational from April 2017.
- The Children and Young People (Scotland) Act 2014 (Part 4 and Part 5 Complaints) Order 2016 gives the SPSO the ability to consider the merits of decisions when dealing with complaints made under parts 4 and 5 relating to the named person and child's plan.
- Further guidance is awaited on the SPSO role and their approach around both pieces of legislation.
- Once guidance is received from SPSO local arrangements will be further developed.

PHIC: Absence

Objective	To manage attendance effectively to ensure a sufficient workforce to meet the needs of the service user.
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
Measure	target is 9 days / 4%
Current Performance	LA - 6.5% / NHS – 4.82%



	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
LA	6.55%	5.24%	4.08%	4.70%	4.94%	4.84%	3.88%	3.44%	5.16%	4.68%	5.56%	5.38%	6.05%
FTE*	913.30												927.70
NHS	5.76%	5.58%	5.25%	6%	6.16%	5.77%	6.21%	7.06%	7.33%	6.50%	6.47%	5.05%	4.82%
FTE*	489.56												486.53

**The ratio of the total number of paid hours during a period (part time, full time, contracted) by the number of working hours in that period.*

**The ratio units are full time equivalent (FTE) units or equivalent employees working full-time. In other words, one FTE is equivalent to one employee working full-time.*

Commentary

To improve attendance at work we have regular meetings with the Chief Officer, Head of Service and HR to identify areas within the HSCP that have high numbers of absence. Support is provided to managers particularly around complex cases.

We provide reports on attendance by employee and distribute to all line managers charged

with managing attendance and also include quarterly workforce information reports.

HR staff have been focusing on long term absence and have been involved in a number of terminations over the past year. There is a focus on referrals to occupational health and producing letters of concern.

Attendance at work is a standing item on the Trade Unions (TU) liaison group who also receive management reports. Improving attendance is also a standing agenda item for the Senior Management Team.

We have improved working environments across the HSCP which can improve attendance as can flexible working which we have introduced across some teams within the HSCP, in line with the Council's Mobile Working Policy and the NHS Agile Working Policy.

The chart shows the number of whole time equivalents at end March 2014/15 and 2015/16, and the absence percentage in year 2014/15 in comparison to 2015/16.

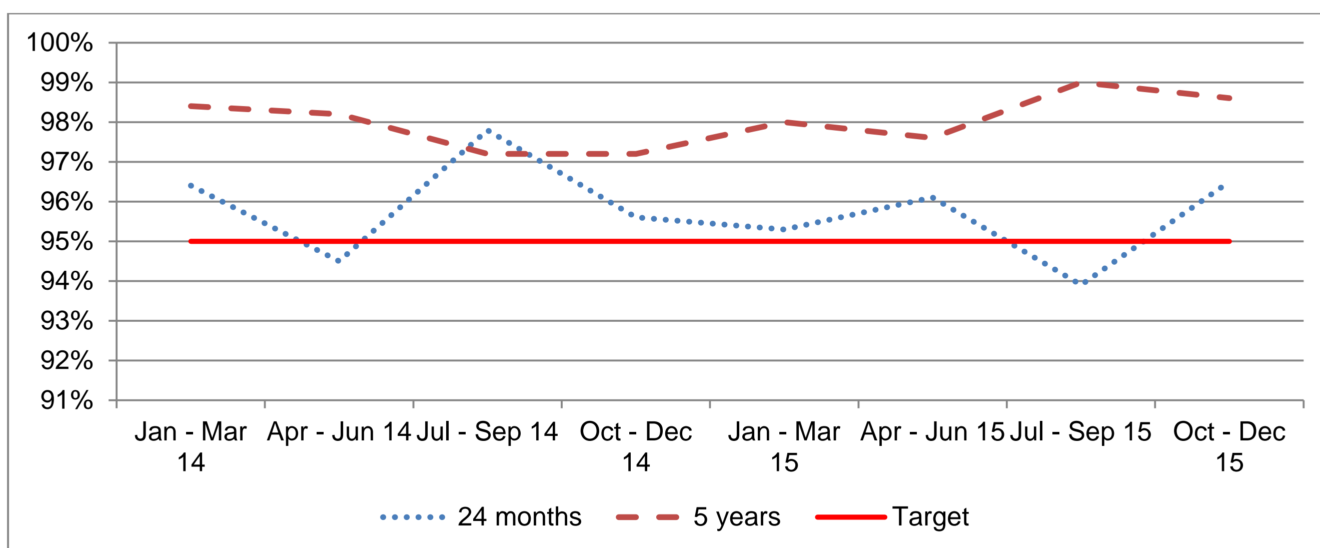
Actions

- Ongoing monitoring of absence information of all service areas
- Regular absence meetings with Chief Officer, Head of Service, HR Council and NHS to explore ways to improve attendance.
- Absence Information provided to each Service Manager on a monthly basis
- Focus on letters of concern / referral to occupation health / long term absence and support returning to work

CFCJ: MMR vaccination

Objective	Deliver childhood immunisation programmes improving uptake of Measles, Mumps and Rubella vaccination (MMR).
Outcome	(9) Resources are used effectively in the provision of health and social care services.
Measure	% children vaccinated MMR at 24 months % children vaccinated MMR at 5 years
Current Performance	% children vaccinated MMR at 24 months is sitting above target by 1.5%. This is the highest uptake since Jul-Sep 2014. % children vaccinated MMR at 5 years is sitting above target by 3.8%.

	Jan - Mar 14	Apr-Jun 14	Jul - Sep 14	Oct - Dec 14	Jan-Mar 15	Apr-Jun 15	Jul - Sep 15	Oct - Dec 15
24 Months	96.4%	94.5%	97.8%	95.6%	95.3%	96.1%	93.9%	96.5%
5 Years	95.9%	95.5%	96.5%	95.6%	95.3%	95.8%	95.5%	95.7%
Target	95%	95%	95%	95%	95%	95%	95%	95%



Commentary
The graph above shows performance against the MMR immunisation target for children aged 24 months and 5 years. The target has been consistently achieved for children aged 5 and only dipped below the target for children aged 24 months on two occasions since January 2014.

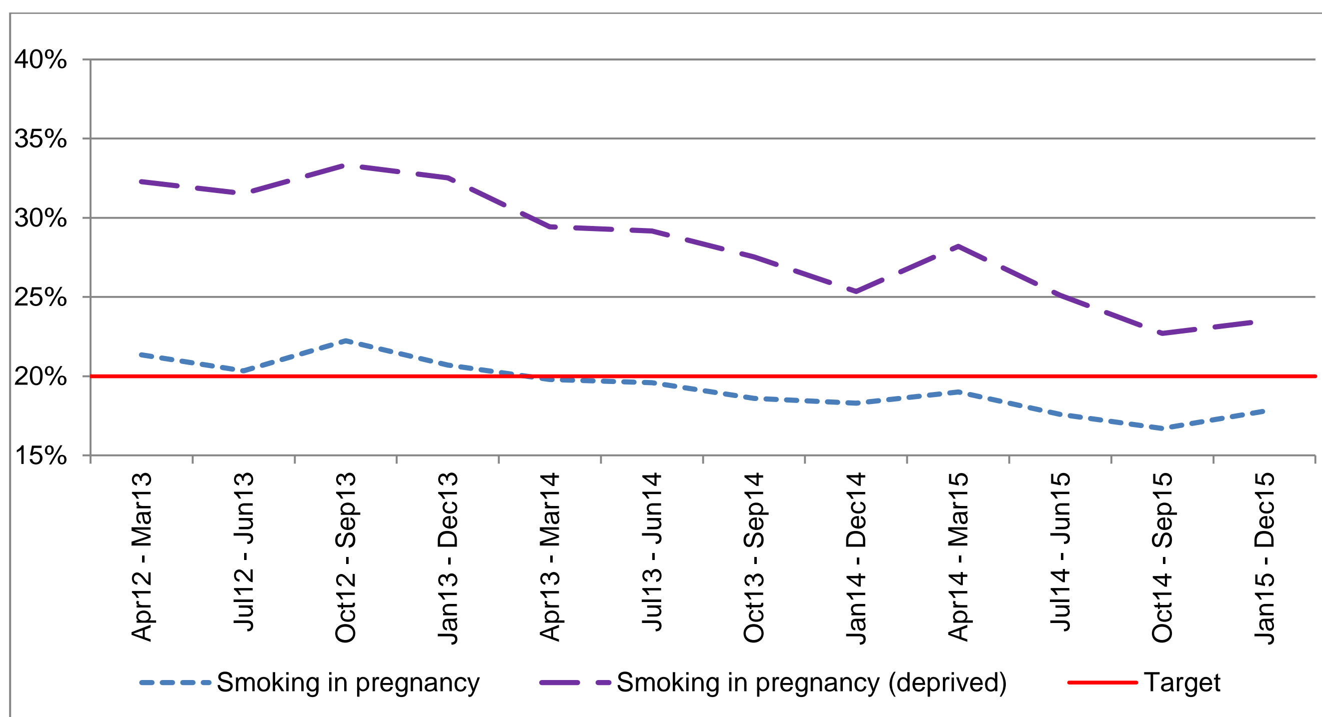
Most immunisations continue to be delivered via the Health Visiting teams. Parents are actively encouraged to bring their children for immunisations. All parents in Inverclyde are given information relating to the benefits of the MMR vaccination, and the importance of attending.

Actions
We will continue to deliver the childhood immunisation programme, with a particular focus on improving uptake of MMR. We will monitor performance via the Children's Services Quarterly Service Review (QSR).

CFCJ: Smoking in Pregnancy

Objective	Reduce smoking in pregnancy and reduce equalities gap through the delivery of targeting smoking cessation services for women in SIMD 1.
Outcome	(5) Health and social care services contribute to reducing health inequalities.
Measure	% of expectant mothers who smoke whilst pregnant (lower = better)
Current Performance	17.8% at Dec 2015 – overall (above target) 23.5% at Dec 2015 – most deprived quintile (below target)

Healthy	Oct12 - Sep13	Jan13 - Dec13	Apr13 - Mar14	Jul13 - Jun14	Oct13 - Sep14	Jan14 - Dec14	Apr14 - Mar15	Jul14 - Jun15	Oct14 - Sep15	Jan15 - Dec15
Smoking in pregnancy	**22.2%**	**20.7%**	**19.8%**	**19.6%**	**18.6%**	**18.3%**	**19.0%**	**17.6%**	**16.7%**	**17.8%**
Number Pregnant	724	744	739	750	742	722	717	695	700	650
Number Smoking	161	154	146	147	138	132	136	122	117	116
smoking in pregnancy (most deprived quintile)	**33.3%**	**32.5%**	**29.4%**	**29.2%**	**27.5%**	**25.3%**	**28.2%**	**25.1%**	**22.7%**	**23.5%**
Number Pregnant	369	369	384	377	374	363	351	327	339	323
Number Smoking	123	120	113	110	103	92	99	82	77	76



Commentary

There has been a continual improvement in reducing the percentage of expectant mothers smoking. In March 2014 we exceeded the 20% target for the Inverclyde area and the trend for the most deprived quintile is moving in the right direction with our lowest percentage to date. The Health Improvement Team facilitated joint development sessions with Health Visitors and Midwives specifically focussed on smoking in pregnancy to ensure referral pathways and joint working arrangements are robust.

The Health Improvement Team will continue to work with maternity Smoke Free Services to support women to reduce the incidence of smoking in pregnancy. The plan is to take the learning from the service evaluation which includes the entire pregnancy pathway from pre conception to post natal;

Reducing smoking in pregnancy is important because it is related to other health issues, particularly low birth weight of babies and poorer child health.

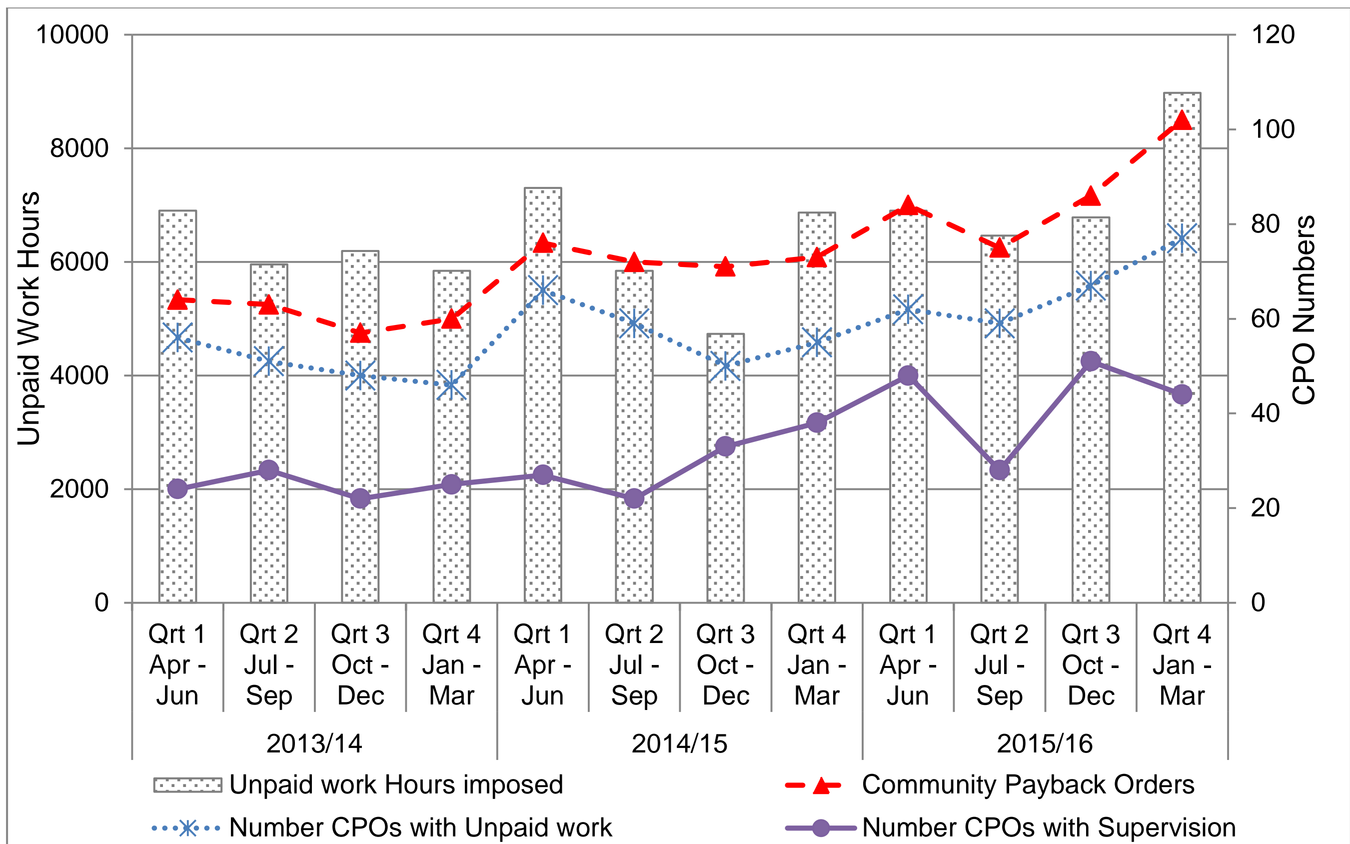
Actions

- We will continue to monitor performance of the target waiting times as part of our established Quarterly Service Reviews (QSR).
- Work with maternity smoke free services to provide all possible support for women to reduce the incidence of smoking in pregnancy.

CFCJ: Community Payback Orders (CPO)

Objective	A Community Payback Order (CPO) is a community sentence which is designed to ensure that individuals who have committed offences payback to society, and in particular their communities, along with providing learning opportunities to support change.
Outcome	(5) Health and social care services contribute to reducing health inequalities.
Measure	• Number of Community Payback Orders (CPOs) • Number of CPOs imposed with Supervision Requirements • Number of CPOs with Unpaid Work Requirements. • Unpaid Work hours imposed
Current Performance	• 102 new CPOs (Jan to Mar 16) • 44 new CPOs with Supervision Requirements (Jan to Mar 16) • 77 CPOs made with Unpaid Work Requirements (Jan to Mar 16) • 8975 hours of Unpaid Work (Jan to Mar 16)

	2013/14				**2014/15**				**2015/16**			
	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar
Community Payback Orders	64	63	57	60	76	72	71	73	84	75	86	102
Number CPOs with Supervision	24	28	22	25	27	22	33	38	48	28	51	44
Number CPOs with Unpaid work	56	51	48	46	66	59	50	55	62	59	67	77
Unpaid work Hours imposed	6900	5958	6194	5845	7300	5843	4735	6870	6900	6464	6782	8975



Commentary

- There has been a 42% increase in the number of CPOs imposed by the courts from 2013/14 to 2015/16 (up from 244 to 347)
- Supervision requirement has increased by 73% (up from 99 to 171)
- CPOs with Unpaid Work have also risen by 14% (up from 201 to 265)
- The amount of hours of Unpaid Work being imposed has also seen a rise of 17% (up from 24,897 to 29,121)
-

The increase in CPO's has a positive impact on the community as the reduction in short term custodial sentences is beneficial to both the person and society in general. Retaining their tenancy, minimal disruption to the family unit and the opportunity to learn new skills have all been positive outcomes for the person. Society benefits from the work being carried out in the community and by the programmes and treatments offered to support the person to be rehabilitated in a community setting.

This upward trend in the imposition of CPOs is mirrored nationally. The resourcing implications in terms of servicing this rise in CPOs has proved extremely challenging given there has been no uplift to the core funding for Criminal Justice Social Work nationally. In addition the recent consultation on extending the presumption against short sentences beyond the current 3 months will certainly, if taken forward, generate a further increase in numbers.

Actions

The Criminal Justice Social Work (CJSW) funding formula is currently under review and Social Work Scotland along with COSLA has actively been involved in this process. The Inverclyde CJSW Service Manager is an active member of Social Work Scotland and from discussions which have

taken place to date it is unlikely that the proposed changes to the formula will deliver an uplift that corresponds to the challenge of meeting this increasing demand, particularly if there is no national uplift in the CJSW funding to which the formula is applied.

The CJSW Management Team has also been proactive in looking at the efficiency and effectiveness of how our current resources are deployed. However, these changes are unlikely to be sufficient in themselves, particularly if the upward trend continues, to meet the demand. The current funding model does not lend well to employing additional staff as for example the transfer of resources from the prison service to the community is only in place on a short term basis. The Scottish Government are currently reviewing this position and it is proposed that a new funding model will be applied to allocate funds on a three year basis. This would support the service to better plan and to employ staff to support the ongoing changes.

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/42/2016/HW**
Contact Officer:	**Helen Watson, Head of Planning, Health Improvement and Commissioning**	**Contact No:**	**01475 715385**
Subject:	**HSCP COMPLAINTS ANNUAL REPORT 2015/16**		

1.0 PURPOSE

1.1 The purpose of this report is to inform the Inverclyde Integration Joint Board (IJB) of the annual performance of the Inverclyde Health and Social Care Partnership (IHSCP) following implementation of the new Integrated Complaints Handling Procedure.

2.0 SUMMARY

2.1 This report describes and analyses performance in handling complaints from 01 April 2015 to 31 March 2016. The annual report provides the following information:

i. Performance Information
ii. Analysis of Complaints Activity
iii. Future Proposals

3.0 RECOMMENDATIONS

3.1 It is recommended that IJB members note the annual performance of the Inverclyde HSCP Integrated Complaints Procedure and comment as required.

3.2 It is recommended that IJB members note the changes to legislation which will require amendments to the local procedure in due course.

Brian Moore
Corporate Director (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The purpose of this report is to inform the Inverclyde Integration Joint Board of the annual performance of the Inverclyde HSCP Integrated Complaints Procedures which encompasses NHS and Statutory Social Work complaints.

4.2 The Inverclyde HSCP Integrated Complaints Procedure issued by the Chief Officer became operational in the 2015/16 reporting period. It supports the Public Bodies (Joint Working) (Scotland) Regulations 2014 to more closely align the respective complaints handling processes of health complaints and social work complaints.

4.3 In line with statutory requirements there is still an additional stage for social work complaints procedure:

Stage 1 – Frontline resolution whereby the complaint is dealt with directly at point of service
Stage 2 - Complaint requires formal investigation and response
Stage 3 – Referral to Independent Complaint Review Committee (CRC) for social work complaints only.

4.4 Complainants have the legal right of referral to the Scottish Public Service Ombudsman (SPSO) to appeal NHS complaint outcomes. For social work complaints, only maladministration of the procedure can currently be investigated by the SPSO.

4.5 The Quality and Development Service has lead responsibility to manage, co-ordinate and record complaints across IHSCP in line with the Integrated Complaints Procedure.

4.6 There are two electronic administrative systems which log health and social work complaints. However there is one central point within IHSCP where all complaints are logged which enables us to report collectively.

4.7 Complaints information is one of several sources of feedback about staff and service performance used to inform service improvements. This is generally obtained locally at the frontline with an overview of these collated within this report.

4.8 The Annual Complaints Report details the following:

- Performance of Frontline Resolution and Investigated Complaints
- Analysis in respect of:
  - Complaint Outcomes
  - Complaint Themes
  - Learning from Complaints
- Learning from Complaints
- Positive Feedback

5.0 PROPOSALS

5.1 The Public Services Reform (Social Work Complaints Procedure) (Scotland) Order 2016 will fully align social work complaints with other public bodies. It repeals the Complaints Review Committee element of the current process and the appeal process will be fully administered by the SPSO, including determining the professional judgement of social work. This is due to come into force in April 2017.

5.2 The Children and Young People (Scotland) Act 2014 (Part 4 and Part 5 Complaints) Order 2016 gives the SPSO the authority to consider the merits of professional decisions made relating to the named person and child's plan when dealing with

complaints.

5.3 Once guidance is received in relation to both areas of legislation, the HSCP will need to determine what support, processes and consultation are required in order to implement this new legislation locally.

6.0 FINANCE

6.1 Financial Implications: There are no financial issues within 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

6.2 There are no legal issues within this report.

HUMAN RESOURCES

6.3 There are no human resources issues within this report.

EQUALITIES

6.4 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.

7.0 CONSULTATION

7.1 None

8.0 BACKGROUND PAPERS

8.1 None.

Inverclyde Health and Social Care Partnership
Annual Complaints Report 2015 – 2016

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1. Introduction

1.1 Background

Inverclyde Health and Social Care Partnership (IHSCP) is a fully integrated partnership incorporating functions and services from Inverclyde Council and NHS Greater Glasgow and Clyde Health Board, to meet the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. This brings together community and primary healthcare, social work and social care services. Inverclyde HSCP goes beyond the minimum requirements of the Act, in that it includes Children & Families and Criminal Justice Services as well as adult services.

Previous work undertaken within the Inverclyde Community Health Care Partnership (ICHCP) has provided a strong foundation on which to embed the new legislation and further improve joint working within and for the benefit of our communities.

Our vision of Improving Lives is underpinned by the values that:

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

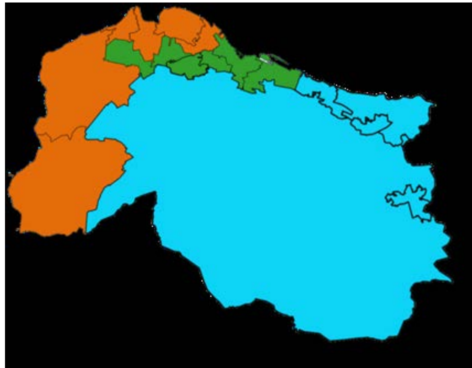
1.2 Our People

Inverclyde Health and Social Care Partnership has 1,666 members of staff employed by both NHS Greater Glasgow and Clyde Health Board and Inverclyde Council to serve a population of 79,860.

1.3 Our Place

Inverclyde is divided into three wellbeing localities which are set out in the map and tables below, with Inverclyde East being the largest wellbeing locality in terms of geography shown in blue; Inverclyde Central is shown in green and Inverclyde West is shown in orange.

The Community Planning Partnership for Inverclyde has made a commitment to Getting it Right for Every Child, Citizen and Community. This is a whole population approach that strives to support everyone in Inverclyde to be Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included.



Within Inverclyde Health and Social Care Partnership our staff strive to work in partnership with individual service users, carers, patients and the local community to ensure that services are user led and co-produced. To support this there are a number of involvement opportunities at strategic, service and on a general level across Inverclyde.

The Health and Social Care Partnership Advisory Group membership is drawn from the broader HSCP People Involvement Network and formally represent service users and carers on the Inverclyde Integrated Joint Board (IJB) and the Inverclyde Alliance (our Community Planning Partnership).

There are service specific arrangements to support ongoing engagement with the people using services and their carers to bring about continuous improvements and change.

Complaints form a valuable part of this continuum of service development and improvement and provide a vital source of information to help analyse a situation or service and pinpoint any recurring, underlying or potential problems. Collectively these can help identify performance within a service or team in order to identify areas for improvement based on sound evidence.

1.4 Current Procedures

The Quality and Development Service has lead responsibility to manage, co-ordinate and record all complaints across the HSCP, including contracted services. A key aspect of the development of the procedure is to focus on the learning from complaints and feedback.

The HSCP Integrated Complaints Procedure based on the Scottish Public Service Ombudsman Model Complaints Handling Procedure became operational in 2015 - 2016. The aim is to provide a quick, simple, streamlined process with a strong focus on local, early resolution by empowered, well trained staff. This enables complainants to have their issues or concerns dealt with close to the event which gave rise to making the complaint.

As far as possible the complainant should be actively and positively engaged with the process from the outset.

Frontline Resolution: Frontline resolution should be attempted where there are straightforward issues, potentially easily resolved with little or no investigation. This should be completed within 5 working days.

Investigation Stage: Where complaints are not resolved at the frontline stage, are complex, serious or high risk a thorough investigation will be undertaken. This typically requires more thorough examination in order to establish facts prior to reaching a conclusion. This should be completed within 20 working days.

Complaints Review Committee: This is a statutory social work review process only, and comprises a formal “tribunal” approach overseen by Elected Members.

Scottish Public Service Ombudsman: NHS appeals of complaints outcomes are reviewed by the SPSO. Currently maladministration of Social Work complaints can be investigated by the SPSO.

1.5 Governance Arrangements

Governance arrangements are in place to report and analyse complaints within the HSCP as follows:

- Heads of Service Meetings;
- HSCP Management Team Meetings;
- Clinical and Care Governance;
- Quarterly Service Reviews (QSRs).

There are also reporting systems within our partner organisations NHS Greater Glasgow and Clyde Health Board and Inverclyde Council which the Inverclyde HSCP contributes to.

Health and social work complaints are logged in two systems, however there is a central point of contact for recording and administering the process.

2. Summary of Performance

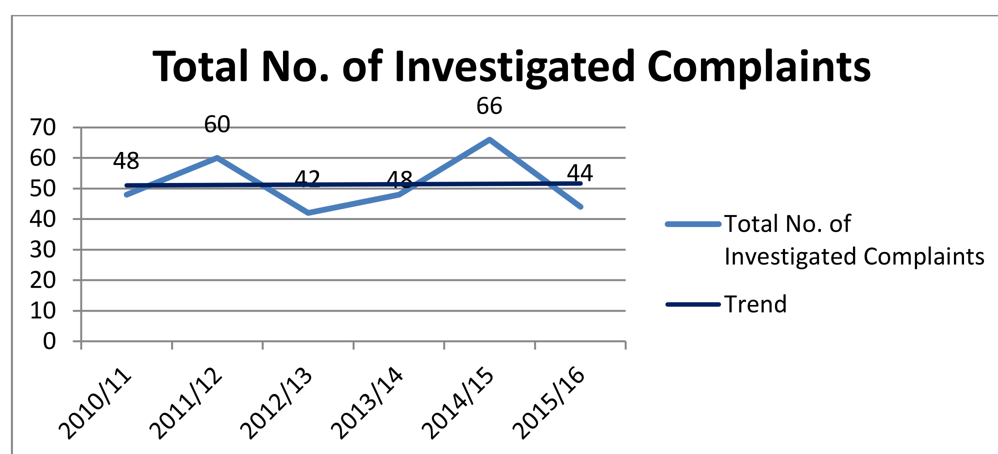
2.1 Number of Complaints

The IHSCP received a total of 66 complaints during the reporting period 2015/16. This is a reduction of sixteen on the previous year. 58 relate to social services and 8 relate to community NHS services. 22 were resolved as frontline resolutions and 44 required to be fully investigated.

	Number of Front Line Resolution 2015/16	Number of Investigated Complaints 2015/16	Number of Front Line Resolution 2014/15	Number of Investigated Complaints 2014/15
Social Work	22	36	13	51
NHS	0	8	3	15
Total	**22**	**44**	**16**	**66**

2.2 Complaint Trends

The number of investigated complaints is down by a third from 66 to 44. This in turn has slightly reduced the annual trend down from an average of 52 to 51 complaints per year.



2.3 Timescales

Along with changes to procedural arrangements, timescales for reporting were also streamlined. Following implementation of the new procedure, a number of frontline and investigated complaints did not meet the designated timescales. Guidance to investigating officers is in place from the outset with additional reminders throughout the process to support this.

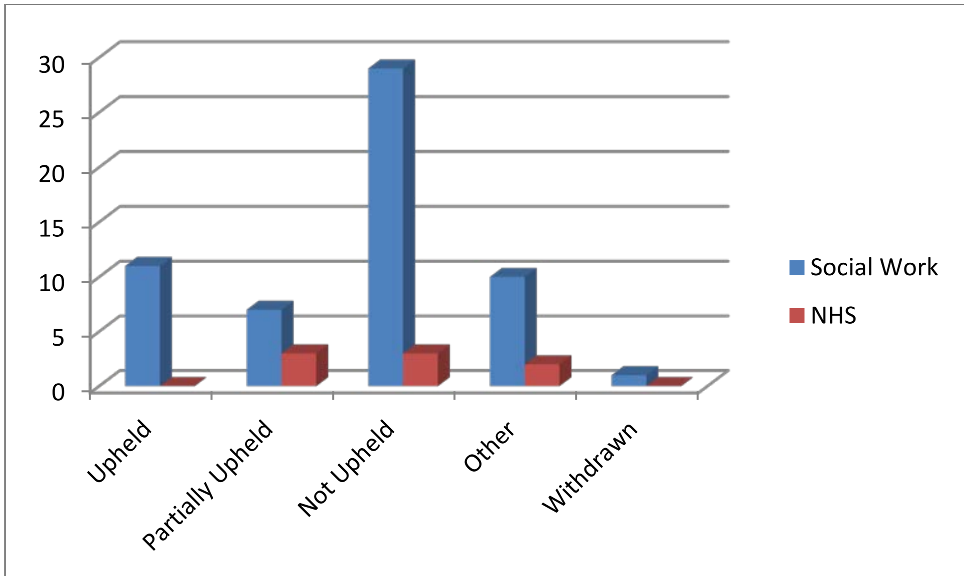
		2015/16	
		Timescale Met	Timescale Not Met
Social Work	Investigated Complaints Acknowledged within Timescale	36	0
	Investigated Complaints Completed within Timescale	23	13
	FLR Complaints Acknowledged within Timescale	18	4
	FLR Complaints Completed within Timescale	16	6
NHS	Complaints Acknowledged within Timescale	8	0
	Complaints Completed within Timescale	7	1

2.4 Complaint Outcomes

Of the 66 complaints received between NHS and Social Work, 32 (48%) were not upheld. Ten (15%) were logged but later removed from the complaints procedure as it was deemed that other avenues for investigation were more appropriate.

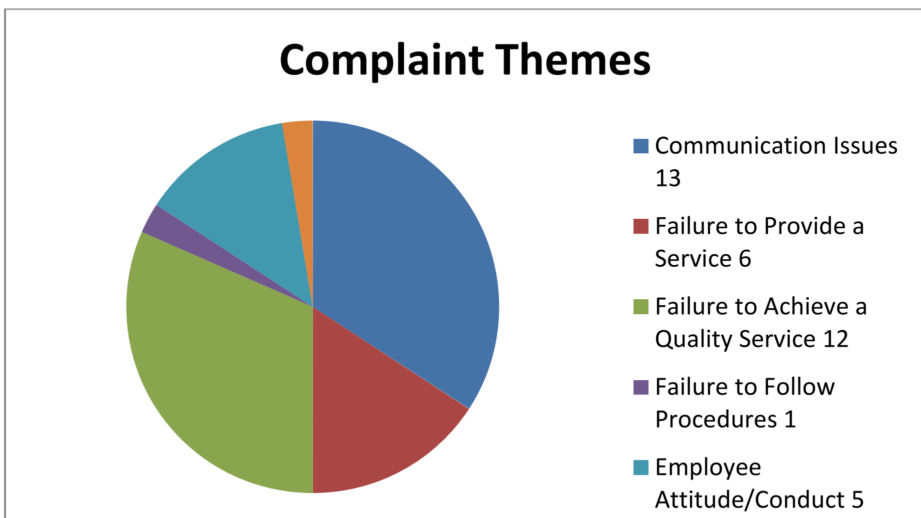
For example those which involved commissioned services, services hosted by other Health and Social Care Partnerships were handled through appropriate service processes, and some of those which related to staff conduct were appropriately investigated through disciplinary procedures. One complaint was withdrawn from the process by the complainant.

Of the 58 Social Work complaints, 11 were upheld and 7 were partially upheld. Of the 8 health complaints, 3 were partially upheld. Two social work complaints were reviewed by the Complaints Review Committee.



2.5 Complaint Themes

The 21 complaints which were upheld or partially upheld were examined for key themes. Multiple themes are evident in 14 of these, whilst 7 specifically related to a single factor. Communication issues followed by a failure to achieve a quality of service are the two main factors resulting in complaints.



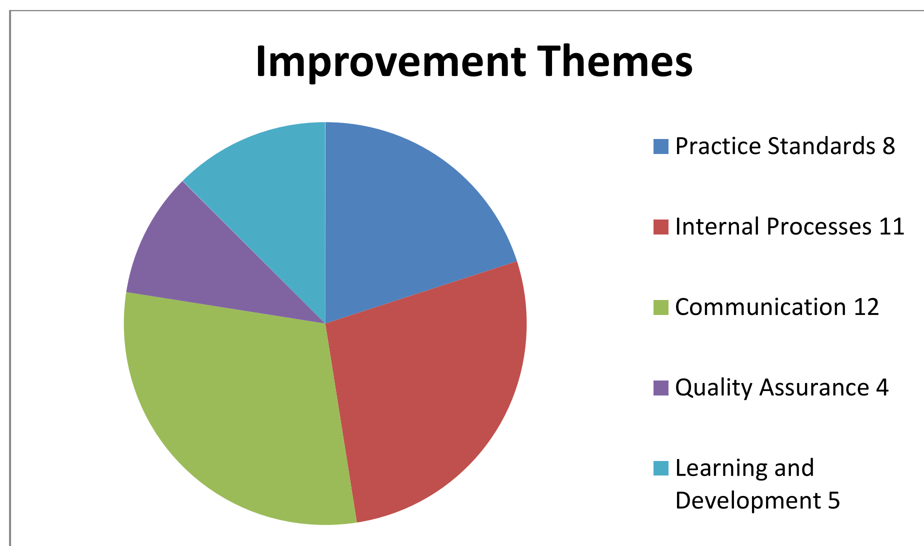
2.6 Learning from Complaints

Inverclyde HSCP is committed to reflecting on occasions when we may not get it right in order to highlight opportunities for improvement. As such where a complaint has been upheld or partially upheld, the service should determine what actions are required to support continuous improvement.

Of the 18 social work complaints upheld or partially upheld, only one generated a full Service Improvement Plan with two recommendations.

However, on reviewing outcome letters to complainants it is reassuring to see that as the new procedures have embedded, some services are adopting a "what happened, what should have happened and what will happen now" approach.

Services were able to advise complainants that they had taken immediate action or that action was imminent so a full service improvement plan was not required. In response to the multiple complaint themes there are also a number of complaints with multiple improvement themes.



2.7 Appeals

Following an investigation and written response, if a complainant remains dissatisfied with the outcome of an investigation they have the right to appeal that decision. For NHS complaints the appeal is directly to the Scottish Public Service Ombudsman.

For Social Work complaints, under the Statutory Complaint Procedure for Social Work Services the appeal process is firstly by Independent Review by the Social Work Complaints Review Committee.

In the reporting period 2015/16, two complaints were reviewed by the Complaints Review Committee. Both related to Children's Services and Criminal Justice, and both were assessed by the Review Committees as not upheld.

There were no complaints investigated by the SPSO from the Inverclyde HSCP in this period.

3. Future Developments

3.1 Social Work Complaints Procedure

To further align social work complaints with other public sector complaints procedures, The Public Services Reform (Social Work Complaints Procedure) (Scotland) Order 2016 sets to abolish the existing social work complaints process.

It removes the current Social Work Complaints Review Committee and allows the Scottish Public Service Ombudsman to undertake the review procedure. Thus, taking into account the professional judgement of Social Work exercised on behalf of local authorities. It also allows for the sharing of information between the SPSO, Care Inspectorate and the Scottish Social Services Council when appropriate.

Guidance has not yet been received from the SPSO but the order is due to come into force on 1 April 2017. The SPSO has announced that it will be working with key stakeholders both in developing the new process and in preparation of their new role.

3.2 Named person and child's plan

The Scottish Parliament also recently passed the Children and Young People (Scotland) Act 2014 (Part 4 and Part 5 Complaints) Order 2016. This order will give the SPSO the ability to consider the merits of decisions when dealing with complaints made under parts 4 and 5 relating to the named person and child's plan. Further guidance is awaited on the SPSO role and their approach.

Inverclyde HSCP will, in due course, undertake consultation to ensure that local people are informed of these changes.

4. Contracted and Commissioned Services Complaints

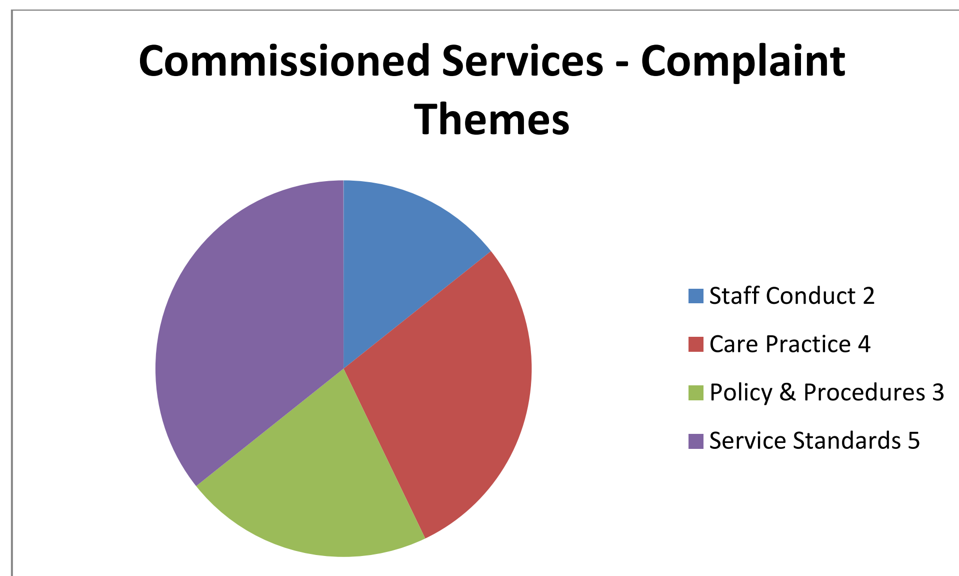
4.1 Commissioned Services Complaints

The HSCP contracts with 137 external care providers who deliver 194 services ranging from Care and Support at Home to Care Homes that meet a range of needs (including Older People; Learning Disability); Supported Accommodation (such as Sheltered Housing and group living accommodation), and some therapeutic services.

There is a notable reduction in the number of complaints received.

	2015/16		2014/15	
Outcome	**Number**	**%**	**Number**	**%**
Upheld	11	37%	22	46%
Partially Upheld	3	10%	6	13%
Not Upheld	14	47%	15	31%
Withdrawn	2	6%	4	8%
Ongoing	0	0%	1	2%
Total	30	100%	48	100%

Of the 14 upheld and partially upheld complaints, service standards and care practice are the two main themes for making a complaint.



4.2 NHS GG&C Contracted Health Services

Independent providers such as GPs, Pharmacists, Optometrists and Dental Practitioners are contracted to deliver community health services on behalf of the NHS.

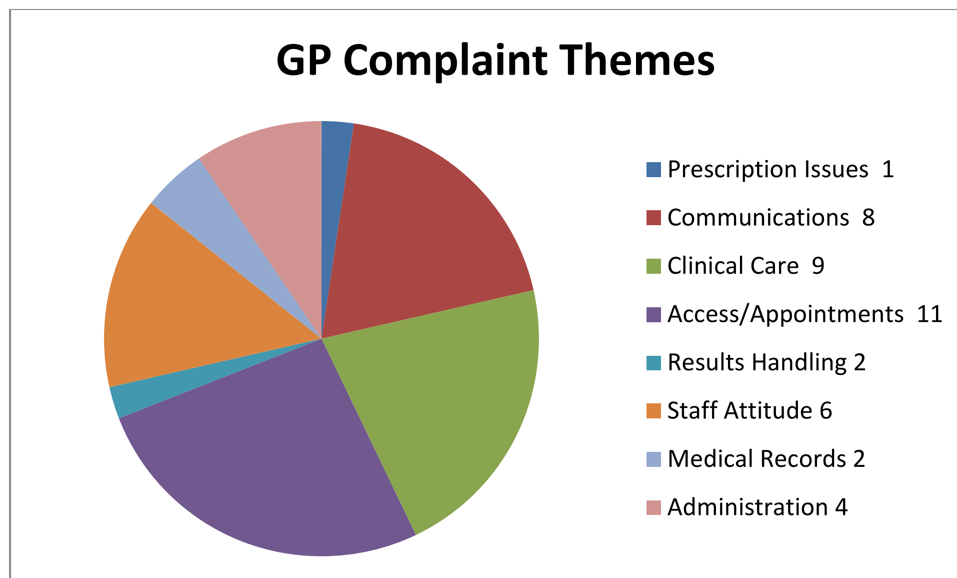
Independent Contractors have their own processes for responding to complaints and undertaking service improvements in response. This complaint activity is monitored

and reported via the Clinical and Care Governance Group where recommendations can be made. One optometry complaint was received which was not upheld. There were no other complaint reports received.

4.3 GP Practices

There were 60 complaints received by the 16 GP practices during the reporting period 2015/16. Of these (57) 95% were responded to within the timescales. 24 of these were fully or partially upheld. 5 complaints were irresolvable.

Of the data available the most common issues were around access to GPs and appointments, communications and staff attitudes.



5. Positive Feedback

5.1 Thank you

It is important that as individual staff members, services and as a whole organisation we learn from complaints. Equally important is when we receive positive feedback to let us know that our staff have done a good job or surpassed expectations. Compliments motivate, encourage and inspire repeat standards of excellence throughout our services.

There is no better example of integrated working than in the following thank you letter. It demonstrates an enabling, joined up approach to supporting a gentleman to remain at home with family and friends in his last few weeks of his life.

Not only were the right professional team in the right place at the right time to enable this to happen but the family were empowered to develop their own confidence and skills to support their Dad.

"On behalf of my family and myself, I would like to nominate the following teams who cared for my late father in the final weeks, days and hours before his peaceful death.

The care provided by HSCP Homecare, District Nurses and Tuckdown staff was outstanding. Each individual demonstrated great professionalism, dedication, compassion, care and support for him. Each carer quickly understood his health and care requirements but equally got to know him personally and respected his preferences and requests with regards to his personal care.

Despite his deteriorating health both Dad and his family appreciated the positivity and humour shown by the team which helped keep his and our spirits up. We personally appreciated the updates given by the care staff following each visit. They were always friendly, honest and kept us abreast of Dad's condition, with practical advice given to us the opportunity to assist him in between their visits.

The care provided made the final weeks immeasurably more comfortable for all. The skill and professionalism of every carer and the collaboration between agencies meant that our dad spent those precious final days in the comforting knowledge that others were fully in control which lifted a great weight from our shoulders during a very difficult time.

I would be delighted to see the care teams achieve some recognition so that the challenging work they do and the positive impact they have on patients and their families can be appreciated by the wider public".

The Advice Service is instrumental in supporting potentially vulnerable members of the community in navigating the welfare system, maximising their income and supporting them in managing their finances.

"I am writing to advise you of the fantastic service I received from staff at the Advice Services. Some years ago my husband had a spell of ill health and was unable to work. As a result I found myself in financial difficulty. This was a very stressful time and I did not feel that I could talk to anyone about the problems I was facing. I was therefore under a great deal of pressure trying to manage the situation and this began to have an impact on my health.

I made contact with Advice Services and was seen by a worker who was very empathic and understanding and led me through my options and supported me to make the right decision. I felt as though a great weight had been lifted from me……..I feel so much more in control of my financial situation. Your service not only helped me out of a spiralling debt problem, but has helped me to budget and manage my finances. I cannot praise the service enough and I ask that you pass on my thanks to your staff".

5.2 Compliments

Here are some from the many other positive comments received across the HSCP about the people and services who support them.

"Just wanted to say thank you to all who helped and supported our Dad over recent months. At difficult times knowing that you were there to care and speak to, helped us along the way. Many thanks".

"Just to say many thanks for managing [named individual's] care so well and with a smile".

"You're brilliant, thanks".

"Just a quick note to say thank you for the level of care you provided my dad. Thank you again".

"The kindness and thoughtfulness you have shown will always be remembered, thank you very much".

"To all thank you for all the support and help".

"For the wonderful care and attention received by my husband during his illness, it was very much appreciated. Thank you once again".

"You are just the sort of person whose kindness means more than you could ever know".

"All the family want to say thank you very much for all your help with my sister. We are very grateful for all your hard work".

5.3 Award Winning Staff

Although every member of staff strives to achieve the best outcomes possible for the people whom they support, special mention must go to Donna MacIntyre who recently received recognition at the SIRCC Residential Childcare Awards 2016.

The Residential Childcare Worker of the Year, nominated by the young people, recognises workers who are a bit extra special, supporting and make real, positive differences to the young people in their care.

In the words of Annie who nominated Donna:

"Donna has always encouraged me to do things, she has advocated on my behalf and ensured that my needs are met. Even after I moved on from Kylemore Children's Unit, Donna has continued to provide me with emotional and practical support and is an excellent example of what a corporate parent should be."

But Donna does this not because she is a corporate parent, she does it because she cares about me".

6. Conclusion

Inverclyde HSCP remains committed to thoroughly investigating, learning from, and taking action as a result of individual complaints where it is found that standards have fallen below the level we expect and where services could be improved. We are also committed to learning from when we get things right.

This has been a year of transition as the new Integrated Complaints Process becomes embedded. Whilst it is welcome that the number of complaints has

reduced over the year, going forward we need to examine our systems and processes to ensure that making a complaint is easy and accessible, and freely available to all who wish to do so.

We will continue to report and publicise noted improvements and as we move to the corporate recording system this will assist the Quality and Development Team to better analyse and report on findings in future.

Finally, whilst there is evidence that there are ongoing learning opportunities for individuals, services and Inverclyde HSCP as a whole, further work is needed to determine how assured complainants are on resolution of their complaint.

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/46/2016/BC**
Contact Officer:	**Beth Culshaw Head of Health and Community Care**	**Contact No:**	**01475 715283**
Subject:	**Delayed Discharge Performance**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board on Inverclyde's performance towards achieving the national target for Delayed Discharge.

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.

3.0 RECOMMENDATIONS

3.1 Members are asked to note the progress towards achieving the target and note the preparation for recording performance for the forthcoming year.

Brian Moore
Corporate Director (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 Since April 2015 the target for Delayed Discharge 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. Members will be aware that the HSCP have been working closely with partners to successfully achieve the target.

4.2 From July 2016 there have been some changes to how Delayed Discharges will be recorded; the census day has been moved from the 15th of each month to the last Thursday of each month and all patients in an acute hospital bed on that day will be counted as a delay breach if they have exceeded 14 days since they were medically fit for discharge. It is not thought that this change in recording will have a significant impact on performance.

4.3 To date, the proposed change in the target from 14 days to 72 hours has not been confirmed.

5.0 PERFORMANCE

5.1 We continue to maintain positive performance in relation to the 14 day Delayed Discharge target (Appendix A). We achieved zero delays of more than 2 weeks at the census date for the whole of 2015/16 and have continued to maintain this performance since April this year.

5.2 This performance has a context of a continued high level of referrals for social care and community supports following discharge (Appendix B). During June 2016, 157 individuals were referred for social care support of which 40 people required a single shared assessment indicating complex support needs. A total of 8 individuals (at census date) were identified as being delayed following the decision they were medically fit for discharge.

5.3 NHS Greater Glasgow and Clyde

Despite an increase in delays and bed days lost during the winter period (in Inverclyde as well as across GG&C) we are achieving the Board target of reducing bed days lost. Across the year (April 15 to March 16), we reached a 76.8% reduction on bed days lost against the 2009/10 baseline. In terms of total beds used by these patients, this has reduced in Inverclyde from 9 (2014/15) to 4 (2015/16).

5.4 Greater Glasgow and Clyde monitoring of bed days lost (Older People) provides a consistent picture of improving performance across all HSCP localities. As a whole, Greater Glasgow and Clyde has had a reduction of 54% in bed days lost based on 2012/13 whilst Inverclyde has a similar reduction of 48% over the same period.

The Chart (Appendix C) illustrates Inverclyde's performance against three HSCPs which are closest in terms of population size.

5.5 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.

6.0 PROPOSALS

6.1 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.

6.2 There is a continued focus to develop integrated and joint improvements to improve the hospital journey and discharge processes. Areas under discussion include development of comprehensive geriatric assessment and consideration of designating acute beds to allow a greater emphasis on older patients who only require a short hospital stay.

Inverclyde HSCP have also been piloting an intermediate care model to avoid unnecessary hospital admission and to provide rehabilitation within an alternative community environment. There have been 35 referrals to step up beds since January 2016 with 11 admissions to the end of May 2016. We are confident that these individuals would otherwise have been admitted to hospital but instead were cared for in a community setting.

6.3 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.

7.0 IMPLICATIONS

Finance

7.1 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

7.2 None.

Human Resources

7.3 There are no Human Resource implications at this time.

Equalities

7.4 Has an Equality Impact Assessment been carried out?

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

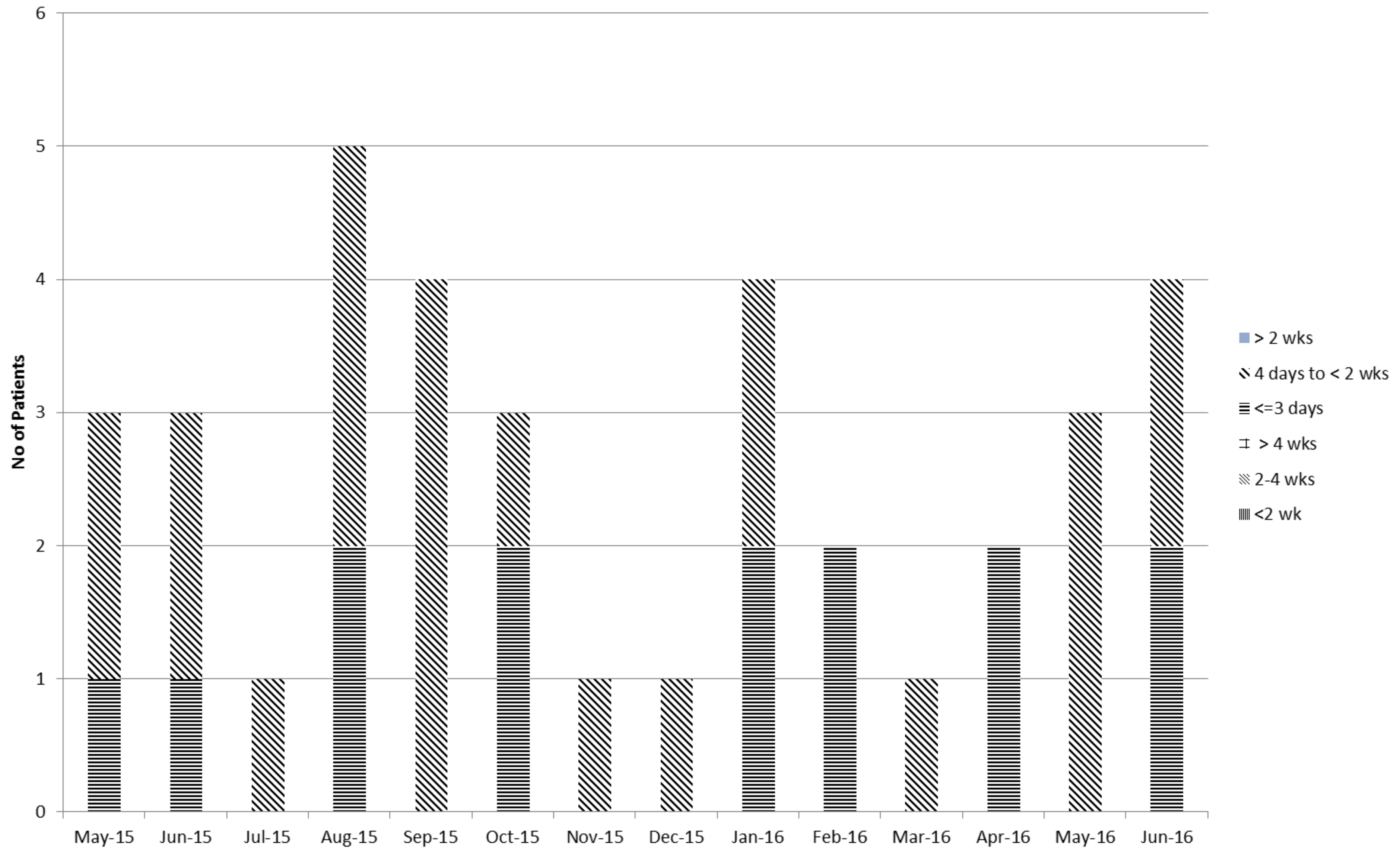
8.0 CONSULTATION

8.1 None.

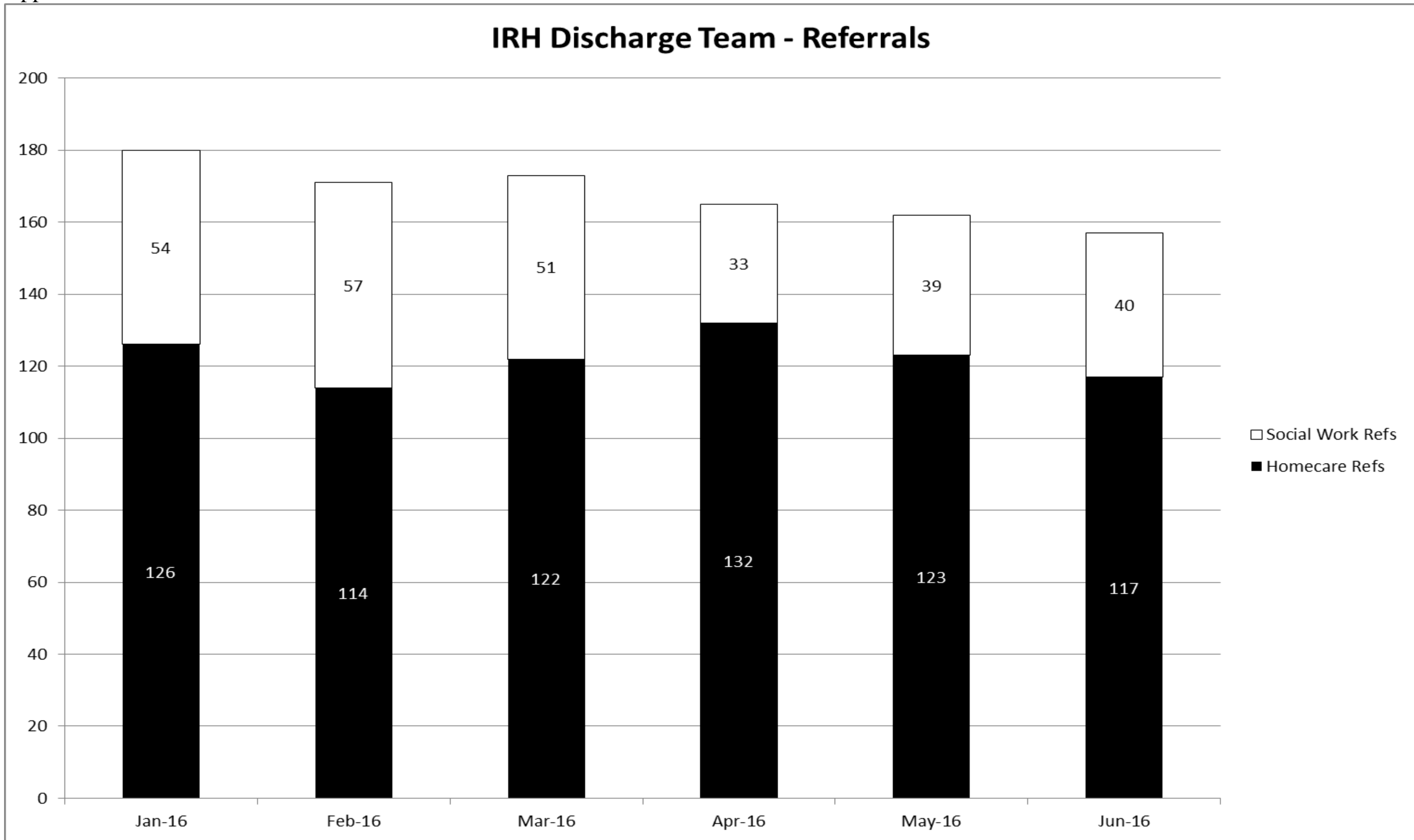
9.0 BACKGROUND PAPERS

9.1 None.

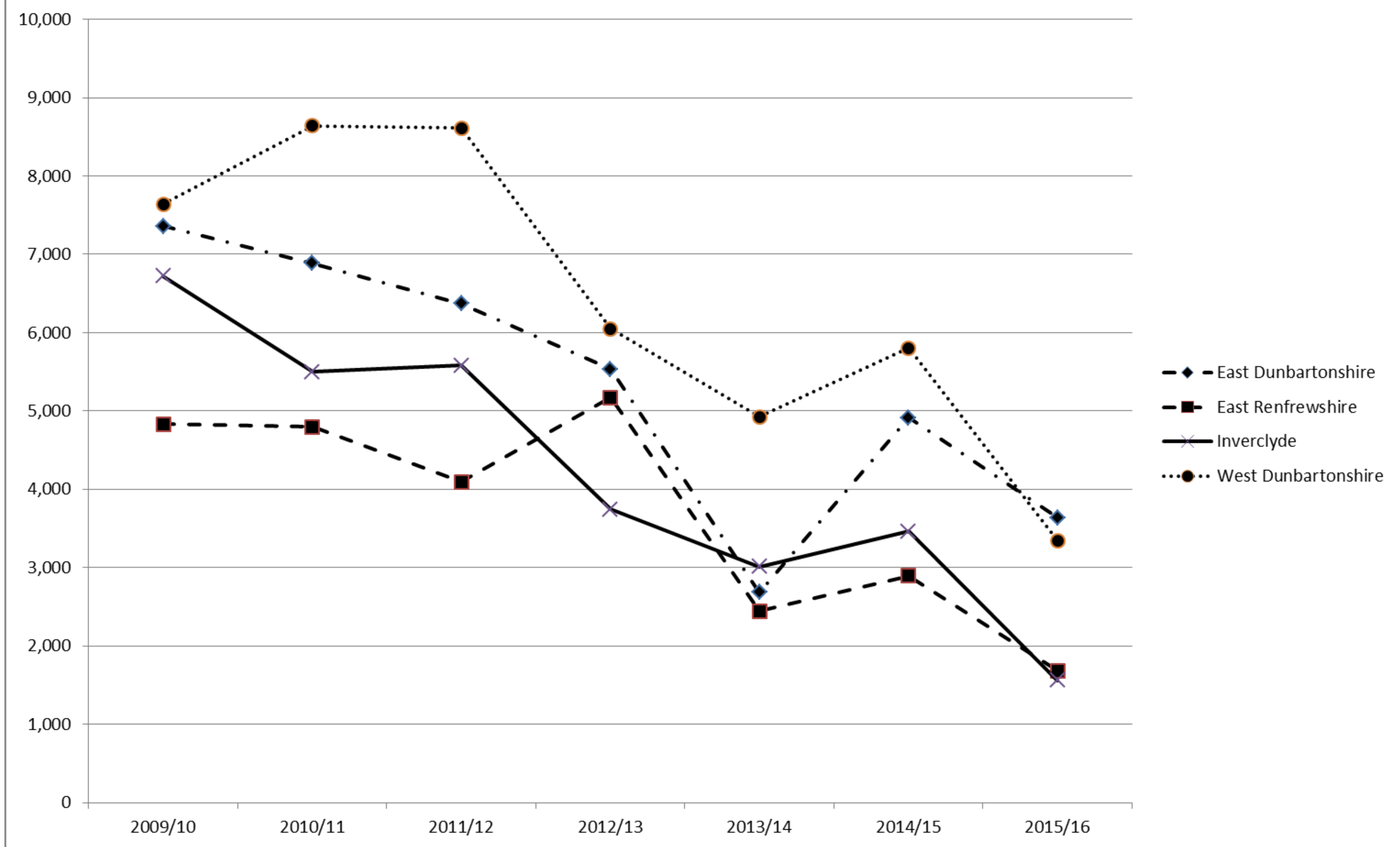
Appendix A



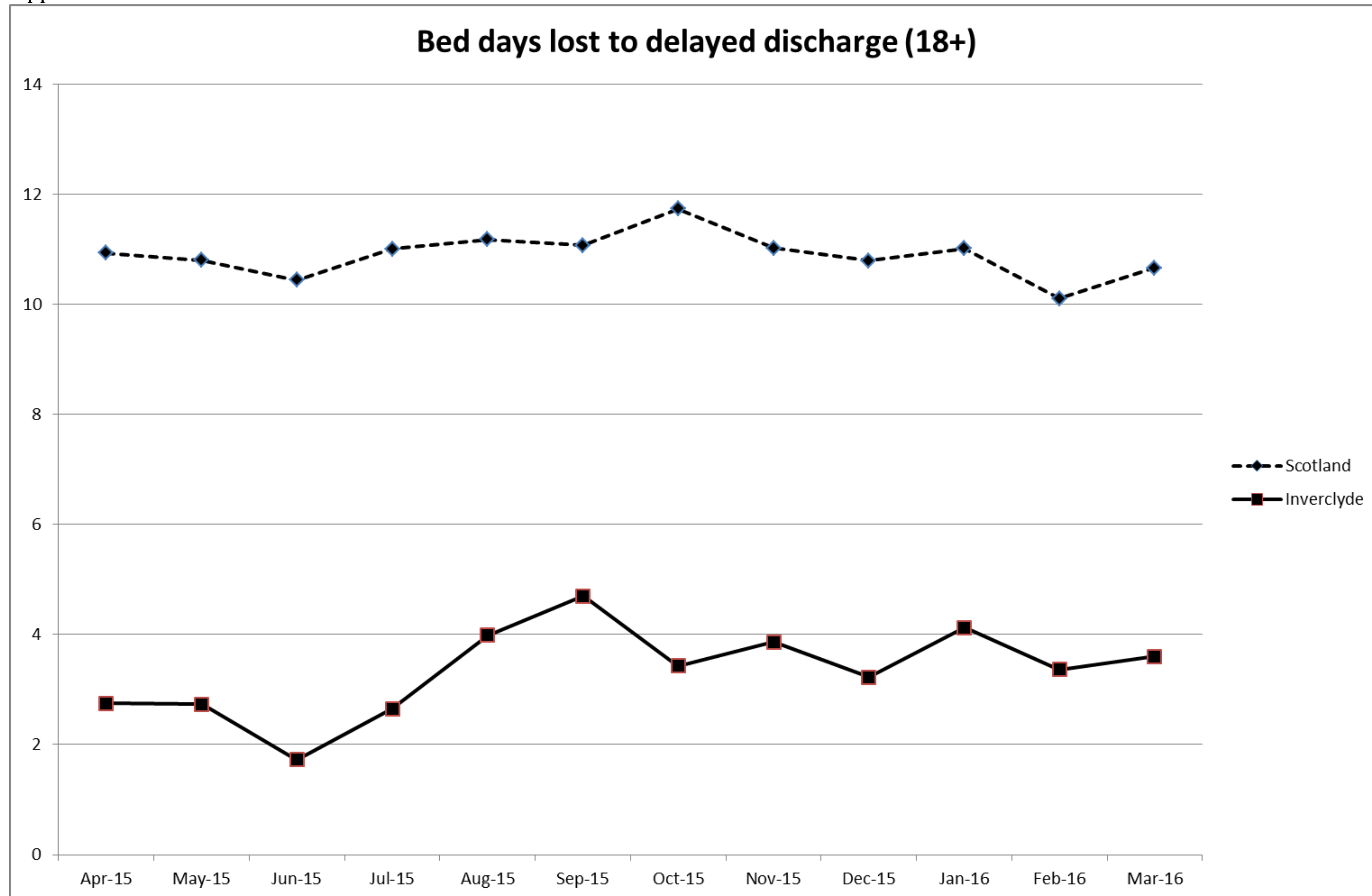
Appendix B



Appendix C



Appendix D



The above chart shows Bed Days lost to Delayed Discharge per 1000 population of those who are 18 years and over. Population data used is the National Records of Scotland Mid-Year Estimate for 2015. This allows for effective comparison between two different population sizes.

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 12

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore** **Corporate Director (Chief Officer)** **Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/40/2016/LA**
Contact Officer:	**Lesley Aird**	**Contact No:**	**01475 712744**
Subject:	**RISK MANAGEMENT POLICY AND STRATEGY**		

1.0 PURPOSE

1.1 The purpose of this report is to seek approval of the enclosed risk management policy and strategy and provide an update on the development of the Inverclyde Integration Joint Board (IJB) Strategic Risk Register.

2.0 SUMMARY

2.1 The Integration Scheme refers to the model risk management policy which was developed by an NHS Greater Glasgow & Clyde IJB Chief Finance Officer working group named the Technical Finance Working Group (TFWG).

2.2 On 10 August 2015, the IJB considered an initial draft of the enclosed Risk Management Policy and Strategy. The policy has now been updated and adapted to reflect the Inverclyde position.

2.3 The Integration Scheme stipulates that the first integrated risk register should be presented to the IJB within six months following the delegation of functions to the IJB. It is proposed that this be discussed and developed further at an IJB development session later this year.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board:

1. Notes the contents of the report;
2. Approves the enclosed Risk Management Policy and Strategy, and
3. Agrees to discuss and finalise the IJB Risk Register at a future IJB development session in 2016.

Brian Moore
Corporate Director (Chief Officer)

Lesley Aird
Chief Financial Officer

4.0 BACKGROUND

4.1 As reported to the IJB in August 2015, a model or 'specimen' Risk Management Policy and Strategy has been developed in collaboration with Health and Local Authority colleagues across the NHS Board area that would be tailored to reflect circumstances in each Partnership.

4.2 The work to tailor the risk management arrangements for Inverclyde was completed over the past couple of months, following the appointment of the Chief Financial Officer. The resulting combined Risk Management Policy and Strategy is attached at Appendix 1.

5.0 KEY MESSAGES FROM THE POLICY AND STRATEGY

5.1 Good risk management will prevent or mitigate the effects of loss or harm and will increase success in the delivery of better clinical and financial outcomes, objectives, achievement of targets and fewer problems.

5.2 The IJB should seek to promote an environment that is risk 'aware' and that strives to place risk management information at the heart of key decisions.

5.3 Strategic risks will represent the potential for the IJB to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan.

5.4 Operational risks will represent the potential for impact within or arising from the activities of an individual service area or team operating within the scope of the IJB's activities. Parent bodies will retain responsibility for managing operational risks as operational risks will be more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders.

5.5 All risks will be analysed and scored consistently in line with the Inverclyde Council approach as being Low, Medium, High or Very High based on the following scoring mechanism:

Risk Impact	Likelihood
1 – Insignificant	1 – Rare
2 – Minor	2 – Unlikely
3 – Moderate	3 – Possible
4 – Major	4 – Probable
5 – Catastrophic	5 – Almost Certain

5.6 Risks will be owned by/assigned to whoever is best placed to manage the risk and oversee the development of any new risk controls required.

5.7 The risk register will be reported through the Audit Committee every six months (from 2017/18 onwards this will be at the beginning of year and a mid year update).

6.0 RISK REGISTER

6.1 A draft Risk Register for the IJB is being developed by officers. This will be formally discussed and refined at a risk management workshop to be arranged as part of an IJB development session later in the year.

7.0 IMPLICATIONS

7.1 **Finance**

There are no specific financial implications arising from this report..

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

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

Human Resources

7.3 There are no specific human resources implications arising from this report.

Equalities

7.4 There are no equality issues within this report.

8.0 CONSULTATION

8.1 This report has been prepared by the IJB Chief Financial Officer. The Chief Officer and Heads of Service have been consulted.

9.0 BACKGROUND PAPERS

9.1 None.

Inverclyde Integration Joint Board

Risk Management Policy and Strategy

Version No.	1.0		
Date Effective:	00/00/0000	Review Date:	00/00/0000

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Policy – the risk management approach

1.1 The **Inverclyde** Integration Joint Board is committed to a culture where its workforce is encouraged to develop new initiatives, improve performance and achieve goals safely, effectively and efficiently by appropriate application of good risk management practice.

1.2 In doing so the Joint Board aims to provide safe and effective care and treatment for patients and clients, and a safe environment for everyone working within the Joint Board and others who interact with the services delivered under the direction of the Joint Board.

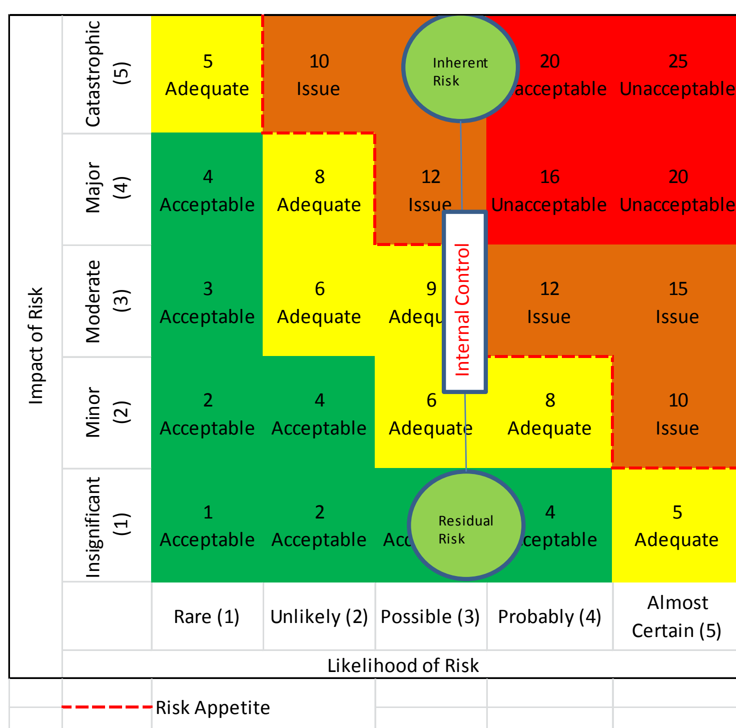
1.3 The Integration Joint Board believes that appropriate application of good risk management will prevent or mitigate the effects of loss or harm and will increase success in the delivery of better clinical and financial outcomes, objectives, achievement of targets and fewer unexpected problems.

Key benefits of effective risk management:

- appropriate, defensible, timeous and best value decisions are made;
- risk ‘aware’ not risk ‘averse’ decisions are based on a balanced appraisal of risk and enable acceptance of certain risks in order to achieve a particular goal or reward;
- high achievement of objectives and targets;
- high levels of morale and productivity;
- better use and prioritisation of resources;
- high levels of user experience/ satisfaction with a consequent reduction in adverse incidents, claims and/ or litigation; and
- a positive reputation established for the Joint Board.

1.4 The Joint Board purposefully seeks to promote an environment that is risk ‘aware’ and strives to place risk management information at the heart of key decisions. This means that the Joint Board can take an effective approach to managing risk in a way that both address significant challenges and enables positive outcomes.

1.5 In normal circumstances the Joint Board’s appetite/ tolerance for risk is as follows:



An explanation of the risk scores and how the risk should be managed is as follows:		
Level of Risk (Inherent Risk Score)	**Indicated By**	**How risk should be managed**
Very High Risk (16 - 25)	Red	**Requires active management.** High impact/high likelihood: risk requires active management to manage down and maintain exposure at an acceptable level.
High Risk (10 - 15)	Amber	**Contingency plans.** A robust contingency plan may suffice together with early warning mechanisms to detect any deviation from plan.
Medium Risk (5 - 9)	Yellow	**Good Housekeeping.** May require some risk mitigation to reduce likelihood if this can be done cost effectively but good housekeeping to ensure the impact remains low should be adequate. Reassess frequently to ensure conditions remain the same.
Low Risk (1 - 4)	Green	**Review periodically.** Risks are unlikely to require mitigating actions but status should be reviewed frequently to ensure conditions have not changed.

1.6 The Joint Board promotes the pursuit of opportunities that will benefit the delivery of the Strategic Plan. Opportunity-related risk must be carefully evaluated in the context of the anticipated benefits for patients, clients and the Joint Board.

1.7 The Joint Board will receive assurance reports (internal and external) not only on the adequacy but also the effectiveness of its risk management arrangements and will consequently value the contribution that risk management makes to the wider governance arrangements of the Joint Board.

1.8 The Joint Board, through the following risk management strategy, has established a Risk Management Framework, (which covers risk policy, procedure, process, systems, risk management roles and responsibilities).

Strategy - Implementing the policy

1. Introduction

1.1 The primary objectives of this strategy will be to:

- promote awareness of risk and define responsibility for managing risk within the Integration Joint Board;
- establish communication and sharing of risk information through all areas of the Integration Joint Board;
- initiate measures to reduce the Integration Joint Board's exposure to risk and potential loss; and,
- establish standards and principles for the efficient management of risk, including regular monitoring, reporting and review.

1.2 This strategy takes a positive and holistic approach to risk management. The scope applies to all risks, whether relating to the clinical and care environment, employee safety and wellbeing,financial risk, business risk, opportunities or threats.

1.3 **Strategic risks** represent the potential for the Integration Joint Board (IJB) to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk.

1.4 **Operational risks** represent the potential for impact (opportunity or threat) within or arising from the activites of an individual service area or team operating within the scope of the Joint Board's activities. Parent bodies will retain responsibility for managing operational risks as operational risks will be more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed for escalation to 'strategic risk' status for the IJB.

1.5 All risks will be analysed consistently with an evaluation of risk based Risk Impact scored 1 to 5 multiplied by likelihood (scored 1 to 5) as follows:

Risk Impact	Likelihood
1 – Insignificant	1 – Rare
2 – Minor	2 – Unlikely
3 – Moderate	3 – Possible
4 – Major	4 – Probable
5 – Catastrophic	5 – Almost Certain

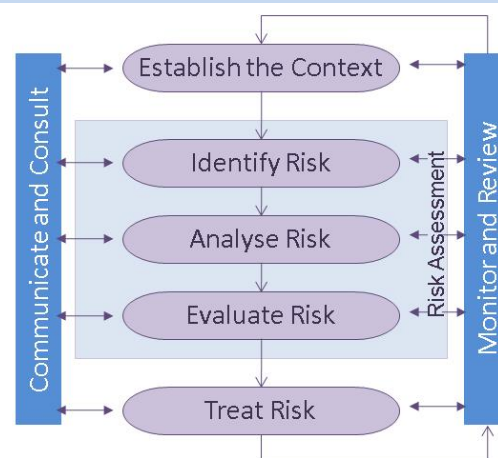
1.6 All risks assessed as scoring 10 or above on the following matrix will be monitored and extreme risk scoring 16 or above will be viewed as significant and therefore subject to closer scruitiny by the IJB Audit Committee.

1.7 This document represents the risk management framework to be implemented across the Joint Board and will contribute to the Joint Board's wider governance arrangements.

2. Risk management process

2.1 Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects[1]. It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that defensible and beneficial decisions are made.

2.2 The IJB embeds risk management practice by consistent application of the risk management process shown in the diagram on the right, across all areas of service delivery and business activities.



[1] Australia/ New Zealand Risk Management Standard, AS/NZS 4360: 2004

3. Application of good risk management across the IJB activities

3.1 Standard procedures (3.1.1 – 3.1.9) will be implemented across all areas of activity that are under the direction of the IJB in order to achieve consistent and effective implementation of good risk management.

3.1.1 Full implementation of the risk management process. This means that risk management information should (wherever possible) be used to guide major decisions in the same way that cost and benefit analysis is used.

3.1.2 Identification of risk using standard methodologies, and involving subject experts who have knowledge and experience of the activity or process under consideration.

3.1.3 Categorisation of risk under the headings below:

- Strategic Risks: such as risks that may arise from Political, Economical, Social, Technological, Legislative and Environmental factors that impact on the delivery of the Strategic Plan outcomes.
- Operational Risks: such as risks that may arise from or impact on Clinical Care and Treatment, Social Care and Treatment, Customer Service, Employee Health, Safety & Well-being, Business Continuity/ Supply Chain, Information Security and Asset Management.

3.1.4 Appropriate ownership of risk. Specific risks will be owned by/ assigned to whoever is best placed to manage the risk and oversee the development of any new risk controls required.

3.1.5 Consistent application of the agreed risk matrix to analyse risk in terms of likelihood of occurrence and potential impact, taking into account the effectiveness of risk control measures in place. The risk matrix to be used is attached in Appendix 1.

3.1.6 Consistent response to risk that is proportionate to the level of risk. This means that risk may be terminated; transferred elsewhere (ie to another partner or third party); tolerated as it is; or, treated with cost effective measures to bring it to a level where it is acceptable or tolerable for the Joint Board in keeping with its appetite/ tolerance for risk. In the case of opportunities, the Joint Board may take an informed risk in terms of tolerating it if the opportunity is judged to be (1) worthwhile pursuing and (2) the Joint Board is confident in its ability to achieve the benefits and manage/ contain the associated risk.

3.1.7 Implementation and maintenance of risk registers as a means of collating risk information in a consistent format allowing comparison of risk evaluations, informed decision-making in relation to prioritising resources and ease of access to information for risk reporting.

3.1.8 Reporting of strategic risks and key operational risks to the IJB Audit Committee on a six monthly basis.

3.1.9 Routine reporting of risk information within and across teams and a commitment to a 'lessons learned' culture that seeks to learn from both good and poor experience in order to replicate good practice and reduce adverse events and associated complaints and claims.

Risk leadership and accountability

4. Governance, roles and responsibilities

4.1 Integration Joint Board
Members of the Integration Joint Board are responsible for:

- oversight of the IJB's risk management arrangements;
- receipt and review of reports on strategic risks and any key operational risks that require to be brought to the IJB's attention; and,
- ensuring they are aware of any risks linked to formal reports and recommendations from the Chief Officer and other senior officers of the Health and Social Care Partnership concerning new priorities/ policies and the like.
- Strategic risk registers will be presented to the IJB Audit Committee for scruitiny and the IJB for approval on an annual basis.

4.2 Chief Officer
The Chief Officer has overall accountability for the IJB's risk management framework, ensuring that suitable and effective arrangements are in place to manage the risks relating to the functions within the scope of the IJB. The Chief Officer will keep the Chief Executives of the IJB's partner bodies informed of any significant existing or emerging risks that could seriously impact the IJB's ability to deliver the outcomes of the Strategic Plan or the reputation of the IJB.

4.3 Chief Financial Officer
The Chief Financial Officer will be responsible for promoting arrangements to identify and manage key business risks, risk mitigation and insurance.

4.4 Partnership Senior Management Team
Members of the Senior Management Team are responsible for:

- supporting the Chief Officer and Chief Financial Officer in fulfilling their risk management responsibilities;
- receipt and review of regular risk reports on strategic, shared and key operational risks and escalating any matters of concern to the IJB; and,
- ensuring that the standard procedures set out in this strategy are actively promoted across their teams and within their areas of responsibility.

4.5 Individual Risk Owners
It is the responsibility of each risk owner to ensure that:

- risks assigned to them are analysed in keeping with the agreed risk matrix;
- data on which risk evaluations are based are robust and reliable so far as possible;
- risks are defined clearly to make explicit the scope of the challenge, opportunity or hazard and the consequences that may arise;
- risk is reviewed not only in terms of likelihood and impact of occurrence, but takes account of any changes in context that may affect the risk;
- controls that are in place to manage the risk are proportionate to the context and level of risk.

4.6 All persons working under the direction of the IJB
Risk management should be integrated into daily activities with everyone involved in identifying current and potential risks where they work. Individuals have a responsibility to make every effort to be aware of situations which place them or others at risk, report identified hazards and implement

safe working practices developed within their service areas. This approach requires everyone to understand:

- the risks that relate to their roles and activities;
- how their actions relate to their own, their patient's, their services user's/ client's and public safety;
- their accountability for particular risks and how they can manage them;
- the importance of flagging up incidents and/ or near misses to allow lessons to be learned and contribute to ongoing improvement of risk management arrangements; and,
- that good risk management is a key part of the IJB's culture.

These operational risks are controlled and monitored by the Council and Health Board rather than the IJB.

4.7 Partner Bodies
It is the responsibility of relevant specialists from the partner bodies, (such as internal audit, external audit, clinical and non clinical risk managers and health and safety advisers) to attend meetings as necessary to consider the implications of risks and provide relevant advice. It is the responsibility of the partner bodies to ensure they routinely seek to identify any residual risks and liabilities they retain in relation to the activities under the direction of the IJB.

4.8 Senior Information Risk Owner
Responsibility for this specific role will remain with the Council and the Health Board.

Resourcing risk management

5. Resourcing the risk management framework

5.1 The Health Board's Director of Finance and Council's Section 95 Officer will ensure that the IJB and its Audit Committee is provided with the necessary technical and corporate support to develop, maintain and scrutinise strategic risk registers.

5.2 Much of the work on developing and leading the ongoing implementation of the risk management framework will be undertaken as part of routine actitity within the IJB.

5.3 Wherever possible the IJB will ensure that any related risk management training and education costs will be kept to a minimum, with the majority of risk-related courses/ training being delivered through resources already available to the IJB (the partner body risk managers/ risk management specialists).

6. Resourcing those responsible for managing specific risks

6.1 Where risks impact on a specific partner body and new risk control measures require to be developed and funded, it is expected that the costs will be borne by that partner organisation.

6.2 Financial decisions in respect of the IJB's risk management arrangements will rest with the Chief Financial Officer.

Training, learning and development

7. Risk management training and development opportunities

7.1 To implement effectively this policy and strategy, it is essential for people to have the competence and capacity for managing risk and handling risk judgements with confidence, to focus on learning from events and past experience in relation to what has worked well or could have been managed better, and to focus on identifying malfunctioning 'systems' rather than people.

7.2 Training is important and is essential in embedding a positive risk management culture across all activities under the direction of the IJB and in developing risk management maturity. The Senior Management Team will regularly review risk management training and development needs and source the relevant training and development opportunities required .

Monitoring activity and performance

8. Monitoring risk management activity

8.1 The Joint Board operates in a dynamic and challenging environment. A suitable system is required to ensure risks are monitored for change in context and scoring so that appropriate response is made.

8.2 Monitoring will include review of the IJB's risk profile at Senior Management Team level every six months.

8.3 It is expected that partner bodies will use IJB risk reports to keep their own organisations updated on the management of the risks, highlighting any IJB risks that might impact on the partner organisation.

9. Monitoring risk management performance

9.1 Measuring, managing and monitoring risk management performance is key to the effective delivery of key objectives.

9.2 Key risk indicators (KRIs) will be linked where appropriate to specific risks to provide assurance on the performance of certain control measures. For example, specific clinical incident data can provide assurance that risks associated with the delivery of clinical care are controlled, or, budget monitoring PIs (Performance Indicators) can provide assurance that key financial risks are under control.

9.3 The performance data linked to the Strategic Plan will also inform the identification of new risks or highlight where existing risks require more attention.

9.4 Reviewing the Joint Board's risk management arrangements on a regular basis will also constitute a 'Plan/ Do/ Study/ Act review cycle that will shape future risk management priorities and activities of the Joint Board, inform subsequent revisions of this policy and strategy and drive continuous improvement in risk management across the Joint Board.

Communicating risk management

10. Communicating, consulting on and reviewing the risk management framework

10.1 Effective communication of risk management information across the Joint Board is essential to developing a consistent and effective approach to risk management.

10.2 Copies of this policy and strategy will be widely circulated via the Senior Management Team and will form the basis of any risk management training arranged by the IJB.

10.3 The Policy and Strategy (version 1.0) was approved by the Integration Joint Board at its meeting of **TBC**.

10.4 This policy and strategy will be reviewed every three years to ensure that it reflects current standards and best practice in risk management and fully reflects the Integration Joint Board's business environment.

Appendix 1 Risk Matrix

Impact of Risk		Rare (1)	Unlikely (2)	Possible (3)	Probably (4)	Almost Certain (5)
	Catastrophic (5)	5 Adequate	10 Issue	15 Issue	20 Unacceptable	25 Unacceptable
	Major (4)	4 Acceptable	8 Adequate	12 Issue	16 Unacceptable	20 Unacceptable
	Moderate (3)	3 Acceptable	6 Adequate	9 Adequate	12 Issue	15 Issue
	Minor (2)	2 Acceptable	4 Acceptable	6 Adequate	8 Adequate	10 Issue
	Insignificant (1)	1 Acceptable	2 Acceptable	3 Acceptable	4 Acceptable	5 Adequate
		Likelihood of Risk				

- - - - - Risk Appetite

Risk Impact

	1 **Insignificant**	2 **Minor**	3 **Moderate**	4 **Major**	5 **Catastrophic**
Financial	<£100k	£100k-£250k	£250k-£500k	£500k-£1,000k	£1,000k>
Reputation	Individual negative perception	Local negative perception	Intra industry or regional negative perception	National negative perception	Sustained national negative perception
Legal and Regulatory	Minor regulatory or contractual breach resulting in no compensation or loss	Breach of legislation or code resulting in a compensation award	Regulatory censure or action, significant contractual breach	Breach of regulation or legislation with severe costs/fine	Public fines and censure, regulatory veto on projects/ withdrawal of funding. Major adverse corporate litigation
Opertional/ Continuity	An individual service or process failure	Minor problems in specific areas of service delivery	Impact on specific customer group or process	Widespread problems in business operations	Major service of process failure impacting majority or major customer groups

Likelihood

	1 **Rare**	2 **Unlikely**	3 **Possible**	4 **Probable**	5 **Almost Certain**
Definition	Not likely to happen in the next 3 years	Unlikely to happen in the next 3 years	Possible to occur in the next 3 years	Likely to occur in the next year	Very likely to occur in the next 6 months

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 13

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore** **Corporate Director, (Chief Officer)** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/37/2016/HW**
Contact Officer:	**Helen Watson** **Head of Service** **Planning, Health Improvement & Commissioning**	**Contact No:**	**01475 715285**
Subject:	**IMATTER UPDATE**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board on the implementation of the staff experience employee engagement tool 'iMatter' across Inverclyde Health & Social Care Partnership.

2.0 SUMMARY

2.1 iMatter is a new team-based employee engagement tool that is being rolled out nationally as part of the 2020 Workforce Vision to support a Healthy Organisational Culture in the NHS.

2.2 The online system is supplied by Webropol (a company from Finland), and the questions used in the model have been extensively validated to accurately measure employee engagement and produce an Employee Engagement Index (EEI) score. iMatter produces team level reports and allows key issues to be identified and improved upon.

2.3 The Scottish Workforce Governance Commitment expects that all areas of the NHS will have run at least one iMatter cycle by the end 2017. Inverclyde HSCP volunteered to be a pilot for the first roll-out within an integrated Partnership. At this point in time, Inverclyde is the only HSCP in Scotland to have rolled out iMatter.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is requested to note the contents of this report.

Brian Moore
Corporate Director (Chief Officer)
Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

4.1 Feedback from both NHS and Council recent staff surveys highlighted that some staff felt disengaged. The results from the surveys highlighted that staff felt too removed from the findings, as the data was not specific to the daily operation of services at team level.

4.2 In addition, previous staff engagement sessions within Inverclyde had highlighted team development as a key issue with practice, opportunity and the need for development being variable between and across services. Feeling more empowered and involved in decision making at team level was identified as a desired objective.

4.3 Acknowledging this feedback from staff and recognising the connection to the HSCP Values and in particular those that state:

> ***We will strive to do better by*** building a competent, confident and valued workforce and
> ***We are accountable*** and everyone is encouraged to make a positive contribution to service improvement and delivery, the decision was taken to volunteer to be the first integrated Partnership in Scotland to roll out the iMatter model of staff engagement.

5.0 THE IMATTER MODEL

5.1 The questionnaire itself consists of 29 questions: 12 questions about the employee's experience as an individual in their role; 7 about the employee's experience of their team and line manager; 9 about the employee's view of Inverclyde Partnership and one final question in which respondents are asked to rate their overall experience of working in Inverclyde HSCP in the past 12 months.

5.2 A team report is produced following completion of the questionnaires (response rate of minimum 60% required and 100% for teams with less than 5). The report shows line managers their overall team response rate, Employee Engagement Index (EEI) score, which is an average score of all questions, and an overview of responses to the questions answered, identifying key strengths and areas for improvement within the team.

5.3 Following receipt of the team report, line managers meet with teams to review and discuss the report and from there identify one team strength and up to three areas for improvement, which then provides an action plan and storyboard to take forward, updating progress on the system. The questionnaire and subsequent actions are then completed annually by each team.

6.0 PROCESS- There are 7 steps in the process. These are:

6.1 Preparation to clarify the reporting line for every member of staff and to raise understanding about iMatter and everyone's responsibility in the process.

6.2 Every Line Manager receives an account login to the iMatter system and confirms all staff that report to them.

6.3 The questionnaire is launched for all staff to complete electronically via email or on paper copy. Questionnaire results contribute to Team Reports.

6.4 Webropol (iMatter system contractor) completes the input of all data.

6.5 The Chief Officer accesses a summary report for the Partnership which contains the Employee Engagement Index (EEI) score and the summary scores for all questions.

6.6 Line Managers access their Team Reports, share these with their teams, agree improvement actions and generate their team's iMatter Storyboard.

6.7 All teams are required to update on the web-based system regarding their improvement action progress.

7.0 CURRENT POSITION

7.1 Team reports and a component report are now available for the HSCP.

7.2 Line managers are currently reviewing their individual team reports at team meetings with team members agreeing on actions for uploading onto action plans. This activity is to be completed by the end of July 2016. Action plans are to include three areas for improving upon and one to celebrate success.

7.3 Progress on agreed actions is to be updated into team action plans by the end of September 2016.

7.4 The cycle recommences in February 2017 with the learning from the initial roll out embedded into the anniversary process.

7.5 The Staff Partnership Forum has been a key partner in the successful implementation of the model.

8.0 CELEBRATING SUCCESS

8.1 The national lead for iMatter requested that Inverclyde's willingness to support the process be acknowledged and visible at The NHS Scotland Annual Event on 14th and 15th June.

8.2 In agreement with the Chief Officer, a film crew, commissioned by the national lead, visited Inverclyde HSCP on 18th May 2016 to film and interview staff on their progress to date and their hopes from this model of staff engagement.

8.3 At the NHS Scotland Event on 14th and 15th June, Inverclyde HSCP was represented by two team leaders and the aligned OD advisor. This involved facilitating a workshop session on the model. The film was shown at the outset of the session, and both days there were over 200 delegates in the workshop sessions.

8.4 Regular updates on iMatter are provided through all communication channels with inserts and updates within The Chief Officer's Brief. A link to access the film will shortly be made available to all staff.

8.5 A report on the key lessons learned from the implementation in Inverclyde has been shared with Partnership Chief Officers across the Greater Glasgow and Clyde area.

9.0 CONCLUSION

9.1 This 'People Management' approach focuses on empowering individuals and on engaging employees in the organisation's purpose. As it takes collective leadership to make the purpose achievable, it is therefore critical that leaders and teams work

together to help clarify how each team is contributing to the overarching vision and values of the HSCP.

9.2 By adopting the iMatter model of staff engagement in Inverclyde, the hope and expectation, based on research data, is that it will help staff feel more connected to the vision of Inverclyde HSCP of ‘Improving Lives’.

10.0 RECOMMENDATIONS

10.1 The Integration Joint Board is asked to note the contents of this report.

11.0 IMPLICATIONS

Finance

11.1 There are no direct financial implications within this report.

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

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

Human Resources

11.3 There are no specific human resources implications arising from this report.

Equalities

11.4 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.

12.0 CONSULTATION

12.1 N/A

13.0 BACKGROUND PAPERS

13.1 N/A

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 14

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/47/2016/HW**
Contact Officer:	**Helen Watson**	**Contact No:**	**01475 715285**
Subject:	**GP HEALTH AND CARE EXPERIENCE SURVEY 2015/16**		

1.0 PURPOSE

1.1 The purpose of this report is to provide the Integration Joint Board with an overview analysis of the results of the GP Health and Care Experience Survey 2015/16.

2.0 SUMMARY

2.1 The Scottish Health and Care Experience Survey asks people about their experiences of their GP practice, as well as local care and support services provided by their local council and other organisations. The survey was posted to potential participants in early December 2015 to a random selection of people aged 17 and over who are registered with a GP practice in Scotland.

2.2 The overall Inverclyde results with regard to the National Wellbeing Outcomes provide a generally positive picture in comparison to the Scottish averages, with all but one outcome scoring at or above average.

2.3 The report, which can be found at http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey, indicates a number of areas for improvement, but also a number of areas where we compare favourably with the rest of Scotland.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the Inverclyde results of the survey, with a view to these being considered a baseline against which future survey results can be compared.

Brian Moore
Corporate Director, (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Scottish Health and Care Experience Survey asks people about their experiences of their GP practice, as well as local care and support services provided by their local council and other organisations. The survey was posted to potential participants in early December 2015 to a random selection of people aged 17 and over who are registered with a GP practice in Scotland. Questionnaires could either be sent back by post, or completed online.

4.2 The survey and sampling approach was developed by the Scottish Government in consultation with a range of stakeholders including NHS Boards, Integration Authorities and NHS National Services Scotland, and the results will be used to inform the national performance framework that gauges levels of delivery on the nine National Wellbeing Indicators. Table 1 below provides an indication of Inverclyde survey results for the questions that align to the National Wellbeing Outcomes. An asterisk (*) denotes that the result has not been tested for statistical significance, and an "s" in superscript indicates that the result is statistically significant.

Wellbeing Outcome	**Overall Positive Score**	**%age Difference from the Scottish Average**
I am able to look after my own health	90%	-4*
Service users are supported to live as independently as possible	88%	+5
Service users have a say in how their help, care or support is provided	85%	$+7^{s}$
Service users' health and care services seem to be well coordinated	79%	+4
Rating of overall help, care or support services	84%	+3
Rating of overall care provided by GP practice	87%	0
The help, care or support improves service users' quality of life	88%	+5
Carers feels supported to continue caring	46%	+5
Service users feel safe	87%	+3

Table 1: Inverclyde survey results relating to the National Wellbeing Outcomes

4.3 The overall Inverclyde results with regard to the National Wellbeing Outcomes provide a generally positive picture in comparison to the Scottish averages, with all but one outcome scoring at or above average. The one outcome showing below the Scottish average is the one relating to the perceived ability of people to look after their own health. In relation to service users having a say in how their help, care or support is provided, the Inverclyde score is 7 percentage points above the Scottish average which is statistically significant. This positive result will be used to help develop our local work on supported self-management, and will hopefully have a positive influence on the future views of people being able to look after their own health (outcome 1).

4.4 The survey provides reports for each of the 16 Inverclyde GP Practices, and results are summarised under five key themes as outlined in table 2.

Theme	Average Positive Responses (Inverclyde)	Inverclyde Range Between GP Practices	%age Points in Range	Scottish Average
Arranging to see a doctor	71%	37% - 99%	62	71%
Arranging to see a nurse	83%	63% - 97%	34	82%
Compassion and understanding	84%	71% - 90%	19	85%
GP Practice Care	88%	74% - 96%	22	86%
Out of Hours Care	73%	64% - 93%	29	71%

Table 2: Summary results from Inverclyde GP practices

4.5 Table 2 demonstrates that when considered across all 16 practices, Inverclyde GPs collectively score on or close to the Scottish average. However there are marked differences between practices as noted in the range of scores within each dimension, and the percentage points within these ranges. The most notable differences are reflected in the patient experience of arranging to see a doctor or nurse, with a range of 62 percentage points in the former and 34 percentage points in the latter. There is likely to be scope for narrowing the patient experience gap through cross-practice learning.

4.6 Further detailed representation of the results is included at appendix one, where Inverclyde responses to each question from the survey are provided, alongside:

- the national average,
- national range, and
- Inverclyde's ranking in terms of positivity (with 1st denoting the most positive reported patient experience).

Each question has been categorised as red, amber or green, based on the level of drift (either way) from the national averages, and the overall ranking of Inverclyde in comparison to the other 30 HSCPs. In future years, analysis will be undertaken on comparisons within Inverclyde, using the current survey results as a baseline. This will help us identify improvements (or otherwise) locally.

4.7 Appendix 1 indicates a number of areas for improvement, but also a number of areas where we compare favourably with the rest of Scotland.

4.8 Areas for improvement

In response to the question "*If you ask to make an appointment with a doctor 3 or more working days in advance, does your GP practice allow you to?*", 67% of Inverclyde people responded positively. This compares to the national average of 77%, and Inverclyde ranked 28th out of 31 Partnerships.

In response to the question "*The last time you needed to see or speak to a doctor or nurse from your GP practice quite urgently, how long did you wait?*", 79% of Inverclyde people responded positively. This compares to the national average of 85%, and Inverclyde ranked 31st out of 31 Partnerships (worst).

In response to the question "*Thinking of the last time you contacted this GP practice by phone, how easy was it for you to get through?*", 76% of Inverclyde people responded positively. This compares to the national average of 83%, and Inverclyde ranked 26th out of 31 Partnerships.

All of these questions relate to issues about contacting the practices and getting access to the primary care team. A review of contact processes, with learning from those practices where patients report a more positive experience might be beneficial. It should be noted that these areas do not relate to clinical care, but, rather, to administrative processes. As such, it could potentially be relatively straightforward to review and perhaps align these processes, to improve the patient experience.

4.9 Areas where positive experience is reported

In response to the question "*The help, care or support improved or maintained my quality of life?*", 88% of Inverclyde people responded positively. This compares to the national average of 85%, and Inverclyde ranked 3rd out of 31 Partnerships.

In response to the question "*I had a say in how my help, care or support was provided?*", 85% of Inverclyde people responded positively. This compares to the national average of 79%, and Inverclyde ranked 3rd out of 31 Partnerships.

In response to the question "*I felt that the nurse had all the information needed to treat me?*", 95% of Inverclyde people responded positively. This compares to the national average of 93%, and Inverclyde ranked 2nd out of 31 Partnerships.

In response to the question "*I felt confident in the nurses' ability to treat me?*", 96% of Inverclyde people responded positively. This compares to the national average of 94%, and Inverclyde ranked 2nd out of 31 Partnerships.

These positive responses indicate that Inverclyde people feel included in negotiating their own care, and have confidence in the primary care team. That positivity can be built upon to help us to realise the nine National Wellbeing Outcomes at a local level, and to do this in the context of our Strategic Commissioning Themes.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications:

There are no financial issues within 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 strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no governance issues within this report.

6.0 BACKGROUND PAPERS

6.1 None.

HSCP_Name	Question	Inverclyde % Positive	National Average Positive	National Range Positive	Inverclyde % Negative	National Average Negative	National Range Negative	Inverclyde Rank Positive	Comment
Inverclyde	Thinking of the last time you contacted this GP practice by phone, how easy was it for you to get through?	76	83	69-97	24	17	3-31	24th	Inverclyde is 7 points below the national average for positive scoring, and 7 points above the national average for negative scoring.
Inverclyde	The last time you phoned the GP practice, how helpful was the person who answered?	93	95	90-100	7	5	0-10	26th	Inverclyde is 2 points below the national average for positive scoring, and 2 points above the national average for negative scoring. Although the ranking of 26th (out of 31) might be regarded as disappointing, it should be noted that there is relatively low variation in scoring on this question.
Inverclyde	The last time you needed to see or speak to a doctor or nurse from your GP practice quite urgently, how long did you wait?	79	85	79-94	21	15	6-21	31st	Inverclyde is 6 points below the national average for positive scoring, and 6 points above the national average for negative scoring. This has ranked Inverclyde as having the poorest patient experience out of all 31 partnerships on this question.
Inverclyde	If you ask to make an appointment with a doctor 3 or more working days in advance, does your GP practice allow you to?	67	77	55-98	33	23	2-45	28th	Inverclyde is 10 points below the national average for positive scoring, and 10 points above the national average for negative scoring. This has ranked Inverclyde as having the 3rd poorest patient experience out of all 31 partnerships on this question.
Inverclyde	When you arrange to see a doctor at your GP practice can you usually see the doctor you prefer?	79	80	69-91	21	20	9-31	20th	Inverclyde is 1 point below the national average for positive scoring, and 1 point above the national average for negative scoring.
Inverclyde	Thinking about the last time your GP practice referred you to other health care services, how would you rate the arrangements for getting to see other services?	78	78	71-87	6	7	3-11	14th	Inverclyde equals the national average for positive scoring, and is 1 point below the national average for negative scoring.
Inverclyde	How helpful do you find the receptionists at your GP practice?	93	94	89-100	7	6	0-11	22nd	Inverclyde is 1 point below the national average for positive scoring, and 1 point above the national average for negative scoring.
Inverclyde	How do you feel about how long you usually have to wait to be seen after you arrive at your GP practice?	85	86	78-94	15	14	6-22	22nd	Inverclyde is 1 point below the national average for positive scoring, and 1 point above the national average for negative scoring.
Inverclyde	Are you involved as much as you want to be in decisions about your care and treatment?	59	63	55-74	5	4	1-7	25th	Inverclyde is 4 points below the national average for positive scoring, and 1 point above the national average for negative scoring.
Inverclyde	In the past year do you believe a mistake was made in your treatment or care by your GP practice (including for example in test results, medicines prescribed, diagnosis)?	94	94	92-96	6	6	4-8	12th	Inverclyde equals the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	Were you satisfied with how it was dealt with overall?	49	47	32-67	51	53	33-68	12th	Inverclyde is 2 points above the national average for positive scoring, and 2 points below the national average for negative scoring.
Inverclyde	Overall, how would you rate the care provided by your GP practice?	87	87	80-97	3	3	0-6	17th	Inverclyde equals the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	Overall, how would you rate the care you experienced out of hours?	72	72	65-79	9	11	7-17	15th	Inverclyde equals the national average for positive scoring, and and is two points below the national average for negative scoring.

Inverclyde	Overall, how would you rate your help, care or support services - excluding the care and help you get from friends and family?	84	82	73-88	3	5	1-11	6th	Inverclyde is 2 points above the national average for positive scoring, and 2 below the national average for negative scoring.
Inverclyde	The doctor listened to me	95	95	93-98	2	2	1-3	13th	Inverclyde equals the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	I felt that the doctor had all the information needed to treat me	91	90	85-92	3	3	2-5	11th	Inverclyde is one point above the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	The doctor took account of the things that matter to me	88	87	84-91	3	3	2-5	10th	Inverclyde is one point above the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	The doctor talked in a way that helped me understand my condition and treatment	90	90	87-93	3	3	1-5	17th	Inverclyde equals the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	I felt confident in the doctors ability to treat me	91	90	87-93	3	3	2-5	9th	Inverclyde is one point above the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	I had enough time with the doctor	89	89	84-95	5	5	2-7	18th	Inverclyde equals the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	The nurse listened to me	96	96	94-98	0	1	0-2	7th	Inverclyde equals the national average for positive scoring, and is 1 point below the national average for negative scoring.
Inverclyde	I felt that the nurse had all the information needed to treat me	95	93	91-95	1	2	1-3	2nd	Inverclyde is 2 points above the national average for positive scoring, and 1 point below the national average for negative scoring.
Inverclyde	The nurse took account of the things that matter to me	91	90	88-94	1	2	1-3	8th	Inverclyde is one point above the national average for positive scoring, and 1 point below the national average for negative scoring.
Inverclyde	The nurse talked in a way that helped me understand my condition and treatment	93	91	88-95	1	1	1-3	6th	Inverclyde is 2 points above the national average for positive scoring, and equal to the national average for negative scoring.
Inverclyde	I felt confident in the nurses ability to treat me	96	94	92-96	1	2	1-3	2nd	Inverclyde is 2 points above the national average for positive scoring, and 1 point below the national average for negative scoring.
Inverclyde	I had enough time with the nurse	96	96	93-98	1	1	0-2	12th	Inverclyde equals the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	It was explained to me why a test was needed	96	96	94-98	1	1	0-2	15th	Inverclyde equals the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	I was satisfied with the length of time I waited for my results	85	85	83-89	7	7	4-10	14th	Inverclyde equals the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	I was satisfied with the way I received my results	82	81	78-85	9	9	7-12	11th	Inverclyde is one point above the national average for positive scoring, and equal to the national average for negative scoring.
Inverclyde	The results of the test were explained to me in a way I could understand	82	81	76-86	7	8	5-11	13th	Inverclyde is one point above the national average for positive scoring, and 1 point below the national average for negative scoring.
Inverclyde	It was easy enough for me to get my medicines	96	96	94-97	3	2	1-4	25th	Inverclyde equals the national average for positive scoring, and is one point above the national average for negative scoring.
Inverclyde	I knew enough about what my medicines were for	97	97	95-99	1	1	0-2	20th	Inverclyde equals the national average for positive scoring, and equals the national average for negative scoring.

Inverclyde	I knew enough about how and when when to take my medicines	98	98	97-100	0	1	0-1	17th	Inverclyde equals the national average for positive scoring, and is one point below the national average for negative scoring.
Inverclyde	I knew enough about the possible side effects of my medicines	82	83	79-87	6	6	3-9	21st	Inverclyde is one point below the national average for positive scoring, and equal to the national average for negative scoring.
Inverclyde	I would know what to do if I had any problems with my medicines	90	90	86-94	4	3	2-5	13th	Inverclyde equals the national average for positive scoring, and is one point above the national average for negative scoring.
Inverclyde	I took my prescription as I was supposed to	98	98	97-99	1	1	0-1	20th	Inverclyde equals the national average for positive scoring, and equals the national average for negative scoring.
Inverclyde	I am treated with respect	91	92	88-98	3	2	0-4	22nd	Inverclyde is one point below the national average for positive scoring, and one point above the national average for negative scoring.
Inverclyde	I am treated with compassion and understanding	82	86	80-96	4	3	1-5	27th	Inverclyde is 4 points below the national average for positive scoring, and one point above the national average for negative scoring.
Inverclyde	The time I waited was reasonable	75	74	67-80	15	17	11-25	14th	Inverclyde is one point above the national average for positive scoring, and 2 points below the national average for negative scoring.
Inverclyde	I felt that the person had all the information needed to treat me	79	78	74-84	9	10	6-12	13th	Inverclyde is one point above the national average for positive scoring, and one point below the national average for negative scoring.
Inverclyde	I felt I was listened to	84	85	80-92	5	7	3-9	15th	Inverclyde is one point below the national average for positive scoring, and 2 points below the national average for negative scoring.
Inverclyde	Things were explained to me in a way I could understand	84	86	82-91	6	5	3-7	27th	Inverclyde is 2 points below the national average for positive scoring, and one point above the national average for negative scoring.
Inverclyde	I felt that the person who treated me was the right person	80	81	76-86	6	7	4-10	15th	Inverclyde is one point below the national average for positive scoring, and 1 point below the national average for negative scoring.
Inverclyde	I felt that I got the right treatment or advice	80	81	76-86	9	8	5-11	23rd	Inverclyde is one point below the national average for positive scoring, and 1 point above the national average for negative scoring.
Inverclyde	I felt that people took account of the things that matter to me	74	76	70-84	9	9	6-12	24th	Inverclyde is 2 points below the national average for positive scoring, and equal to the national average for negative scoring.
Inverclyde	People took account of the things that matter to me	88	86	80-92	4	4	0-8	10th	Inverclyde is 2 points above the national average for positive scoring, and equal to the national average for negative scoring.
Inverclyde	I had a say in how my help, care or support was provided	85	79	72-86	6	7	2-13	3rd	Inverclyde is 6 points above the national average for positive scoring, and one point below the national average for negative scoring.
Inverclyde	I was aware of the help, care and support options available to me	80	77	65-87	8	10	2-16	7th	Inverclyde is 3 points above the national average for positive scoring, and 2 points below the national average for negative scoring.

Inverclyde	I was treated with respect	92	92	86-92	1	2	0-6	11th	Inverclyde equals the national average for positive scoring, and is one point below the national average for negative scoring.
Inverclyde	I was treated with compassion and understanding	89	88	82-96	2	3	0-8	14th	Inverclyde is one point above the national average for positive scoring, and 1 point below the national average for negative scoring.
Inverclyde	My health and care services seemed to be well coordinated	79	76	60-85	7	9	4-15	11th	Inverclyde is 3 points above the national average for positive scoring, and 2 points below the national average for negative scoring.
Inverclyde	I was supported to live as independently as possible	88	84	78-92	5	4	1-9	9th	Inverclyde is 4 points above the national average for positive scoring, and one point above the national average for negative scoring.
Inverclyde	I felt safe	87	85	79-87	5	4	0-9	8th	Inverclyde is 2 points above the national average for positive scoring, and one point above the national average for negative scoring.
Inverclyde	The help, care or support improved or maintained my quality of life	88	85	77-92	3	4	0-7	3rd	Inverclyde is 3 points above the national average for positive scoring, and one point below the national average for negative scoring.
Inverclyde	I have a good balance between caring and other things in my life	70	69	62-78	10	13	8-20	10th	Inverclyde is one point above the national average for positive scoring, and 3 points below the national average for negative scoring.
Inverclyde	Caring has had a negative impact on my health and wellbeing	39	41	31-52	33	34	29-42	22nd	Inverclyde is 2 points below the national average for positive scoring, and one point below the national average for negative scoring.
Inverclyde	I have a say in services provided for the person I look after	49	51	41-62	18	20	13-28	18th	Inverclyde is 2 points below the national average for positive scoring, and 2 points below the national average for negative scoring.
Inverclyde	Local services are well coordinated for the person(s) I look after	44	44	35-58	20	22	17-28	13th	Inverclyde equals the national average for positive scoring, and is 2 points below the national average for negative scoring.
Inverclyde	I feel supported to continue caring	46	43	34-59	14	20	14-27	6th	Inverclyde is 3 points above the national average for positive scoring, and 6 points below the national average for negative scoring.
Inverclyde	Overall how would you rate the arrangements for getting to see a doctor and/or nurse in your GP practice? (Getting to see a doctor)	68	72	56-94	13	10	1-21	20th	Inverclyde is 4 points below the national average for positive scoring, and 3 points above the national average for negative scoring.
Inverclyde	Overall how would you rate the arrangements for getting to see a doctor and/or nurse in your GP practice? (Getting to see a nurse)	82	83	73-98	4	4	0-7	17th	Inverclyde is one point below the national average for positive scoring, and equals the national average for negative scoring.

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 15

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/39/2016/BM**
Contact Officer:	**Brian Moore**	**Contact No:**	**01475 712722**
Subject:	**Strategic Service Planning**		

1.0 PURPOSE

1.1 The purpose of this paper is to enable the Integration Joint Board to:-

- Give early consideration to the Board's proposed approach;
- Consider how the IJB wishes to engage in the proposed process;
- Respond to the NHS Board's request that early engagement in the process is established through the HSCPs patient and public engagement arrangements

2.0 SUMMARY

2.1 This attached paper has been approved by the NHS Board as the basis to develop a strategic plan for acute services (Appendix 1). Responsibility for strategic service planning is now shared between the Health Board and Integration Joint Boards and IJBs have been asked to consider how they wish to engage in the planning process.

2.2 The Health Board is responsible for the overall planning for acute services, working with IJBs on planning the delivery of unscheduled care and on the shaping of the primary care and community services which are critical to the delivery of acute care.

2.3 The IJB's are responsible for strategic planning for the health and social care services for which they are responsible and for the strategic commissioning of unscheduled care services.

2.4 The paper acknowledges the importance of the relationship to IJBs in this regard as:-

- Integration of planning for acute services with the planning led by IJBs for community and primary care services;
- Shaping of acute services to respond to IJBs Strategic Commissioning Plans, including forward financial planning.
- Achieving early patient and pubic engagement;

3.0 RECOMMENDATIONS

3.1 That the Integration Joint Board :-

- Note the process proposed by NHS Greater Glasgow and Clyde to develop a

strategic plan for acute services;
- Note the local arrangements established by the HSCP for engaging with the Acute sector.

Brian Moore
Corporate Director (Chief Officer)
Inverclyde HSCP

4.0 CURRENT POSITON ON STRATEGIC PLANNING FOR ACUTE SERVICES

4.1 The paper outlines the local, regional and national position on planning for acute services.

4.2 At **national level,** there are a series of programmes of work which will inform strategic planning and the National Clinical Strategy (NCS) was published in February 2016 following an extensive programme of development and engagement. The Strategy sets out a framework for the development of health services across Scotland for the next 10-15 years. It gives an evidence-based high level perspective of why change is needed and what direction that change should take. The Strategy sets out the case for:-

- Planning and delivery of primary care services around individuals and their communities;
- Planning hospital networks at a national, regional or local level based on a population paradigm;
- Providing high value, proportionate, effective and sustainable healthcare;
- Transformational change supported by investment in e-health and technological advances.

The full strategy can be found at:-

http://www.gov.scot/Publications/2016/02/8699

4.3 A further critical part of the national scene, particularly critical to the IJB is the work to develop a new GP contract which needs to provide the platform to enable the transformation of primary care.

4.4 There are well established regional planning arrangements which set the direction for a number of our services which are provided to populations beyond the Board area.

4.5 At NHS Board level there is a comprehensive Clinical Services Strategy approved by the Board in January 2015 and endorsed by the IJBs.

4.6 The key aims of that 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.

4.7 IJBs have published their first Strategic Commissioning Plans; these highlight the need for Partnerships to establish a real focus on changing the way their populations use hospital services in their future planning.

5.0 DEVELOPING THE STRATEGIC PLAN: PROPOSED PROCESS

5.1 The Board proposes a two stage process with the aim of developing and describing the changes we need to make in 2017/18 in the context of describing a longer term strategic change programme.

5.2 The first stage, to be completed by October 2016, is to update the key elements of

the Clinical Services Review including:-

- Population health analysis;
- Drivers for change;
- Future clinical models;
- Progress on implementation;
- An informed forward look at population and other changes which will require service transformation;
- A joint appraisal with IJBs of the implications of their strategic commissioning plans for the delivery of acute services;
- Analysis of service changes emerging from regional and national planning to deliver the National clinical strategy;
- An outline of proposed service changes for 2017/18 from the Acute Division's clinical planning processes, which are focused on delivering high quality, safe and sustainable care;
- A strategic service and estate appraisal of our hospital sites;
- An initial forward financial framework for acute services, developed with the Integration Joint Boards;

5.3 The NHS Board proposes extensive clinical engagement and engagement with wider stakeholders during this stage.

5.4 The output of this first stage would enable further discussion with IJBs with the aim that this work can be finalised to move to a second stage with the NHS Board approving for publication, and formal public engagement, proposed service changes for 2017/18 set in the context of a longer term strategic plan.

5.5 A series of meetings with colleagues from Acute Services in Clyde, including Clinicians, Planning and Operational managers, have already taken place over the last 12 months. These have focused on how we share information, develop services and plan for the future, as well as beginning to develop further the relationships required to effectively underpin the strategic responsibilities of the IJB. Close working on a range of operational issues, such as Winter Planning, Delayed Discharges and pathways supporting Older People, as well as the impact of interface working to improve the appropriateness of Orthopaedic Referrals, has already proven to assist our use of resources and improve the care and experience of our population.

6.0 CONCLUSION

6.1 The shape and delivery of acute services are critical to the responsibilities of the IJB and will also be an important issue for local people. Therefore active engagement as this work develops is important.

6.2 The NHS Board has committed to work with IJB Chief Officers to establish the detail of the required processes to develop proposed process.

7.0 IMPLICATIONS

FINANCE

7.1 **Financial Implications**:

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

7.2 There are no legal issues within this report.

HUMAN RESOURCES

7.3 There are no human resources issues within this report.

EQUALITIES

7.4 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.

8.0 CONSULTATION

8.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with Greater Glasgow & Clyde Planning Team.

9.0 BACKGROUND PAPERS

9.1 None.

APPENDIX 1

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde

NHS BOARD MEETING
28th June 2016

Catriona Renfrew
Director of Planning and Policy

Paper No: 16

Strategic Service Planning

Recommendation:

The Board consider the approach to Strategic planning for acute services.

1. Background and Purpose

1.1. This paper proposes a process for the strategic planning for acute services. The approach outlined will enable:-

- Coordination of our planning with the developing regional and national approaches.
- The wide engagement of our clinical staff in strategic planning;
- Integration of planning for acute services with the planning led by IJBs for community and primary care services;
- The shaping of acute services to respond to IJBs Strategic Commissioning Plans.
- The further development of our existing extensive planning;
- The delivery of early patient and pubic engagement;

1.2. This purpose of the paper is to enable the Board to contribute at this early stage to shaping the strategic planning process, informing the further development of the process.

2. Planning Roles and Responsibilities

2.1. Responsibility for strategic service planning is now shared between the Health Board and Integration Joint Boards.

2.2. The Health Board is responsible for the overall planning for acute services, working with IJBs on planning the delivery of unscheduled care and on the shaping of the primary care and community services which are critical to the delivery of acute care.

2.3. The IJB's are responsible for strategic planning for the health and social care services for which they are responsible and for the strategic commissioning of unscheduled care services;

3. Strategic direction and principles for planning

3.1. The Board already has a clear strategic direction which sets out our purpose as:

"***Deliver effective and high quality health 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 inequalities.***"

3.2. That purpose is amplified with five strategic priorities, these are:

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

3.3. In planning for 2016/17 the Board also developed a series of principles to establish a clear framework for planning. These principles, set out below continue shape our approach to planning, particularly our approach to the assessment of available resources and how they should be deployed.

- Make financial decisions which are in line with and enable us to move in coherence with our purpose, strategic direction and related strategies all of which are focussed on ensuring our services are focussed on the needs of patients.
- Continue to play our part in trying to reduce the inequalities which affect our population and have a strong focus on equality impacts in making our decisions.
- Ensure that our decisions do not have unintended consequences such as unplanned transfers of pressures, responsibilities or costs to other parts of the system.
- Aim to continue to deliver the key Scottish Government targets.
- Focus first on changes which make clinical and service sense and increase efficiency and productivity and reduce our unit costs.
- Ensure that where we propose to restrict access to services or stop planned developments we will have a clear framework for prioritisation of patient care linked to clinical benefit.
- Shift the balance of care and resources but also recognise the pressures on acute services.
- Test all new national initiatives and proposals which have financial implications against our strategy and report to Board for decision.
- Underpin our decision making with evidence about what delivers the safest, highest quality and most cost effective healthcare.
- Explicitly consider risks and benefits in making decisions.
- Remain committed to the importance of innovation and research to shape changes in the way we deliver care.
- Work across boundaries with other Health Boards and public bodies to identify ways in which we can deliver services more efficiently.
- Take a whole system approach not localised savings targets, that approach driven by:
  - cost scrutiny in every part of the organisation, led by the local teams; and
  - a whole system programme of change to deliver cost reduction.
- Commitment to engagement with patients and the wider public.
- Commitment to fully engage with our staff and their representatives in shaping, planning and delivering the changes to services which will be required

3.4. The Strategic Direction, strategic priorities and principles will underpin our approach to strategic planning for acute services.

4. Current position on strategic planning for acute services

4.1. This section describes the local, regional and national position on planning for acute services, which set the context within which this next phase of our planning will be developed.

4.2. At **national level,** there are a series of programmes of work which will inform our strategic planning. These include:-

- The work of the Transformation Board which is overseeing a range of reviews including for planning for seven day services, the review of out of hours services and the current maternity and neonatal services review.
- Service strategies including for cancer;
- Planning being established for future scheduled care capacity;

4.3. In addition to these elements of national direction, the National Clinical Strategy (NCS) was published in February 2016 following an extensive programme of development and engagement. The Strategy sets out a framework for the development of health services across Scotland for the next 10-15 years. It gives an evidence-based high level perspective of why change is needed and what direction that change should take. The Strategy sets out the case for:-

- Planning and delivery of primary care services around individuals and their communities;
- Planning hospital networks at a national, regional or local level based on a population paradigm;
- Providing high value, proportionate, effective and sustainable healthcare;
- Transformational change supported by investment in e-health and technological advances.

The full strategy can be found at http://www.gov.scot/Publications/2016/02/8699
The programe to establish the framework, which will enable implementation of the strategy, bringing together Scottish Government Directors with Board Chief Executives, is currently being established.

4.4. A final a critical part of the national scene is the work to develop a new GP contract which needs to provide the platform to enable the transformation of primary care.

4.5. At **Regional level,** there are well established planning arrangements which set the direction for a number of our services which are provided to populations beyond the Board area. The Regional Planning Group is discussing how to extend the range and depth of planning done at regional level to respond to the NCS and the growing reality that a wider range of services need to be planned for larger populations and that we need to create clinical networks for service delivery beyond Board boundaries.

4.6. At our **Board level** we have a comprehensive Clinical Services Strategy approved by the Board in January 2015 and since endorsed by the IJBs.

4.7. 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.

4.8. 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;

4.9. We have also developed a delivery plan for the Acute Division which focuses on resolving short term challenges but also describes a series of strategic service issues which we need to address.

4.10. IJBs have published their first Strategic Commissioning Plans, these highlight the need for Partnerships to establish a real focus on changing the way their populations use hospital services in their future planning.

5. Developing our Strategic Plan: proposed process

5.1. We know from our planning for 2016, and from the material outlined in the previous section, that it is imperative that we reshape acute services in the short, medium and longer term. Our proposed approach is to bring together those three horizons for planning into an integrated process so that we develop and describe the changes we need to make in 2017/18 in the context of describing a longer term strategic change programe.

5.2. To begin this process it is proposed that we complete a series of strands of work for consideration by a Board seminar in October 2016. The proposed strands are:-

An update of the key elements of the Clinical Services Review including:-

- Population health analysis;
  Drivers for change;
- Future clinical models;
- Progress on implementation;
- An informed forward look at population and other changes which will require service transformation;
- A joint appraisal with IJBs of the implications of their strategic commissioning plans for the delivery of acute services;
- Analysis of service changes emerging from regional and national planning to deliver the National clinical strategy;
- An outline of proposed service changes for 2017/18 from the Acute Division's clinical planning processes, which are focussed on delivering high quality, safe and sustainable care;
- A strategic service and estate appraisal of our hospital sites;

5.3. We also need to produce an initial forward financial framework for acute services, developed with the Integration Joint Board's;

5.4. The development of each of these strands will include extensive clinical engagement and engagement with wider stakeholders including other Boards and Scottish Government

5.5. The Acute services Committee will receive regular updates as this work develops to ensure continuing Non Executive input. Following the October Seminar, enabling the Board to consider and shape this material, there would be further discussion with IJBs with the aim that this work can be finalised to enable the Board to approve for publication, and public engagement, proposed service changes for 2017/18 set in the context of a longer term strategic plan.

6. Conclusion

6.1. Subject to the Board discussion the Board Executive team will work with IJB Chief Officers to establish the required processes to develop the material outlined in this paper.

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 16

Report To:	**Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore** **Corporate Director** **Inverclyde Health & Social Care Partnership (HSCP)**	**Report No: IJB/50/2016/HW**	
Contact Officer:	**Helen Watson** **Head of Service** **Planning, Health Improvement & Commissioning**	**Contact No: 01475 715285**	
Subject:	**CHIEF OFFICER'S REPORT**		

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on a number of workstreams that are currently underway.

2.0 SUMMARY

2.1 As we move forward, there are a number of issues or business items or workstreams that the IJB will want to be aware of, that perhaps do not require a full IJB Report. IJB members can of course ask that more detailed reports are developed in relation to any of the topics covered. 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 notes the Chief Officer's Report and advises the Chief Officer if any further information is required.

3.2 That the Integration Joint Board approves the revised template for IJB Reports.

Brian Moore
Corporate Director, (Chief Officer)
Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

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

4.2 Community Weight Management Service

In April 2016 NHS Greater Glasgow and Clyde Local Medical Committee outlined support for the introduction of both self-referral and primary care referral options for the community weight management service. The service involves referral to Community Weight Management (Weight Watchers) and the Specialist GGCWMS service - patients will be directed to the most appropriate service based on co morbidities and weight by the weight management admin hub. Patients can also self-refer if they have established Diabetes, Stroke and CHD.

Anyone who is eligible for the Weight Watchers Programme will get:

- Twelve weeks free membership to Weight Watchers, attending any meeting of their choice.
- They will be given access to online Weight Watchers tools.
- In addition they will be permitted two holiday weeks and two unforeseen circumstance weeks in a sixteen week period.
- People, who successfully lose 5kg and meet the attendance criteria of twelve weeks participation are eligible for a further twelve week block. Subsequent blocks are available based on continued weight loss and attendance until a healthy weight is achieved.

Promotional materials will be distributed to all GP practices, and patients will be able to call the administration hub directly by the first week in August. In addition, it is planned to actively promote the service with the most deprived practices and a series of local roadshows will be undertaken in targeted health centres to raise awareness with both staff and self-referral patients. It is anticipated the Inverclyde roadshows will take place at the beginning of August. Your local Health Improvement Team is involved in the planning of these events.

In addition to the above we continue with the Weigh to Go Programme that has been delivered in Inverclyde since 2013. This programme offers support through access to weight management services and physical activity opportunities to young people aged 15 – 18 years who are concerned about their weight and meet the eligibility criteria. In Inverclyde an encouraging 65% of those taking part have lost weight with almost 12% losing 5% of their body mass. The pilot is due to finish in October 2016. There are proposals being discussed currently on how to take it forward. The final evaluation will be available in 2017.

4.3 Telecare/Telehealth Funding

In February 2016, Inverclyde HSCP submitted a bid for TEC (Technology Enabled Care) Programme funding from the Scottish Government. While not all requests for funding were supported, a formal offer of grant amounting to £200,000 was awarded to Inverclyde HSCP on 6th July 2016 to develop and upscale Technology Enabled Care.

Areas to be developed include:-

- Recruit a Project Lead post to oversee the planning and implementation of the Technology Enabled Care Programme within Inverclyde.
- Recruit a part time Trainer post to take forward engagement with all stakeholders in raising awareness of the benefits of TEC.

- Upscale the use and improve joint working with local nursing homes; Scottish Fire and Rescue Service; Intermediate Care; local Falls Pathway; post diagnostic support for those with Dementia and the rolling out of I-Care Assessment kits.

It is anticipated that the funding will benefit up to 800 individuals within the community over the 2 year funding period from 2016-2018.

4.4 Update on Named Persons Following Supreme Court Decision

The Children and Young People Act 2014 introduced a Named Person Service for all children in Scotland aged 18 and under. It is the intention that this part of the act commences on the 31st August 2016. The service is working to ensure that the Named Person arrangements can be delivered by that date. However, there has been a statement from the Cabinet Secretary indicating that there is a potential for a delay in implementing this part of the act as a consequence of an appeal to the Supreme Court.

4.5 Update on People Plan

We are required to develop a workforce plan by April 2017, which should encompass our HSCP Organisational Development Plan and an HSCP Training Plan. We also need to profile our current and future required workforce; to consider our position in relation to supporting volunteering, our approach to engaging carers as equal partners in care and workforce development in the provider/ partner sector as well as internal to the HSCP.

4.6 We have a multi-agency People Plan Working Group (PPWG) in place, as a sub group of the Strategic Planning Group. The PPWG has developed some core principles for integrated people planning as follows –

Mindful - We will make time to actively listen and reflect to inform our approach.

Transparent - We will develop and review the People Plan in a transparent and inclusive way reflecting the current and future needs of our health and social care community - bottom up and top down.

Respect - We will ensure the People Plan develops skills across our health and social care community by respecting the diverse needs of all individuals.

Prepared - Our People Plan will help our people be informed, skilled, committed, supported and empowered to meet the opportunities and challenges within our community both now and in the future.

Connections - Our People Plan will support us to make connections to complement, extend and innovate in our practice.

Fair - We will promote fair access to development opportunities.

Share - We will use the People Plan to share ideas, skills and resources to inform and respond to decisions to achieve the best outcomes for our people and our communities.

Inclusive - We will strive to meet the needs and expectations of our community by embracing difference and maximising opportunities.

4.7 Our People Profile will be presented around four main categories of ‘People’ as follows:

1: People who are registered with a regulatory /professional body to deliver health and social care as an individual professional practitioner.

2: People who are employed to deliver health and social care in Inverclyde, but not specifically registered to do so as a practitioner.

3: two parts

(a) People who contribute to the provision of health and social care in Inverclyde in the course of their work;
(b) People who contribute to the provision of health and social care in a voluntary, non-employed capacity.

4: People in the community of Inverclyde, in workplaces, in shops and businesses and in community groups who can make a difference to outcomes for local people.

4.8 The PPWG has commissioned a piece of work across its membership to review the outcome of a range of surveys of the local people resource to determine how engaged people currently feel, and how prepared/ supported they are to undertake their respective roles. In addition, we have embarked on a review of volunteering in health and social care locally to determine the extent and nature of volunteering across Inverclyde linked to supporting people with health and social care needs – either as volunteers themselves or supported by volunteers.

4.9 Our approach in developing our People Plan is ambitious. Most other partnerships across the country are only undertaking one or other aspect to the People Plan (e.g. workforce profiling or workforce development). Most are keeping planning for development of the workforce very separate to each agency. We are an ambitious partnership with good grounding in this area so are keen to be progressive. There are risks we are alive to that all of the training and development identified as a result of People Plan cannot be met within existing resources across the partners and may require specific development/ investment to deliver. The People Plan aims to respond to this exploring where interagency collaboration can help meet that challenge.

4.10 Care Inspectorate Report on Inverclyde Care and Support at Home Service & Care Services

4.11 The Care Inspectorate carried out an unannounced inspection for Hillend Day Service on 21 January 2016 and for Care and Support at Home on Thursday 12 May 2016. Reflecting the history of previous inspections, these were carried out on a low intensity basis.

4.12 A full public report of the inspection and grades is published for both services on the Care Inspectorate website.

4.13 The summary of grades awarded is:-

Care & Support at Home

Quality of care and support	5 Very Good
Quality of staffing	5 Very Good

Hillend Day Service

Care & Support	5 Very Good
Environment	6 Excellent
Staffing	5 Very Good
Management & Leadership	5 Very Good

4.14 **Conclusion of inspections:**

Care & Support at Home is a very well-liked and well-received service by the people who use it. The staff in the service work hard to improve standards of care whilst promoting independence and person-centred care. There is a very good culture of learning and continuous improvement. Some elements of the service are innovative. The service is prepared to try new ideas with the involvement of people who use the service at every stage. Any areas for improvement that have been identified at this inspection are clearly understood by the provider and we are confident that they will work hard to address these.

Hillend Day Service continues to provide an overall very good standard of service to people who attend. The management and staff team continue to focus their efforts to ensure that service users are involved in the decision making processes. The service users we spoke to were very complimentary and appreciative of the centre and in particular the quality of the staff team. We found the staff to be welcoming, helpful and friendly. There was a very good atmosphere within the centre and service users and their families valued this.

The grades awarded reflect that Inverclyde's Care & Support at Home and Hillend Day Services continue to maintain very high standards. Continuous improvements in the services have been noted by the Care Inspectorate, enabling both the services to sustain gradings from previous years.

4.15 Sod Cutting – New Mental Health Inpatient Continuing Care Beds Facility (Orchard View)

Progress continues to be made in taking forward the redesign of Mental Health services. Preparations are underway for a Ministerial visit on 11 August to formally "cut the turf" to commence the next stage of the formal work. Whilst largely symbolic as a gesture, it does mark the commencement of long-anticipated building work.

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.

5.2 Revised Template for IJB Reports

Our Integration Scheme lays out how we intend to deliver improved outcomes under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014. In the spirit of the legislation, all that we do should contribute to delivering better outcomes for the people who use our services. Clearly we have a responsibility to be explicit and transparent in our business and how our work contributes to the Inverclyde Equality Outcomes and the nine National Wellbeing Outcomes. On that basis, it is proposed that the current template used for IJB reports is amended to include new sections that require officers to describe how the subject of the report contributes to delivery of these important outcomes. A draft of the proposed new template is appended for consideration and approval.

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 None

APPENDIX

AGENDA ITEM NO:

Report To:	**Inverclyde Integration Joint Board**	**Date:**	
Report By:	**Brian Moore** **Corporate Director, (Chief Officer)** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	
Contact Officer:	**Head of Service**	**Contact No:**	
Subject:			

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board…..

2.0 SUMMARY

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3.0 RECOMMENDATIONS

3.1 The Integration Joint Board ……

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Brian Moore
Corporate Director, (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

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5.0 IMPLICATIONS

FINANCE

5.1 **Financial Implications**:

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/are no legal issues within this report.

HUMAN RESOURCES

5.3 There are/are no human resources issues within this report.

EQUALITIES

5.4 There are/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.

5.4.1 How does this report address our Equality Outcomes.

5.4.1.1 People, including individuals from the above protected characteristic groups, can access HSCP services.

5.4.1.2 Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.

5.4.1.3 People with protected characteristics feel safe within their communities.

5.4.1.4 People with protected characteristics feel included in the planning and developing of services.

5.4.1.5 HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.

5.4.1.6 Opportunities to support Learning Disability service users experiencing gender based violence are maximised.

5.4.1.7 Positive attitudes towards the resettled refugee community in Inverclyde are promoted.

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are /are no governance issues within this report.

5.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes.

5.6.1 People are able to look after and improve their own health and wellbeing and live in good health for longer.

5.6.2 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.

5.6.3 People who use health and social care services have positive experiences of those services, and have their dignity respected.

5.6.4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

5.6.5 Health and social care services contribute to reducing health inequalities.

5.6.6 People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.

5.6.7 People using health and social care services are safe from harm.

5.6.8 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.

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 …….

7.0 LIST OF BACKGROUND PAPERS

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