# Notice of Meeting and Agenda
# Renfrewshire Health & Social Care Integration Joint Board

| Date | Time | Venue |
|---|---|---|
| Friday, 15 January 2016 | 09:30 | Council Chambers (Renfrewshire), Council Headquarters, Renfrewshire House, Cotton Street, Paisley, PA1 1AN |

KENNETH GRAHAM
Head of Corporate Governance

## Members

Councillor Iain McMillan: Councillor Derek Bibby: Councillor Jacqueline Henry: Councillor Michael Holmes: Donny Lyons: John Brown: Donald Sime: Morag Brown: Karen Jarvis: Stephen McLaughlin: Alex Thom: Liz Snodgrass: David Wylie: Alan McNiven: Helen McAleer: Stephen Cruickshank: John Boylan: Graham Capstick: David Leese: Sarah Lavers: Peter Macleod.

Councillor Iain McMillan (Chair) and Donny Lyons (Vice Chair)

## Further Information

This is a meeting which is open to members of the public.

A copy of the agenda and reports for this meeting will be available for inspection prior to the meeting at the Customer Service Centre, Renfrewshire House, Cotton Street, Paisley and online at www.renfrewshire.cmis.uk.com/renfrewshire/CouncilandBoards.aspx

For further information, please either email democratic-services@renfrewshire.gov.uk or telephone 0141 618 7112.

## Members of the Press and Public

Members of the press and public wishing to attend the meeting should report to the customer service centre where they will be met and directed to the meeting.

## Apologies
Apologies from members.

## Declarations of Interest
Members are asked to declare an interest in any item(s) on the agenda and to provide a brief explanation of the nature of the interest.

**9** **Audit Scotland Health and Social Care Integration Report** **85 - 142**
Report by Chief Officer.

**10** **Draft Strategic Plan for Consultation** **143 - 218**
Report by Chief Officer.

**11** **Date of next meeting**
Note that the next meeting will be held at 9.30 am on 18 March, 2016. Venue to be confirmed.

## Development Session
Please note that following the meeting there will be a presentation on the Clinical Services Review.

# Minute of Meeting
# Renfrewshire Health & Social Care Integration Joint Board

| Date | Time | Venue |
|---|---|---|
| Friday, 20 November 2015 | 09:30 | Rooms 1 & 2, Johnstone Town Hall, 25 Church Street, Johnstone PA5 8FA, |

**PRESENT**

Councillors Iain McMillan, Michael Holmes, Eddie Devine (substitute for Councillor Jacqueline Henry) and B Brown (substitute for Councillor Derek Bibby) (Renfrewshire Council); Donny Lyons, John Brown, Donald Sime and Morag Brown (Greater Glasgow & Clyde Health Board); Karen Jarvis (Registered Nurse); Alex Thom (Registered Medical Practitioner (non-GP)); Liz Snodgrass (Council staff member involved in service provision); Alan McNiven (third sector representative); Helen McAleer (unpaid carer residing in Renfrewshire); Stephen Cruickshank (service user residing in Renfrewshire); John Boylan (trade union representative for Council staff); Graham Capstick (trade union representative for Health Board staff); David Leese, Chief Officer and Sarah Lavers, Chief Finance Officer (both Renfrewshire Health and Social Care Partnership).

**CHAIR**

Councillor Iain McMillan, Chair, presided.

**IN ATTENDANCE**

Ken Graham, Head of Corporate Governance, Anne McMillan, Head of Resources and Elaine Currie, Senior Committee Services Officer (all Renfrewshire Council); and I Beattie, Head of Adult Services, Jean Still, Head of Administration, Fiona Mackay, Head of Planning & Health Improvement, Mandy Ferguson, Operational Head of Service, Katrina Philips, Head of Mental Health, Addiction and Learning Disability Services, Sheila Brown, Admin Development Manager, Frances Burns, Health and Social Care Integration Programme Manager and James Higgins, Project Officer-Health and Social Care Integration (all Renfrewshire Health and Social Care Partnership).

**APOLOGIES**

Councillors Derek Bibby and Jacqueline Henry and Peter Macleod, Chief Social Work Officer (all Renfrewshire Council); Stephen McLaughlin (registered Medical Practitioner (GP)) and David Wylie (Health Board staff member involved in service provision).

## DECLARATIONS OF INTEREST

There were no declarations of interest intimated prior to the commencement of the meeting.

## 1 MINUTE

The Minute of meeting of the Integration Joint Board held on 18 September, 2015 was submitted.

It was noted that Morag Brown was in attendance at the meeting.

**DECIDED:** That the Minute, subject to the above amendment, be approved.

## 2 OVERVIEW OF THE DEVELOPMENT OF GOVERNANCE ARRANGEMENTS

Under reference to item 7 of the Minute of the meeting of this Joint Board held on 18 September, 2015 the Chief Officer submitted a report relative to the programme of work being undertaken to ensure that all the necessary processes, policies and plans were in place as required to allow local implementation of integrated health and social care services by 1 April, 2016 in terms of the Public Bodies (Joint Working) (Scotland) Act 2014.

Progress made in terms of communication and engagement, strategic plan, performance management and finance and audit were detailed in the report and the appendix to the report.

**DECIDED:** That the planned activity and reporting dates for the key legislative and other commitments to put in place sound governance arrangements for the Renfrewshire Health and Social Care Partnership from 1 April, 2016 be noted.

## 3 FINANCIAL REPORT - PERIOD 6

The Chief Finance Officer submitted a report relative to the revenue and capital budget positions from 1 April to 18 September, 2015 for Social Work and from 1 April to 30 September, 2015 for the Health Board.

The report intimated that the budget strategy for 2016/17 had commenced for both partners. The Partnership had submitted detailed proposals for service based services to Renfrewshire Council and had identified future demand and pressures and potential corresponding mitigation for Council approval. It was anticipated that the outcome of this process would be finalised towards the end of the calendar year and a summary of the agreed proposals would be submitted to a future meeting of the Joint Board for information.

The financial planning process for NHService Greater Glasgow and Clyde for 2016/17 had currently identified a draft savings target of between £60m to £64m. The final savings target would be dependent on the nationally agreed uplift and this would not be clarified until at least Spring 2016. However, it was expected that the level of cash releasing savings for the NHS element in the Health and Social Care Partnerships across NHS Greater Glasgow & Clyde would be between £18m and £23m, making the local savings target for Renfrewshire significantly higher than in any previous year. Further discussions at NHS Board level would be required in order for Partnerships to be able to deliver cash releasing savings through collectively agreed service and efficiency programmes.

**DECIDED:**

(a) That the financial position to date be noted; and

(b) That it be noted that the financial planning process for 2016/17 was now underway.

## 4 RISK MANAGEMENT UPDATE

Under reference to item 15 of the Minute of the meeting of this Joint Board held on 18 September, 2015 the Chief Officer submitted a report relative to the progress being made with regards to the specific risks reported previously and information on new risks being added. The appendix to the report detailed a list of social work and health key risks in order that the Joint Board had awareness at this time of the more operational risks being managed by the Joint Board's partner organisations.

**DECIDED:** That the progress being made in managing the key risks identified be noted.

## 5 RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE MANAGEMENT REPORT 2015/16

Under reference to item 19 of the Minute of the meeting of this Joint Board held on 18 September, 2015 the Chief Officer submitted a report relative to the mid-year update on the agreed performance scorecard for 2015/16, which formed the appendix to the report, together with an outline of the further work to be undertaken to develop a Performance Management Framework for 2016/17.

**DECIDED:**

(a) That the mid-year update on the 2015/16 performance scorecard, as detailed in the appendix to the report, be noted. The Joint Board would receive a further performance update for year end, April 2015 to March 2016, in June 2016. It should be noted that the indicators in the scorecard are reported at a number of frequencies and that information may not always be available at the end of a reporting period. Updates would include all information available at that point; and

(b) That the Outcomes and Performance Management Integration Work Stream take forward the development of the Health and Social Care Partnership 2016/17 Performance Management Framework as outlined in the report to the Joint Board on 18 September, 2015. A Performance Management Framework for 2016/17 would be submitted to the Joint Board in March 2016.

## 6 RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP WINTER PLAN 2015/16

The Chief Officer submitted a report relative to the Renfrewshire Health and Social Care Partnership's Winter Plan 2015/16.

The report intimated that Health Boards had received guidance from the Scottish Government to support planning and preparation for winter 2015/16. Health Boards required to be satisfied that potential disruption to NHS services, patients and carers was minimised.

Health and Social Care Partnerships in NHS Greater Glasgow and Clyde had produced Winter Plans to support the NHS Greater Glasgow and Clyde Board Winter Plan. The Winter Plan for Renfrewshire had been produced by the Health and Social Care Partnership in collaboration with acute services and Renfrewshire Council. The final draft of the Winter Plan formed the appendix to the report.

**DECIDED:** That the Renfrewshire Health and Social Care Partnership's draft Winter Plan for 2015/16 be noted.

## 7 FIRST DRAFT STRATEGIC PLAN

Under reference to item 18 of the Minute of the meeting of this Joint Board held on 18 September, 2015 the Chief Officer submitted a report relative to the first draft of the Strategic Plan in line with the requirements of integration legislation. The first draft of the Strategic Plan formed the appendix to the report.

The report intimated that at the meeting of the Joint Board held on 18 September, 2015, the approach for developing the Strategic Plan and the proposed structure and content of the Strategic Plan had been approved. In line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, the Joint Board remitted these proposals to the local Strategic Planning Group seeking members' views. The first draft Strategic Plan had now been developed in line with legal requirements and reflected national guidance on the joint strategic commissioning process.

In line with the process and timeline previously approved, the first draft of the Strategic Plan, once approved, would be remitted to the Strategic Planning Group seeking members' views. Thereafter the views gathered would be taken into account when preparing the second draft for the Joint Board's consideration at its meeting to be held on 15 January, 2016. Subject to approval of the second draft of the Strategic Plan, a formal consultation exercise would be undertaken with stakeholders and feedback would be taken into account when preparing the final draft.

At this time, it was proposed that the draft final version of the Strategic Plan would be reported to the Council and the Health Board and shared with Joint Board members during February 2016 and submitted to the Joint Board meeting to be held on 18 March, 2016 for approval.

It was proposed that the information contained in diagram 6 of the Strategic Plan include information on the number of unpaid carers and the work they do and that the information concerning the level of activity carried out in a typical week be at the same point of time. This was agreed.

**DECIDED:**

(a) That the Joint Board consider the themes emerging from the views expressed by Strategic Planning Group members on the Strategic Plan proposals;

(b) That the approach adopted to take account of the views expressed by Strategic Planning Group members be noted;

(c) That the change to the strategic planning timeline to facilitate reporting to appropriate governance bodies be noted;

(d) That diagram 6 of the Strategic Plan be amended to include information on the number of unpaid carers and the work they do and that the information concerning the level of activity carried out in a typical week be at the same point of time;

(e) That the first draft of the Renfrewshire Health and Social Care Partnership Strategic Plan be approved; and

(f) That the first draft Strategic Plan be remitted to the Strategic Planning Group to seek its members' views in line with legislative requirements.

## 8 ESTABLISHMENT OF AN AUDIT COMMITTEE

Under reference to item 14 of the Minute of the meeting of this Joint Board held on 18 September, 2015 the Chief Officer submitted a report relative to the establishment of an Audit Committee from 1 April, 2016. The draft Terms of Reference and Procedural Standing Orders for the Audit Committee formed the appendix to the report.

The report intimated that in developing the Terms of Reference, due regard was given to the national financial guidance developed by the Integrated Resources Advisory Group to support effective health and social care integration, which recommended that appropriate and proportionate arrangements should be put in place; national professional best practice guidance on audit committee principles as set out in CIPFA's recent Position Statement on this subject; and emerging practice in other Partnerships in the NHS Board area and across Scotland.

An Audit Committee was a key component of the Joint Board's governance framework. Its core function was to provide the Joint Board with independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of the financial reporting and annual governance processes.

The effectiveness of the arrangements for the operation of the Joint Board Audit Committee would be reviewed after its first full year of operation to ensure that the arrangements remained fit for purpose.

**DECIDED:** That the establishment of an Audit Committee from 1 April, 2016, the terms of reference and standing orders for which were detailed in the appendix to the report, be approved.

## 9 PARTICIPATION, ENGAGEMENT AND COMMUNICATION STRATEGY

The Chief Officer submitted a report relative to the development of a Participation, Engagement and Communication Strategy, which formed the appendix to the report.

The report intimated that in terms of the Integration Scheme, the Joint Board required to develop and approve a Participation and Engagement Strategy within six months of the Joint Board being legally established. When the Strategy was in place, a 2016/17 Participation, Engagement and Communication Implementation/Action Plan would be developed which would set out how the Partnership would deliver on its Participation, Engagement and Communication objectives through a defined set of actions.

**DECIDED:**

(a) That the Participation, Engagement and Communication Strategy, which underpinned how the Joint Board would ensure it had a clear and effective participation and engagement approach which put co-production at the heart of reforming health and social care service; effectively deliver its Strategic Plan which outlined how it will progress and deliver on the agreed 9 national outcomes; enable the Partnership's vision and make it a reality; and inform decision making processes in the carrying out of integration functions be approved;

(b) That it be noted that this Strategy would be subject to an annual review which would be shared with the Joint Board;

(c) That it be noted that a 2016/17 Participation, Engagement and Communication Implementation/Action Plan would be developed when the Strategy was in place; and

(d) That it be noted that regular Participation, Engagement and Communication updates would be submitted to the Joint Board.

## 10 DATE OF NEXT MEETING

It was noted that the next meeting of the Integration Joint Board would be held on Friday, 15 January, 2016 at 9.30 am. Members would be advised of the venue when confirmed.

**To:** **Renfrewshire Integration Joint Board**

**On:** **15 January 2016**

**Report by:** **Chief Finance Officer**

**Heading:** **Financial Report 1st April to 30th November 2015**

## 1. Purpose

1.1. The purpose of this report is to advise the Integration Joint board (IJB) of the Revenue and Capital Budget current year position as at the 13th November (Social Work) and 30th November 2015 (Health).

## 2. Recommendation

2.1. That the Integration Joint Board:

a) are requested to note the financial position to date.
b) note that the progress of the financial planning process for 2016/17
c) note the progress to date on due diligence
d) the Chief Officer is delegated responsibility for issuing directions to the Constituent bodies (Renfrewshire Council and NHS Greater Glasgow and Clyde), in consultation with the Chair and Vice Chair of the IJB, by 1 April 2016

## 3. Summary

3.1. The overall revenue position for the HSCP at 30th September is an underspend of £28k as detailed in the table below (and appendices 1 and 2).

| Division | Current Reported Position | Previously Reported Position |
|---|---|---|
| Social Work – Adult Services | Breakeven | Breakeven |
| Renfrewshire Health Services | £27k underspend | £23k underspend |
| **Total Renfrewshire HSCP** | **£27k underspend** | **£23k underspend** |

3.2. The key pressures are highlighted in section 4 and 5.

**4.** **Social Work – Adult Services**

**Current Position:** **Breakeven**
**Previously Reported:** **Breakeven**

4.1 **Older People**

Current Position: Net underspend of £23k
Previously Reported: Net underspend of £13k

As previously reported, the net underspend within Older People services is due to an underspend in the external care home placement budget reflecting higher than anticipated turnover levels offset by significant pressures within the care at home service.

In addition to pressures within the care at home service, there continues to be an under recovery of income from the Council's residential Care Homes reflecting current occupancy levels.

4.2 **Physical Disabilities**

Current Position: Net overspend of £53k
Previously Reported: Net overspend of £41k

As previously reported, this overspend is due to increases in the purchase of equipment to support service users to stay in their own homes reflecting the shift in the balance of care to the community and their associated needs.

4.3 **Learning Disabilities**

Current Position: Net under spend of £155k
Previously Reported: Net under spend of £131k

This underspend is mainly due to the time taken to recruit to new posts within the Learning Disability day services, the majority of which have now been filled. This underspend offsets an overspend on the Adult Placement budget reflecting increased changes in the budget profile in relation to the funding of SDS packages.

4.4 **Mental Health**

Current Position: Net overspend of £30k
Previously Reported: Net overspend of £29k

This overspend is mainly due to higher than anticipated payroll costs.

4.5 **Addictions**

Current Position: Net overspend of £94k
Previously Reported: Net overspend of £71k

This overspend is mainly due to higher than anticipated payroll costs.

**5.** **Renfrewshire Health Services**

**Current Position:** **£27k Underspend**
**Previously Reported:** **£23k Underspend**

5.1 **Addictions**

Current Position: Net underspend of £148k
Previously Reported: Net underspend of £89k

This underspend is mainly due to lower than anticipated payroll costs reflecting the position staff are currently placed on the pay scale, along with slippage in the filling of vacant posts due to the timescales involved in the recruitment process.

5.2 **Adult Community Services**

Current Position: Net overspend of £54k
Previously Reported: Net overspend of £43k

As previously reported, this net overspend reflects: continued pressure on the community equipment budget (EQUIPU); overspends on the salaries within RES (Rehabilitation and Enablement Service) where additional physiotherapy staff have been employed to focus on the reduction of waiting list times, there is also increased pressure in relation to District Nurse travel costs due to the increase in FTE following the recent recruitment drive.

These overspends are partially offset by underspends within the podiatry service where there are a number of vacancies.

5.3 **Children's Services**

Current Position: Net underspend of £173k
Previously Reported: Net underspend of £144k

Overall, Children's Services are reporting an underspend of £173k. This is mainly due to general nursing underspends within Specialist services reflecting delays in the filling of posts associated with the service redesign, and CAMHS (Children and Adolescent Mental Health Services) due to ongoing recruitment issues for psychologists.

5.4 **Learning Disabilities**

Current Position: Net overspend of £55k
Previously Reported: Net overspend of £31k

The overspend within Learning Disabilities is due to costs associated with speech therapy agency staff, who will be required until the current service redesign process is completed. There is also additional pressure in relation to medical agency locum fees covering long term sickness; this is likely to continue into 2016/17.

5.5 **Hosted Services**

Current Position: Net underspend of £153k
Previously Reported: Net underspend of £130k

As previously reported, this underspend reflects historical underspends within the service due to vacant administrative and special project posts.

5.6 **Mental Health**

Current Position: Net overspend of £137k
Previously Reported: Net overspend of £86k

Overall, Mental Health services are reporting an overspend of £137k. As previously reported, this overspend is due to a number of contributing factors within both adult and in-patient services which are offset by an underspend within the adult community budget due to vacancies within the service.

The main overspends within the in-patient services relate to costs associated with significant numbers of patients requiring enhanced levels of observation across all ward areas. Staffing for enhanced observations is unfunded, and as a result reliance is on the nurse bank to provide safe staffing levels to meet level of demand and activity. In addition, there are emerging pressures in relation to maintaining the recommended safe staffing and skill mix for registered nurse to bed ratios.

These areas will continue to be the subject of ongoing monitoring and review.

5.7 **Other Services**

Current Position: Net overspend of £183k
Previously Reported: Net overspend of £177k

The overspend within other services is mainly in relation to the impact of the 15/16 workforce planning savings.

5.8 **Prescribing**

Current Position: Breakeven
Previously Reported: Breakeven

Overall, for NHSGG&C the prescribing budget is currently showing an overspend of £1.4m, and it is unlikely that a year end break-even position will be achievable despite the application of non-recurring funding which is being used to partially offset the current overspend.

For HSCP's the forecast remains a breakeven as the Board's intention is to maintain the risk sharing arrangement and not to pass any over-spends to the HSCPs in 2015/16. However, this will be kept under review in light of the Board's financial position.

6. **2015/16 Capital Programme**

| Description | Original Budget | Revised Budget | Spend to Date | Still to Spend |
|---|---|---|---|---|
| Anchor Centre Roof Replacement | £400k | £310k | £0k | £310k |
| **Total SW** | **£400k** | **£310k** | **£0k** | **£310k** |
| | | | | |

As previously highlighted, work on the Anchor Centre roof has been delayed until April 2016, due to potential weather difficulties over the winter months. The cost of the works which was originally estimated at £400k has now been reduced to £310k based on the results of the feasibility study. The works are currently out to tender and it is anticipated that the contract will be awarded early in 2016.

**7. Due Diligence Process Update**

7.1 The Chief Officer and Chief Finance Officer have been working with the NHS Board Finance Director and the Council's Director of Finance and Resources to carry out the required financial due diligence work, in line with Scottish Government guidance. The due diligence process is required to ensure that resources delegated on 1 April 2016 are sufficient for the Integrated Joint Board (IJB) to carry out its functions.

7.2 This process ensures consistency in approach, setting out continuing pressures, demands and associated risks in relation to the delegated functions and identifies relevant and necessary management action to be taken, including any baseline funding adjustments. This process will enable the Chief Finance Officer to advise the IJB whether the budgets being transferred by both partners to the IJB are acceptable and adequate to meet anticipated levels of demand to allow the HSCP to proceed on a sound financial basis.

7.3 It is however recognised that the budget set for any large scale, complex public sector organisation will never be free of risk and will always require careful, diligent and pro-active management throughout the financial year, to manage risk and planned and unplanned demand and pressures. The IJB will be no different in this regard. Officers within the Council, the Chief Officer and Chief Financial Officer of the IJB, and the Director of Finance from NHSGG&C will continue to develop and appropriately support the completion of the financial due diligence process by March 2016.

7.4 The budget setting process for both partner organisations is set against a context of emerging risks relating to:

- the uncertainty around the impact of the 2016/17 Local Government Settlement on HSCP budgets
- the delays in the allocation of the 2016/17 health budget and its possible impact on HSCP budgets

- the well documented demographic pressures facing Renfrewshire, and Scotland, as a result of an ageing population including: considerable growth in the older adult (65+) population and the consequent rise in people with complex health and social care needs resulting from increased life expectancy and improved treatments which enable people to live into very old age.
- Health inequalities also continue to pose a challenge for services, with large differences in life expectancy between affluent and more deprived areas, and higher than average rates of hospitalisation for a number of chronic conditions, particularly those linked to unhealthy lifestyles such as smoking, excessive alcohol consumption and drug misuse.

7.5 In terms of Council adult social care budgets, over recent years Social Work services have managed a number of demographic and financial pressures within the service through a range of demand and cost mitigation measures in order to minimise the level of additional investment by the Council. The strategy for 2016/17 remains consistent with this approach, building on ongoing proactive work within the service with a focus on shifting the balance of care to community based settings.

7.6 The main pressures relating to adult social care services are in relation to demographics and increased demand from adult protection related issues. The impact of these, along with the anticipated inflationary increases on externally provided services, are summarised below:

- Impact of increasing demand in relation to adult protection referrals on adult protection
- Anticipated inflationary increases on the National Care Home and Care at Home contracts
- Impact of Demographic Growth
- Impact of the introduction of new national insurance pressures in relation to new state pension arrangements for 2016/17

7.7 In addition to the above, the IJB should also be aware of potential pressures emerging from the impact of national government commitments on both the minimum and living wage.

7.8 As well as the adult social care budget, additional Council budgets require to be delegated for functions which have not historically sat within social care services, namely Housing Adaptations and Gardening Assistance. These functions must be delegated to the IJB by 1 April 2016 under the Public Bodies (Joint Working) (Scotland) Act 2014. It is acknowledged that there are demand pressures in relation to the housing adaptations budget, and more detailed review work is underway to quantify what risk this presents to the IJB, and what mitigating action can be taken prior to 1 April 2016.

7.9 In terms of the NHS budgets, similar to the Council, NHS Greater Glasgow and Clyde is facing significant financial challenges. In the current financial year NHSGG&C continue to develop proposals to

meet savings required to balance the overall current year budget for 2015/16. The NHS Board has reported significant financial pressures particularly relating to acute hospital services. Savings plans for HSCPs across NHSGG&C in 2015/16 are already agreed and have been accounted for in current year budgets and this exercise includes those service budgets that will transfer into the IJB in 2016/17. Moving into 2016/17, further cost pressures from demand led growth, pension and pay pressures being experienced similar to the Council, pressures emerging from the ending of non-recurring funding sources and requirements to support the achievement of key performance standards such as 4 hour waiting targets in A&E, will continue to present significant financial challenges for the NHS Board. This could potentially have implications for the proposed IJB budgets for 2016/17. Only recently, Audit Scotland published a national report highlighting such financial risks being faced by the NHS in Scotland and the consequential need for the Scottish Government and the NHS to accelerate the delivery of change and modernisation as a key response to mitigating the impact brought about by cost pressures.

7.10 The approach taken to carry out this due diligence process for the 2016/17 budget is set out in *appendix 1: Due diligence process 2015/16 budgets.* A key element of this process is the 2016/17 budget being assessed against actual expenditure for the most recent three financial years including analysis of non-recurring costs and agreed efficiencies. The process covers Renfrewshire Council and NHS GGC budgets relating to the delegated functions set out in the Integration Scheme.

7.11 The report on the due diligence process and Chief Finance Officer recommendations will be presented to the IJB on the 18 March 2016 when the IJB will approve their strategic plan and supporting 2016/17 budget.

7.12 The IJB's Chief Internal Auditor will carry out an audit of the due diligence process undertaken by the Chief Finance Officer and will submit a separate report on her findings on the 18 March 2016. This paper will provide the IJB will additional, idependent assurance of the process followed.

## 8. Issuing of Directions to Parent Organisations

8.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (sections 26 and 27) requires the IJB to issue directions to the constituent bodies (Renfrewshire Council and NHS Greater Glasgow and Clyde) for each function being delegated to it as the integration authority.

8.2 The Act states that "where the integration authority is an integration joint board, it must give a direction to a constituent authority to carry out each function delegated to the integration authority".

8.3 Sections 26 and 27 of the 2014 Act contain more detail regarding what the direction should cover. This includes the method of determining payments that are to be made to the person carrying out the function,

how that payment is to be used and it may regulate the manner in which the function is to be carried out.

8.4 The directions are the mechanism by which the IJB instructs the constituent authority to carry out the delegated functions. These are documents which set out how the IJB expect the Constituent bodies to deliver each function, and spend IJB resources, in line with the Strategic Plan.

8.5 When the IJB approve their Strategic Plan, this will allow for health and adult social care functions to be delegated from the constituent bodies to the new integrated authority. The IJB must then issue Directions for all the delegated functions as set out in the integration scheme.

8.6 Given the statutory timetable for the approval of the Strategic Plan, and the Scottish Government's delay issuing supporting guidance, there is insufficient time to finalise the directions and submit them for IJB approval ahead of 1 April 2016. It is therefore proposed that the IJB delegate this responsibility to the Chief Officer, who will work in consultation with the Chair and Vice Chair of the IJB.

8.7 The Chief Officer will prepare the directions with the Chief Finance Officer and also liaise other Chief Officers within the Greater Glasgow and Clyde (GGC) area to ensure these Directions are in line with the anticipated national guidance, from the Integrated Resource Advisory Group (IRAG) and satisfy the statutory requirements.

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**Implications of the Report**

1. **Financial –** Expenditure will be contained within available resources.
2. **HR & Organisational Development** – none
3. **Community Planning** - none
4. **Legal –** none
5. **Property/Assets –** none.
6. **Information Technogloy –** none
7. **Equality & Human Rights –** The recommendations containted within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be publised on the Council's website.
8. **Health & Safety –** none
9. **Procurement** – none
10. **Privacy Impact** – none.

**List of Background Papers –** none

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**Author:** Sarah Lavers, Chief Finance Officer

## Social Work Revenue Budget Position
## 1st April 2015 to 13th November 2015

| Subjective Heading | Annual Budget £000's | Year to Date Budget £000's | Actual to Date £000's | Variance £000's | Variance % | Variance |
|---|---|---|---|---|---|---|
| Employee Costs | 24,415 | 14,495 | 14,627 | (132) | -0.9% | overspend |
| Property Costs | 1,014 | 487 | 521 | (34) | -7.0% | overspend |
| Supplies and Services | 1,450 | 845 | 919 | (74) | -8.8% | overspend |
| Contractors | 45,797 | 26,422 | 26,185 | 237 | 0.9% | underspend |
| Transport | 733 | 415 | 412 | 3 | 0.7% | underspend |
| Administrative Costs | 246 | 141 | 120 | 21 | 14.9% | underspend |
| Payments to Other Bodies | 4,234 | 1,552 | 1,548 | 4 | 0.3% | underspend |
| Capital Charges | 1,404 | - | - | - | 0.0% | breakeven |
| **Gross Expenditure** | **79,293** | **44,357** | **44,332** | **25** | **0.1%** | **underspend** |
| | | | | | | |
| **Income** | **(23,758)** | **(8,519)** | **(8,495)** | (24) | 0.3% | overspend |
| **NET EXPENDITURE** | **55,535** | **35,838** | **35,837** | **1** | **0.00%** | **underspend** |

**Position to 18th September is a breakeven of** **£0** **0.00%**
**Anticipated Year End Budget Position is a breakeven of** **£0** **0.00%**

| Client Group | Annual Budget £000's | Year to Date Budget £000's | Actual to Date £000's | Variance £000's | Variance % | Variance |
|---|---|---|---|---|---|---|
| Older People | 35,347 | 21,291 | 21,268 | 23 | 0.1% | underspend |
| Physical or Sensory Difficulties | 5,057 | 3,123 | 3,176 | (53) | -1.7% | overspend |
| Learning Difficulties | 12,582 | 8,755 | 8,600 | 155 | 1.8% | underspend |
| Mental Health Needs | 950 | 1,806 | 1,836 | (30) | -1.7% | overspend |
| Addiction Services | 949 | 726 | 820 | (94) | -12.9% | overspend |
| Integrated Care Fund | 650 | 137 | 137 | - | 0.0% | breakeven |
| **NET EXPENDITURE** | **55,535** | **35,838** | **35,837** | **1** | **0.00%** | **underspend** |

**Position to 18th September is a breakeven of** **£0** **0.00%**
**Anticipated Year End Budget Position is a breakeven of** **£0** **0.00%**

## Health Revenue Budget Position
## 1st April 2015 to 30th November 2015

| Subjective Heading | Annual Budget | Year to Date Budget | Actual to Date | Variance | | |
|---|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | % | |
| Employee Costs | 42,530 | 28,260 | 27,801 | 459 | 1.6% | underspend |
| Property Costs | 788 | 409 | 365 | 44 | 10.8% | underspend |
| Supplies and Services | 11,303 | 5,028 | 5,388 | (360) | -7.2% | overspend |
| Purchase of Healthcare | 44 | 30 | 36 | (6) | -20.0% | overspend |
| Resource Transfer | 16,590 | 11,060 | 11,060 | - | 0.0% | breakeven |
| Family Health Services | 79,207 | 52,400 | 52,394 | 6 | 0.0% | underspend |
| Savings | (173) | (116) | - | (116) | 100.0% | overspend |
| Capital Charges | 1,573 | 1,050 | 1,050 | - | 0.0% | breakeven |
| **Gross Expenditure** | **151,862** | **98,121** | **98,094** | **27** | **0.0%** | **underspend** |
| | | | | | | |
| **Income** | **(4,398)** | **(2,891)** | **(2,891)** | - | 0.0% | breakeven |
| **NET EXPENDITURE** | **147,464** | **95,230** | **95,203** | **27** | **0.03%** | **underspend** |

**Position to 30th September is an underspend of** **£23k** **0.03%**
**Anticipated Year End Budget Position is a breakeven of** **£0** **0.00%**

| Client Group | Annual Budget | Year to Date Budget | Actual to Date | Variance | | |
|---|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | % | |
| Addiction Services | 2,684 | 1,516 | 1,368 | 148 | 9.8% | underspend |
| Adult Community Services | 15,076 | 9,266 | 9,320 | (54) | -0.6% | overspend |
| Children's Services | 5,124 | 3,533 | 3,360 | 173 | 4.9% | underspend |
| Learning Disabilities | 957 | 641 | 696 | (55) | -8.6% | overspend |
| Mental Health | 18,446 | 12,283 | 12,420 | (137) | -1.1% | overspend |
| Hosted Services | 3,442 | 2,326 | 2,173 | 153 | 6.6% | underspend |
| Prescribing | 32,985 | 22,185 | 22,185 | - | 0.0% | breakeven |
| GMS | 24,229 | 15,482 | 15,482 | - | 0.0% | breakeven |
| Other | 19,897 | 13,240 | 13,240 | - | 0.0% | breakeven |
| Planning and Health Improvement | 1,530 | 820 | 838 | (18) | -2.2% | overspend |
| Other Services | 3,237 | 1,681 | 1,864 | (183) | -10.9% | overspend |
| Resource Transfer | 16,590 | 11,060 | 11,060 | - | 0.0% | breakeven |
| Integrated Care Fund | 3,267 | 1,197 | 1,197 | - | 0.0% | breakeven |
| **NET EXPENDITURE** | **147,464** | **95,230** | **95,203** | **27** | **0.03%** | **underspend** |

**Position to 30th September is an underspend of** **£23k** **0.03%**
**Anticipated Year End Budget Position is a breakeven of** **£0** **0.00%**

**for information:**

1. Adult Community Services includes: District and Out of Hours Nursing; Rehabilitation Services, Equipu and board wide responsibility for Podiatry
2. Children's Services includes: Community Services - School Nurses and Health Visitors; Specialist Services - Children's Mental Health Team, Speech Therapy
2. GMS = costs associated with GP services in Renfrewshire
3. Other = costs associated with Dentists, Pharmacists, Optometrists
4. Hosted Services = board wide responsibility for support to GP's for areas such as eg breast screening, bowel screening
5. Other Services = Business Support staff; Admin related costs, hotel services and property related costs including rates and rental costs.

## Appendix 1: Due diligence process 2015/16 budgets

The budget in the financial plan for 2015/16 has been assessed against actual expenditure reported in the management accounts for the most recent three years:

- the identification of the former Community Health Partnership budget to be delegated is clear
- the identification of the NHS GGC's budget relating to the delegated set aside (Acute Services) budget is clear
- the identification of that part of the Council's former SW and Housing budgets relating to the delegated services is clear
- the treatment of corporate support services is clear
- the prior year figures can be reconciled back to Council and NHS GGC budget papers and final management accounts, or equivilent.
- the review of prior years and into 2015/16 show adequate budget provision for the delegated functions.
- The assumptions used in rolling forward the budget from 2014/15 to 2015/16 plans and the associated risks are fully transparent.
- Material non-recurrent funding and expenditure budgets for the delegated services and related risks are transparent.
- The medium term financial forecast for the delegated services and associated assumptions and risks is reviewed
- Savings and efficiency targets and any schemes identified are clearly identified and the assumptions and risks are understood by all partners
- Corporate efficiency targets are clear from parent organisation Board papers
- Demand management activity in relation to health and adult social care services is transparent

Budget for 2015/16 to be set taking into account:

- Cost inflation
- Activity change such as demographic pressure
- Cost impact of any legislative changes
- efficiencies

Ensure the amount set aside for the IJB consumption of large hospital services to consistent with the methods recommended in the IRAG guidance on the set aside resource and that the assumptions and risks are assessed - part of NHS due diligence exercise.

**To:** **Renfrewshire Integration Joint Board**

**On:** **Friday 15 January 2016**

**Report by:** **Chief Officer**

**Heading:** **Information Sharing and Information Governance Arrangements**

## 1. Summary

1.1 The purpose of this report is to advise the members of the Integration Joint Board (IJB) of the information sharing arrangements amongst NHS Greater Glasgow & Clyde, Renfrewshire Council and Renfrewshire Integration Joint Board (IJB) and the IJB's responsibilities in relation to information governance issues.

1.2 The Integration Scheme obliges Renfrewshire Council and NHS Greater Glasgow and Clyde to ratify the arrangements for information governance by April 2016.

## 2. Recommendation

It is recommended that members:

2.1 Note the content of this Report and the protocols established to meet the information governance requirements of the Integration Scheme.

2.2 Note the appointment of the Chief Officer as Senior Information Risk Owner (SIRO) for the IJB.

## 3. Background

3.1 Effective, lawful and secure sharing of information about service users is essential to providing an integrated service and achieving efficient service delivery. The Public Bodies (Joint Working) (Scotland) Act 2014 allows for information sharing between a Local Authority, a Health Board and an

Integration Joint Board for the purposes of carrying out of integrated functions.

3.2 The Integration Scheme requires the Chief Officer to ensure that appropriate arrangements are in place in respect of information governance for the IJB. Such arrangements can be achieved by Information Sharing Protocols ("ISPs").

3.3 The Council and the Health Board are both individually Data Controllers under the Data Protection Act 1998 ("DPA") and are therefore each responsible for their own compliance with the provisions of the DPA. Although the Council and Health are working in partnership as Renfrewshire Health and Social Care Partnership ("RHSCP"), the Council is the Data Controller of Council data and the Health Board is the Data Controller of Health data.

3.4 It is likely that the IJB will only rarely be in possession of "Personal Data" (in terms of the DPA) as information reported by the Council and the Health Board to the IJB will, generally, be in aggregated form. This means that the Council and the Health Board retain legal responsibility for this data. The IJB is Data Controller for its own Strategic Plan and other documents it authors, for example IJB and SPG action notes, strategies and policies. Other notable exceptions are that the IJB will also be Data Controller for information it holds about IJB enquiries, IJB complaints, feedback etc. as well as any information held in relation to group membership/ local contacts. The IJB will be Data Controller for those categories of IJB information and will, therefore, be legally responsible for that data. The IJB, as Data Controller of this data, must ensure that the processing of this is compliant with the DPA.

3.5 Although the DPA only regulates the processing of personal data, it is of note that all information held by the IJB is covered by the Freedom of Information (Scotland) Act 2002. A separate report was submitted to the first meeting of the IJB detailing freedom of information responsibilities.

3.6 All parties, including the IJB, must have appropriate technical and organisational measures in place to ensure the security of any Personal Data shared between the parties. The ISPs amongst the parties make provision for this, including arrangements for the management of any information security incidents. The IJB should therefore have its own Information Security Policy and Information Incident Reporting Procedures.

## 4. Local Information Sharing Protocol

4.1 The Integration Scheme sets out certain information sharing and data handling requirements. The Scheme states that the Health Board and the Council will work together to agree an information sharing accord and specific

procedures for the sharing of information in relation to integrated services (between themselves and the IJB). It is specified that the accord and procedures will be developed from existing information sharing and data handling arrangements.

4.2 Renfrewshire Council and NHS Greater Glasgow and Clyde were parties to an existing Information Sharing Protocol (ISP). This ISP has been updated to reflect the new information sharing and data handling arrangements between the Parties, as a result of the Scheme (including adding the IJB as a Party to the ISP) and sets out the principles under which information sharing will be carried out. It defines the processes and procedures that apply to sharing information for any purpose connected with the Integration Scheme or the carrying out of integration functions. The aim of the ISP is to facilitate the sharing of information between the relevant parties and put in place a framework which will allow this information to be exchanged in ways which respect the rights of people about whom information is shared.

4.3 The ISP is subject to ongoing review (at least annually). This positively encourages staff to share information appropriately about their service users when it benefits their care and when it is necessary to protect vulnerable adults or children. This was signed by Renfrewshire Council on 14 December 2015 and is now with the Health Board for signing. This will be passed to the IJB for signing in January 2016.

## 5. Information Services Division (ISD) Information Sharing Protocol

5.1 There is also a wider ISP in place amongst Renfrewshire Council, NHS Greater Glasgow & Clyde, Renfrewshire Integration Joint Board and the Common Services Agency for the Scottish Health Service. This ISP will be used to support all aspects of The Health and Social Care Data Integration and Intelligence Project (HSCDIIP).

5.2 The ISP takes account of all the legal requirements necessary to ensure the secure receipt of social care data, CHI seeding and linkage to health data, and sharing of this amongst ISD, NHS Greater Glasgow & Clyde, Renfrewshire Council and IJB through the HSCDIIP platform. The ISP acknowledges that ISD will be both data processors and data controllers in common with NHS Greater Glasgow & Clyde, Renfrewshire Council and the IJB. In order to support integrated information needs, ISD can therefore receive relevant social care data.

5.3 In terms of the ISD ISP, IJB is using the linked data supplied to it by National Services Scotland (NSS) ISD to prepare an integration scheme and/or

strategic plan and carry out integration functions pursuant to its statutory purposes in terms of the Public Bodies (Joint Working) (Scotland) Act 2014**.**

5.4 This was signed by Renfrewshire Council on 14 December 2015 and is now with the Health Board for signing. This will be passed to the IJB for signing in January 2016.

## 6. Service Level Agreement

6.1 A Service Level Agreement (SLA) on Health and Social Care Integration has also been agreed by Renfrewshire Council, NHS Greater Glasgow & Clyde, Renfrewshire Integration Joint Board and the Common Services Agency for the Scottish Health Service. This is to deal with more practical issues to ensure that appropriate staff in NHS Greater Glasgow & Clyde, Renfrewshire Council and IJB can access the right level and type of information. This SLA is subject to annual review.

6.2 This was signed by Renfrewshire Council on 14 December 2015 and is now with the Health Board for signing. This will be passed to the IJB for signing in January 2016.

## 7. Senior Information Risk Owner (SIRO)

7.1 Both the Cabinet Office and the Scottish Government advocate that all public bodies should appoint a Senior Information Risk Owner (SIRO) who is responsible for information risk as good practice. As a public body, it is appropriate that the IJB also has a SIRO.

7.2 The SIRO is responsible for:

- the information risk profile of the IJB;
- identifying all of the information risks in relation to the responsibilities of the IJB;
- making sure that appropriate mitigations are in place so that the risks can be accepted.

7.3 The Chief Officer will act as the SIRO of behalf of the IJB.

## 8. Joint monitoring and review arrangements

8.1 Renfrewshire Council and NHS Greater Glasgow and Clyde have an ongoing responsibility to continue to develop information technology systems and procedures to enable information to be shared appropriately and effectively between themselves and the IJB.

8.2 The Information Sharing Protocols amongst the parties provide for the information sharing initiatives and information governance arrangements in place to be reviewed regularly to ensure that they continue to meet their objectives.

8.3 Each of the relevant documents provide for the services to notify one another in the event of an information security incident. This will be done in line with the service's own Information Security Policy or Incident Management Reporting Procedures.

## 9. IJB operational guidance and procedures

9.1 Individual services will be required to develop detailed operational information sharing procedures to ensure that information flows and the methods of information sharing are understood by practitioners and staff to support the care of people who use services.

9.2 The Chief Officer should ensure the required guidance and procedures are developed and implemented on behalf of the IJB during 2016/17.

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**Implications of the Report**

1. **Financial -** None.
2. **HR & Organisational Development –** None.
3. **Community Planning –** None.
4. **Legal –** the Integration Scheme between Renfrewshire Council and NHS Greater Glasgow and Clyde sets out certain information-sharing and data handling requirements at clause 10. This clause requires Renfrewshire Council and NHS Greater Glasgow and Clyde to develop information technology systems and procedures to enable information to be shared appropriately and effectively between the Parties and the IJB. The Information Sharing Protocols, both locally and with the ISD will ensure that there is appropriate and lawful information sharing between the relevant parties, thereby ensuring compliance with the Data Protection Act 1998 as well fulfilment of the parties' own statutory responsibilities in terms of service user care by ensuring there is an appropriate flow of relevant information.

5. **Property/Assets –** None**.**
6. **Information Technology –** managing information and making information available may require ICT input.
7. **Equality & Human Rights -** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.
8. **Health & Safety –** None.
9. **Procurement –** None.
10. **Risk –** None.
11. **Privacy Impact** - Privacy Impact Assessments have been carried out by the ISD and by NHS Greater Glasgow and Clyde. The Privacy Impacts identified in those Assessments are managed through the documentation which is to be signed.

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**List of Background Papers**

1. Information Sharing Protocol in relation to Health and Social Care Integration amongst the Renfrewshire Council, NHS Greater Glasgow & Clyde and Renfrewshire Integration Joint Board.
2. Information Sharing Protocol in relation to Health and Social Care Integration amongst Renfrewshire Council, NHS Greater Glasgow & Clyde, Renfrewshire Integration Joint Board and the Common Services Agency for the Scottish Health Service.
3. Service Level Agreement in relation to Health and Social Care Integration amongst Renfrewshire Council, NHS Greater Glasgow & Clyde, Renfrewshire Integration Joint Board and the Common Services Agency for the Scottish Health Service

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0141 618 7022

**To:** **Renfrewshire Integration Joint Board**

**On:** **15 January 2016**

**Report by:** **Chief Officer**

**Heading:** **Freedom of Information Arrangements**

## 1. Summary

**1.1** The purpose of this report is to advise the Integration Joint Board (IJB) of the arrangements for meeting its obligations under the Freedom of Information (Scotland) Act 2002 ("FOISA").

**1.2** The Council and the Health Board are, as public authorities, both separately subject to FOISA, but this does not satisfy the IJB's obligations under the Act. Although the IJB will itself hold a very limited amount of information, it is designated as a 'public authority' under FOISA and so has its own obligations under FOISA. As a result, the IJB will need to respond to requests for information which it holds within the statutory timescale and have its own Publication Scheme.

## 2. Recommendation

It is recommended that the IJB:-

**2.1** Notes the arrangements for dealing with requests for information in respect of functions undertaken by the IJB.

**2.2** Approve adoption of the Publication Scheme in Appendix 1.

## 3. Background

**3.1** FOISA came into force on 1 January 2005 and created a general right to obtain information from any designated Scottish public authority subject to limited exemptions. Most of the exemptions are only available if the request fails the "public interest" test. In other words, information must still be released if it is of greater benefit to the public to release the information than withhold it. Anyone, anywhere, can exercise their rights under FOISA and they need not tell the public authority why they want the information.

**3.2** The IJB is subject to FOISA as a "Public Authority" under the Freedom of Information (Scotland) Act 2002 (Scottish Public Authorities) Amendment Order 2014.

**3.3** In addition to putting into place the necessary arrangements for properly responding to requests for information, Section 23 of FOISA imposes a specific duty on Scottish Public Authorities to adopt and maintain a scheme that relates to the publication of information by the authority (a "Publication Scheme"). This requirement complements

the public's right to request information from public authorities by encouraging authorities to proactively publish as much information as possible. The aim is that access to public information becomes more “self serve” whereby the public can easily access information for themselves without having to make a formal request for information.

**3.4** It is likely that the IJB will only hold a very limited amount of information to begin with and the Publication Scheme reflects that. However, it should be noted that any information the IJB creates will be subject to FOISA and therefore should be considered for the purposes of the Publication Scheme. For example, the Strategic Plan and other documents the IJB authors (i.e. strategies, policies and management of finances). Anything included in an approved Publication Scheme is automatically, and absolutely, exempt from release in response to an FOI request.

**3.5** The Publication Scheme at Appendix 1 follows the model approved by the Scottish Information Commissioner, the regulator for freedom of information. Once a public authority has agreed to adopt the scheme, the Commissioner must be notified of its adoption and informed of the individual responsible for keeping the scheme up to date. This will be the RHSCP Coordinator, Jean Still.

**3.6** It is important to note that the IJB must respond to FOI requests made directly to the IJB for information which it holds. The IJB cannot simply refer requests onto the Council or the Health Board, though it may be appropriate to redirect requestors to the Council or Health Board if the information requested is not held by the IJB. The parent organisations will continue to be responsible for FOIs relating to information they hold about the delivery of health and adult social care services under their existing FOI procedures.

**3.7** When a parent organisation receives a FOI relating to the operational delivery of health and adult social care services:

- The parent organisation will share the FOI with the RHSCP Coordinator, to allow the RHSCP to retain a central record of all FOIs related to it;
- The parent organisation will share the FOI response with the RHSCP Coordinator to allow the records to be updated;
- In the event of an internal review or appeal, the RHSCP Coordinator will be notified, and kept informed of progress to ensure completeness of records.

**3.8** All requests received by the IJB will be recorded by the RHSCP Coordinator, who will, on behalf of the IJB, keep a central record of FOI enquiries received, their progress, and the responses sent. The IJB’s Chief Financial Officer will be responsible for overseeing and approving responses prior to release.

**3.9** Under FOISA, if a requester is dissatisfied with the way their request has been handled, they are entitled to ask the authority for an internal review of the process. Any review will be handled by the Chief Officer. Requesters are also entitled to submit an appeal to the Scottish Information Commissioner if unhappy with the review decision reached by a public authority. In this event the Chief Officer will lead on that process.

**3.10** In addition to having arrangements in place for responding to requests and maintaining a Publication Scheme, the Scottish Information Commissioner requests that authorities publish quarterly reports on numbers of requests received to their online statistics portal (https://stats.itspublicknowledge.info/). There is currently no legal obligation to do so, but participation by authorities is highly encouraged by the Commissioner. As the IJB is likely to receive relatively few requests for information, participation will have a minimal impact on resources.

**3.11** In order to help meet its duties under FOISA, the IJB will be able to call upon professional support from Renfrewshire Council Information Governance Team, and NHS Greater Glasgow and Clyde if required, not only in relation to freedom of information, but also on matters of data protection, information security and records management

**4.0 What's Next**

**4.1** The IJB's FOI Publication Scheme will be published on the Renfrewshire Health and Social Care Partnership's web pages (currently under development) once approved.

**4.2** The required notification will be submitted to the Scottish Information Commissioner informing them of its adoption.

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**Implications of the Report**

1. **Financial -** None.
2. **HR & Organisational Development –** None.
3. **Community Planning –** None.
4. **Legal –** the IJB is legally required under the Freedom of Information (Scotland) Act 2002 to respond to requests for information and have a Publication Scheme in place.
5. **Property/Assets –** None**.**
6. **Information Technology –** managing information and making information available may require ICT input.
7. **Equality & Human Rights -** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.
8. **Health & Safety –** None.
9. **Procurement –** None.
10. **Risk –** None.
11. **Privacy Impact** – None. The information to be made available via the Publication Scheme is information which would be disclosed in response to a request under the Freedom of Information (Scotland) Act 2002. This therefore would not include Personal Data as defined by the Data Protection Act 1998.

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**List of Background Papers –**

1. Model Publication Scheme 2015
2. Model Publication Scheme 2015 Guidance

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# Appendix 1:  Renfrewshire Integration Joint Board (IJB)

**Publication Scheme**

## Introduction

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.

Renfrewshire Integration Joint Board (IJB) has adopted the Model Publication Scheme 2015 produced by the Scottish Information Commissioner. The Commissioner has approved this scheme until 31 May 2019.

The Publication Scheme is split into the following six sections:

- availability and formats;
- exempt information;
- copyright and re-use;
- charges;
- contact details; and
- the classes of information

In instances where the IJB does not hold the information requested, we will work with applicants to ensure that they are directed to the correct authority.

## Availability and formats

Information published through this scheme is, wherever possible, available on the authority's website. We offer alternative arrangements for people who do not wish to, or who cannot, access the information either online or by inspection at our premises. For example, we can usually arrange to send out information to you in paper copy on request (although there may be a charge for doing so).

## Exempt information

If information described by the classes cannot be published and is exempt under Scotland's freedom of information laws (for example sensitive personal data or a trade secret), we may withhold the information or provide a redacted version for publication and will explain why we have done so.

## Copyright and re-use

Where the IJB holds copyright in its published information, the information may be copied or reproduced without formal permission, provided that:

- it is copied or reproduced accurately;
- it is not used in a misleading context; and

- the source of the material is identified

Where the IJB does not hold the copyright in the information we publish, we will make this clear.

Access to the information does not mean that copyright has been waived, nor does it give the recipient the right to re-use the information for a commercial purpose. If you intend to re-use information obtained from the scheme, and you are unsure whether you have the right to do so, you are advised to make a request to the IJB (see Contact Details below).

**Charges**

Unless otherwise specified in the classes of information, all information published through this scheme is available free of charge where it can be downloaded from our website, or where it can be sent to you electronically by email.

We reserve the right to impose charges for providing information in paper copy or on computer disc. Charges will reflect the actual costs of reproduction and postage to the authority as set out below.

In the event that a charge is to be levied, you will be advised of the charge and how it has been calculated. Information will not be provided to you until payment has been received.

Photocopied information will be charged at a standard rate of 11p per A4 side of paper (black and white copy).

Postage costs will be charged at the rate paid to send the information to you.

This charging schedule does not apply to our commercial publications (see Class 8 below) where pricing may be based on market value.

**Contact details**

You can contact us for assistance with any aspect of this scheme, Guide to Information and to ask for copies of the authority's published information.

Renfrewshire Health and Social Care Partnership
Third Floor
Renfrewshire House
Cotton Street
Paisley
PA1 1AL

Our e-mail address is: Renfrewshire.HSCP@ggc.scot.nhs.uk

Telephone: 0141 618 7629

We will also provide reasonable advice and assistance to anyone who wants to request information which is not published.

**Duration**

Once published, the information will be available for at least the current and previous two financial years. Where information has been updated or superseded, only the current version might be available but previous versions may be requested from the authority.

**The Classes of Information**

| **Class 1: About the authority** |
|---|
| **Class description:** Information about the authority, who we are, where to find us, how to contact us, how we are managed and our external relations. |
| Background on health and social care integration and the IJB can be found here: http://www.renfrewshire.gov.uk/webcontent/home/services/social+care+and+health/social_care_and_health_integration/sw-hsci-backgroundtointegration<br><br>If you have any enquiries about health and social care integration, please contact us at:<br><br>e-mail Renfrewshire.HSCP@ggc.scot.nhs.uk<br><br>By telephone: 0141 618 7629<br><br>Our postal address is:<br><br>Renfrewshire Health and Social Care Partnership<br>Third Floor<br>Renfrewshire House<br>Cotton Street<br>Paisley PA1 1AL<br><br>Our management structure can be found here:<br>http://www.renfrewshire.gov.uk/webcontent/home/services/social+care+and+health/social_care_and_health_integration/sw-hsci-hscpstructure |

| **Class 2: How we deliver our functions and services** |
|---|
| Class description: Information about our work, our strategies and policies for delivering functions and services and information for our service users |
| The Strategic Plan will set out what the IJB wants to achieve and detail how we will do it. It will set out the actions needed to improve health and social care services to meet changing local demands and will be firmly based on evidence and developed by engaging with local stakeholders, including staff, to ensure services are designed around the people who use them and their communities.<br><br>The Strategic Plan must be approved by the IJB before the council and health board are able to delegate functions. This must happen before 1 April 2016. When the strategic plan has been approved it will be published here:<br><br>http://www.renfrewshire.gov.uk/webcontent/home/services/social+care+and+health/social_car |

e_and_health_integration/sw-hsci-strategicplan

The IJB's programme of work is published here:

http://www.renfrewshire.gov.uk/webcontent/home/services/social+care+and+health/social_care_and_health_integration/sw-hsci-workprogramme

What we want to achieve with integration is published here:

http://www.renfrewshire.gov.uk/webcontent/home/services/social+care+and+health/social_care_and_health_integration/sw-hsci-nationaloutcomes

| **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 |
| Our decisions, including the minutes and reports of the Board Meetings and sub-committees, will be published here:<br><br>http://renfrewshire.cmis.uk.com/renfrewshire/JointBoardsandOtherForums/RenfrewshireHealthSocialCareIntegrati.aspx |

| **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) |
| Details of our spending will be place on our WebPages here:<br><br>http://renfrewshire.cmis.uk.com/renfrewshire/JointBoardsandOtherForums/RenfrewshireHealthSocialCareIntegrati.aspx |

| **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 the authority. |
| The services commissioned by the IJB will be delivered by Renfrewshire Council and NHS Greater Glasgow and Clyde Board. Therefore the IJB does not contain any information within this class but information can be found through each organisation's respective publication scheme.<br><br>Renfrewshire Council Publication Scheme:<br><br>http://www.renfrewshire.gov.uk/webcontent/home/services/council+and+government/data+protection+and+freedom+of+information/ce-publicationscheme<br><br>NHS Greater Glasgow & Clyde Board Publication Scheme:<br><br>http://www.nhsggc.org.uk/about-us/freedom-of-information-foi/publication-scheme-and-guide- |

| |
|---|
| to-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 services commissioned by the IJB will be delivered by Renfrewshire Council and NHS Greater Glasgow and Clyde Board. Therefore the IJB does not contain any information within this class but information can be found through each organisation's respective publication scheme.<br>Renfrewshire Council Publication Scheme:<br>http://www.renfrewshire.gov.uk/webcontent/home/services/council+and+government/data+protection+and+freedom+of+information/ce-publicationscheme<br><br>NHS Greater Glasgow & Clyde Board Publication Scheme:<br><br>http://www.nhsggc.org.uk/about-us/freedom-of-information-foi/publication-scheme-and-guide-to-information/ |

| **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 IJB publishes performance information through reports to Board, which can be found here:<br><br>http://renfrewshire.cmis.uk.com/renfrewshire/JointBoardsandOtherForums/RenfrewshireHealthSocialCareIntegrati.aspx |

| **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. |
| The IJB does not create information within this class. |

**To:** **Renfrewshire Integration Joint Board**

**On:** **15 January 2016**

**Report by:** **Chief Officer**

**Heading:** **Risk Management Update**

## 1. Summary

1.1. This paper provides a further update on the progress being made with regards to risks relating to the activities of the Integration Joint Board (IJB) up to 1 April 2016, namely:

- The programme of work to ensure all legal requirements and commitments are in place in line with legislation;
- The IJB's organisational readiness for the delegation of health and adult social care functions.

## 2. Recommendation

2.1. It is recommended that the IJB notes the progress being made with regards to managing the key risks identified.

## 3. Background

3.1. Ten risk areas and issues were previously reported to the Integration Joint Board in November 2015. The table overleaf shows how management of the risks has progressed since then.

| Risk Area and Risk Issues | | How this is being addressed | Progress since November Report to Board |
|---|---|---|---|
| **PROGRAMME MANAGEMENT -** Delivering on legal requirements and commitments<br>! **A failure in delivering in any of the undernoted aspects could result in challenges in effective decision making, breaches in legislative compliance and significant reputational harm to the IJB** | | | |
| 1. | Legal requirements and commitments as set out in the Integration Scheme | Programme of work is underway to ensure key legislative requirements set out in the Act and Integration Scheme, which must be in place by 1 April 2016. | WORK IN PROGRESS |
| 2. | Financial governance and due diligence | The joint budget for the Health and Social Partnership will be agreed and all governance arrangements implemented:<br>• IJB Audit arrangements will be agreed<br>• IJB will sign off financial governance arrangements as per the national guidance<br><br>**Due for completion by 18 March 2016:**<br>• IJB report on due diligence on delegated baseline budgets moving into 2016/17<br>• Draft proposal for the 2016/17 Integrated Budget based on the Strategic Plan approved by IJB<br>• Draft proposal for the Integrated Budget based on the Strategic Plan presented to the Council and the Health Board for consideration as part of their respective annual budget setting process<br>• Parent organisations will confirm final IJB budget<br>• Financial statement will be published with Strategic Plan<br>• Resources for delegated functions will transfer to IJB<br>• Audit Committee will be established | COMPLETED<br><br>WORK IN PROGRESS |
| 3. | Clinical and care governance | The IJB will approve its quality, care and professional governance framework for their duties under the Act. | COMPLETED |

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| | | **Due for completion by 18 March 2016:**<br>• The IJB will implement robust quality, care and professional arrangements. | WORK IN PROGRESS |
| 4. | Performance management | A list of targets and measures in relation to delegated and non delegated functions will be prepared.<br>Partners will develop proposals on targets and measures for 2015/16 'interim' performance framework to be submitted to an early meeting of the IJB<br>IJB will agree its reporting arrangements and supporting plan to develop 2016/17 performance framework with partners<br><br>**Due for completion by 26 June 2016:**<br>IJB agree 2016/17 performance framework, taking account of localities, reporting arrangements and plans to publish the annual performance report. | COMPLETED<br><br>WORK IN PROGRESS |
| 5. | Decisions around the Strategic Plan to ensure it is fit for purpose and deliverable (localities, finance and performance) | Establish a Strategic Planning Working Group<br><br>**Due for completion by 18 March 2016:**<br>The IJB will develop the Strategic Plan in consultation with the Strategic Planning Group and other prescribed stakeholders. | COMPLETED<br><br>WORK IN PROGRESS |

| Risk Area and Risk Issues | How this is being addressed | Progress since November Report to Board |
|---|---|---|
| **READINESS -** Partnership and IJB's readiness to deliver all delegated services by 1 April 2016 in line with its Strategic Plan<br>! **Moving beyond the programme management phase, if the IJB and individual partners are not ready to deliver all delegated services under** | | |

| | | | |
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| | **the direction of the IJB with effect from April 2016, this could result in challenges around operational decisions, maintaining effective links with relevant services in the partner organisations, service continuity issues and significant reputational harm to the IJB** | | |
| 6. | IJB decision making and protecting the reputation of the Health and Social Care Partnership | Development of Organisational Development plans for the Senior Leadership Group, Integration Joint Board, Strategic Planning Group and workforce | WORK IN PROGRESS |
| 7. | Partnership and Partner Organisation readiness to run with new, fit for purpose operational arrangements from 1 April 2016 | Development of a participation and engagement strategy to enable users, patients, carers and partners to shape the new organisation.<br><br>Programme of work is underway to ensure all the necessary processes, policies and plans are in place as required to allow local implementation of integrated health and social care services in terms of the Public Bodies (Joint Working)(Scotland) Act 2014 by 1 April 2016 | COMPLETED<br><br>WORK IN PROGRESS |
| 8. | Information Governance | The Chief Officer will act as SIRO for the IJB.<br>Information sharing protocols between NHS GGC and Renfrewshire Council have been updated to meet the requirements of the Integration Scheme. | COMPLETED, subject to IJB approval on 15 January 2016 |
| 9. | Data Security | As IJB data will be stored on the parent organisation systems, the Council and NHS GCC are preparing an appropriate response regarding the security controls already implemented on their networks and infrastructure to provide assurance to the IJB that their data will be appropriately protected from a malicious attack or data loss. | WORK IN PROGRESS |
| 10. | Continuity in the transition of Council functions | Develop the most appropriate and pragmatic approaches and supporting mechanisms/ structures for each of the following functions:<br>Addictions Services | COMPLETED - Addiction Services and Domestic Abuse, |

| | | | |
|---|---|---|---|
| | which currently sit outwith Adult Social Work Services e.g. Addictions, Domestic Abuse and Housing Adaptations | Domestic Abuse<br><br>Housing Adaptations<br>Gardening Assistance | WORK IN PROGRESS |
| 11. | Children's Services and Housing Services interface | There are already close working relationships between the RHSCP, Children's Services and Housing Services and these will continue.<br>To further support integrated revised arrangements have been agreed -<br>The Chief Officer and the Director of Children's Services as Chief Social Work Officer (CSWO) have a schedule of regular meetings.<br><br>Chief Social Work Officer (CSWO) has a schedule of regular meetings with operational Social Work managers in adult services.<br><br>A joint management group of Heads of Service from across Children's Services, the RHSCP and Housing Services has been established and will meet regularly. | COMPLETED |
| 12. | Acute interface | Plans in place to build effective planning for Winter 2015/16 and beyond<br><br>Building ways of working and understanding around service budgets for which the IJB will be responsible. | WORK IN PROGRESS |

3.2. Moving forward, the Senior Leadership Group will participate in a risk management workshop in January 2016 to facilitate the identification of the key risks going forward from April 2016.

3.3. It should be noted that at this point in time, all identified risks are being managed in line with expectations with no significant concerns with regards to the ongoing work to contain or reduce the risks as the Integration Joint Board prepares for full implementation of delegated functions.

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**Implications of the Report**

**1. Financial**

There are no financial implications arising from the submission of this paper.

**2. HR & Organisational Development -** There are no HR & OD implications arising from the submission of this paper

**3. Community Planning -** There are no Community Planning implications arising from the submission of this paper

**4. Legal -** There provision of this report is in keeping with the Integration Scheme.

**5. Property/Assets -** There are no property/ asset implications arising from the submission of this paper.

**6. Information Technology -** There are no ICT implications arising from the submission of this paper.

**7. Health & Safety** – There are no health and safety implications arising from the submission of this paper.

**8. Equality and Human Rights -** There are no equality and human rights implications arising from the submission of this paper.

**9. Procurement Implications -** There are no procurement implications arising from the submission of this paper.

**10. Privacy Impact -** There are no privacy implications arising from the submission of this paper.

**11. Risk Implications –** As per the subject content of this paper.

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**List of Background Papers – None**

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**Author: Frances Burns, Health and Social Care Integration Programme Manager**

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|---|---|
| **To:** | **Renfrewshire Integration Joint Board** |
| **On:** | **15 January 2016** |
| **Report by:** | **Chief Officer, Renfrewshire Health and Social Care Partnership** |
| **Heading:** | **Non-financial Governance Arrangements** |

## 1. Summary

1.1. In line with the Integration Scheme, this report provides an overview of the proposed non-financial governance and support arrangements from 1 April 2016 when health and adult social care functions will be delegated to the Integration Joint Board (IJB).

## 2. Recommendation

2.1. It is recommended that members:

- Approve the IJB non-financial governance arrangements which will be implemented and operational from 1 April 2016
- Approve arrangements for the provision of support services to the IJB
- Approve arrangements for both the provision and delivery of NHS GGC hosted services to the IJB

## 3. Background

3.1. The Renfrewshire Integration Scheme sets out a series of commitments in relation to the establishment of sound governance arrangements by 1 April 2016.

3.2. Officers within the Renfrewshire Health and Social Care Partnership (RHSCP) have worked with experts from both the parent organisations to develop non-financial governance arrangements which will support the local implementation of integrated health and social care services, in relation to:

- Freedom of Information (FOI) and Publication Scheme
- Complaints
- Health and Safety
- Business Continuity
- Risk Management
- Insurance and Claims
- Information Sharing and Information Governance

3.3. A number of these arrangements and supporting strategies have already been brought to the IJB for approval –

- The IJB's Risk Management Strategy, Policy and Procedures were approved by members on 18 September 2015

- Also on the 18 September 2015, members agreed that voting members of the IJB would seek protection through the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) Scheme which covers the following areas of liability in relation to its strategic role:
  - Clinical Negligence
  - Employers Liability
  - Public Liability
  - Personal Injury, Loss, Damage to Property or other Wrongful Act
  - Dishonest, Fraudulent, Criminal or Malicious Activities
  - Defamation
  - Directors and Officers Liability
  - Consequential or Ancillary Expense
  - Financial Loss Suffered by Member
  - Fraud/Dishonesty/Theft

3.4. Further reports have been brought to this meeting of the IJB for approval, covering

- Information Governance and Information Sharing arrangements

- Freedom of Information (FOI) requests and Publication Scheme for the IJB.

3.5. These arrangements take account of the IJB and parent organisations, respective roles in relation to the planning and provision of health and adult social care services with Renfrewshire. A recent report produced by Audit Scotland Report: Health and Social Care Integration (December 2015) sets out these roles -

- An IJB is responsible for planning and commissioning health and adult social care services;

- The parent organisations are responsible for delivering those services.

This Audit Scotland Report is the subject of a separate report to this meeting of the IJB

3.6. Consistent with these definitions of responsibility, Appendix 1 provides an overview of all the proposed arrangements outlined in 3.2, setting out:

- Proposed amendments to the current parent organisations' procedures from 1 April 2016 in relation to the operational delivery of health and adult social care services to reflect integrated working arrangements
- IJB arrangements in relation to the strategic planning and commissioning of health and adult social care services
- Monitoring, review and reporting arrangements for health and adult social care services to ensure the IJB have appropriate assurance and oversight.

3.7. Subject to members approval, these arrangements will be implemented and operational from 1 April 2016.

Support Services

3.8. The Integration Scheme sets out that an agreement for the provision of support services, such as legal, financial and administrative services, will be put in place. In relation to these, it is proposed that existing support arrangements for operational services delegated will continue to be provided by the parent organisations.

3.9. Administrative support to the IJB will be provided by Renfrewshire Council's Committee Services.

3.10. The Chief Officer will put in place monitoring arrangements to ensure effective working. This will be done through engagment with the parent organisations

Hosted Services

3.11. Under previous organisational structures, Community Health Partnerships (CHPs) had responsibilities for hosting of a variety of NHS Greater Glasgow and Clyde (NHSGGC) wide services.

3.12. It has been agreed that these responsibilities will now be delegated to the new Integrated Joint Boards (IJBs), to be hosted through the six Health and Social Care Partnerships (HSCPs) within Greater Glasgow and Clyde.

3.13. Renfrewshire HSCP will host the two services previously managed by the Renfrewshiee Community Health Partnership on behalf of NHSGGC. These are Podiatry Services and Primary Care Contractual Support.

3.14. Existing hosting agreements have been updated to reflect integrated arrangements which set out that:

- Renfrewshire HSCP is responsible for the operational oversight of the services;
- The Chief Officer is responsible for the operational management of the services, on behalf of the IJB;
- Renfrewshire HSCP will be responsible for the strategic planning and operational budget of these services.

3.15. The IJB shall retain oversight for any services delivered to the people of Renfrewshire that are hosted on its behalf by another IJB. The Chief Officer will engage with the host integration authority and the relevant Chief Officer on any relevant issues arising in relation to these services. The Chief Officers of all HSCPs across NHSGG&C will also continue to meet regularly and, through this arrangement, will enable hosted service issues to be flagged, discussed and addressed wherever possible.

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**Implications of the Report**

1. **Financial –** sound financial governance arrangements are being put in place to support the work of the Partnership
2. **HR & Organisational Development** – Clinical and Care Governance arrangements are being put in place
3. **Community Planning** - n/a
4. **Legal –** The governance arrangements support the implementation of the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014.
5. **Property/Assets –** property remains in the ownership of the parent bodies.
6. **Information Technology –** An agreed information sharing protocol and supporting agreements are being developed fo the Partnership
7. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be publised on the Council's website.

**8.** **Health & Safety –** health and safety processes and procedures are being reviewed to in order to support safe and effective joint working

**9.** **Procurement** – procurement activity will remain within the operational arrangements of the parent bodies.

**10.** **Risk –** None.

**11.** **Privacy Impact** – n/a.

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**List of Background Papers –** none

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**Author:** Frances Burns, Health and Social Care Integration Programme Manager, 0141 618 7612
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**Appendix 1: Integration Joint Board – Non-financial Governance Arrangements**

| Area of Governance | Amendment to existing parent organisation arrangements from 1 April 2016 (operational service delivery) | Process specific to the activities of the IJB (strategic planning and commissioning) | IJB monitoring, review and reporting arrangements |
|---|---|---|---|
| **1. Freedom of Information (FOI)** | The parent organisations will continue to be responsible for FOIs relating to the delivery of health and adult social care services under their existing FOI procedures.<br><br>When a parent organisation receives a FOI relating to the operational delivery health and adult social care services–<br><br>• The parent organisation will share the FOI with the RHSCP Coordinator, to allow the RHSCP to retain a central record of all FOIs<br>• The Parent organisation will share the FOI response with the RHSCP Coordinator to allow RHSCP records to be updated<br>• In the event of an internal review or appeal, the RHSCP Coordinator will be notified, and kept informed of progress to ensure completeness of records | In relation to FOIs specifically relating to the strategic role of the IJB -<br>• The RHSCP Coordinator will keep a central record of all FOI enquiries received<br>• The Chief Finance Officer will be responsible for overseeing and signing off the FOI response<br>• The RHSCP Coordinator update central records with all FOI responses issued<br>• In the event of a requirement for Review, the review process will be led by the Chief Officer (SIRO), supported by the RHSCP Coordinator.<br>• In the event of an Appeal to the Scottish Information Commissioner , the process will be led by the Chief Officer (SIRO), supported by the RHSCP Coordinator<br><br>The IJB's FOI Publication Scheme will be published on the RHSCP's web pages once approved | • The RHSCP Coordinator will bring quarterly reports to the RHSCP Senior Leadership Group<br><br>• The Chief Officer will bring a twice yearly performance report on governance monitoring to the IJB, which will include FOIs<br><br>• The RHSCP Coordinator will review the IJB Publication Scheme annually or sooner dependent on anything changing that requires updates |
| **2. Complaints** | The parent organisations will continue to be responsible for complaints relating to the delivery of health and adult social care services under their existing complaints procedures. | The IJB and the RHSCP complaints process will be published on the RHSCP web pages from 1 April 2016.<br><br>In relation to complaints specifically | • The RHSCP Coordinator will bring quarterly reports to the RHSCP Senior Leadership Group |

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|---|---|---|---|
| | When a parent organisation receives a complaint relating to health and adult social care services -<br>• The parent organisation will share the complaint with the RHSCP Coordinator, to allow the RHSCP to retain a central record of all complaints in relation to the operational delivery of services<br>• The parent organisation will share the complaint response with the RHSCP Coordinator to allow RHSCP records to be updated<br>• In the event of an appeal, the RHSCP Coordinator will be notified, and kept informed of progress to ensure completeness of records | relating to the strategic role of the IJB -<br>• The RHSCP Coordinator will keep a central record of all complaints received<br>• The Chief Officer will identify a Responsible Officer on a cases by case basis, who will oversee and sign off the complaint response<br>• The RHSCP Coordinator will update HSCP record with all responses issued<br>• In the event of an appeal, the review process will be led by the Chief Officer, supported by the RHSCP Coordinator.<br><br>Going forward, the RHSCP are committed to developing a joint single complaints database with the parent organisations. | • The Chief Officer will bring a twice yearly performance report on governance monitoring to the IJB, which will include complaints |
| **3. Health and Safety** | The parent organisations will continue to be responsible for the health and safety of their staff who are involved in the delivery of health and adult social care services under existing their existing health and safety policies and procedures.<br><br>In the event of a healthy and safety incident relating to health and adult social care services,<br>• The parent organisation will notify the RHSCP Coordinator of the incident, to allow the RHSCP to retain a central record of all health and safety incidents in relation to the operational delivery of services<br>• The Parent organisation will update the | As the IJB has no staff, they have no requirement for their own health and safety policies and procedures however they must be alert to the possible health and safety implications of any decisions they make. | • The RHSCP Health and Safety Committee will meet on a quarterly basis with service representatives and Trade Unions, supported by Health and Safety staff from parent organisations<br><br>• The RHSCP Coordinator will bring an quarterly report to the RHSCP Senior Leadership Group |

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|---|---|---|---|
| | RHSCP Coordinator throughout the process and on the final outcome.<br><br>The RHSCP Health and Safety Committee will ensure the regular review all IJB and parent organisation policies and procedures. The Committee will work towards creating a joint repository of all health and safety data relating health and adult social care services. | | • An annual health and safety report will be brought to the IJB |
| **4. Business Continuity** | The HSCP have worked with the parent organisations to collate business continuity plans and procedures relating to the delivery of health and adult social care services, which feed into the parent organisations' overarching corporate business continuity plan. | No business continuity plans are required for the specific activities of the IJB as they do not engage in operational activity, however they must be alert to any possible business continuity implications in relation to decisions taken. | • The RHSCP Coordinator will be a member of the Renfrewshire Council Resilience Management Team (CRMT) which meets quarterly, and in the event of an incident.<br><br>• The RHSCP Coordinator will bring the RHSCP business continuity plans to RHSCP Senior Leadership Group for annual review<br><br>• The Chief Officer will report by exception to IJB |
| **5. Risk Management** | The parent organisation will manage risks in relation to the operational delivery of health and adult social care services under their existing risk management strategies, policies and | The IJB approved its Risk Management strategy, policy and procedures on 18 September 2015. | • The RHSCP Coordinator will review the RHSCP risk register (covering both parent organisation |

| | | | |
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| | procedures.<br><br>The parent organisations will share risks relating to the operational delivery of health and adult social care services with the Senior Leadership Group on a quarterly basis, via the RHSCP Coordinator. | This strategy covers risks relating specifically to the strategic role and activities of the IJB.<br><br>The parent organisations and RHSCP have developed a joint risk management database to allow effective coordination of risk management reports in relation to health and adult social care services. | and strategic IJB risks) with Senior Leadership Group on a monthly basis<br><br>• An updated risk register will be brought monthly to the IJB for review |
| **6. Insurance and Claims** | Claims to the parent organisations in relation to the operational delivery of health and adult social care services will be managed under existing arrangements<br><br>When a parent organisation receives a claim relating to health and adult social care services -<br>• The parent organisation will notify the RHSCP Coordinator of the claim, to allow the RHSCP to retain a central record of all claims<br>• The Parent organisation will report on claims data to the Senior Leadership Group | The IJB voting members of the IJB have protection through the CNORIS Scheme which will cover claims specifically relating to the strategic role and activities of the IJB<br><br>In relation to a claim made against the IJB -<br>• The RHSCP Coordinator will act as the single point of contact for claims, on behalf of the Chief Officer<br>• The Chief Officer, or a delegated officer, will oversee the claim process | • The RHSCP Coordinator will bring an annual claims report to the RHSCP Senior Leadership Group in relation to health and adult social care services<br><br>• The Chief Officer will report by exception to the IJB |
| **7. Information Sharing and Governance** | Information sharing protocols between NHS GGC and Renfrewshire Council have been updated to meet the requirements of the Integration Scheme.<br><br>In the event of a security notification relating to health and adult social care services -<br>• The parent organisation will share any | The Chief Officer will act as SIRO for the IJB.<br><br>In relation to a security notification specifically relating to the strategic role of the IJB -<br>• The RHSCP Coordinator will act as the single point of contact for security | • The RHSCP Coordinator will prepare an annual report for the SIRO which will highlight any information governance risks and provide an overview security notifications relating to |

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| | relevant notifications, and its subsequent findings / recommendations with the Chief Officer (SIRO) | notifications, on behalf of the Chief Officer<br>• The Chief Finance Officer will be responsible for overseeing any data breach investigations and the supporting findings / recommendations | health and adult social care services<br><br>• The Chief Officer will report by exception to the IJB<br><br>• The Information Sharing Protocols amongst the services provide for the services to notify one another in the event of an information security incident. This will be done in line with the service's own Information Security Policy or Incident Management Reporting Procedures.<br><br>• The Information Sharing Protocols and the Service Level Agreement amongst the services will each be reviewed on an annual basis. |

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|---|---|
| **To:** | **Renfrewshire Integration Joint Board** |
| **On:** | **15 January 2016** |
| **Report by:** | **Chief Officer, Renfrewshire Health and Social Care Partnership** |
| **Heading:** | **Integration of Health and Social Care Services in Renfrewshire - programme update report** |

## 1. Summary

1.1. A progress update on the work being taken forward in Renfrewshire to prepare for the practical implementation of integrated working is provided to each meeting of the Integration Joint Board. This report and attached appendix provide Board members with an outline of the current status and planned activity to provide assurance that all the necessary processes, policies and plans will be in place as required to allow local implementation of integrated health and social care services in terms of the Public Bodies (Joint Working)(Scotland) Act 2014 by 1 April 2016.

## 2. Recommendation

2.1. That Integration Joint Board members:

- note the planned activity and reporting dates for the key legislative and other commitments to have in place sound governance arrangements for Health and Social Care Partnership from 1 April 2016.

## 3. Background

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014, supporting statutory and non statutory guidance, and Integration Scheme for the Partnership set out a number of provisions relating to good governance, proportionate to the breadth and scale of the legislative changes both operationally and financially.

3.2 In order to provide assurance to IJB members Appendix 1 to this paper provides an overview of the legal and other commitments across all the areas of work, planned activity to meet these commitments, and the anticipated dates for completion and reporting to the IJB.

3.3 In line with the plan set out in Appendix 1, the following are submitted for consideration and approval at this meeting –

3.3.1 Governance

- The proposed Freedom of Information (FOI) arrangements for health and adult social care services from 1 April 2016 and a draft IJB Publications Scheme
- The proposed governance arrangements for health and adult social care services from 1 April 2016, including the provision of support services and hosted services

3.3.2 Strategic Plan

- The second draft of the Strategic Plan, taking account of Strategic Planning Group feedback

3.3.3 Finance and Audit

- An update on the financial position and the development of financial governance and assurance arrangements for the IJB

3.3.4 ICT and Information Sharing

- The proposed Information Sharing arrangements between Renfrewshire Council, NHS GGC and the IJB from 1 April 2016

3.4 Activity is well underway in relation to all of the other required elements of work and is currently on target to meet the scheduled reporting dates to the IJB, which will ensure legislative and other deadlines are met.

**Implications of the Report**

1. **Financial –** sound financial governance arrangements are being put in place to support the work of the Partnership
2. **HR & Organisational Development** – Clinical and Care Governance arrangements are being put in place
3. **Community Planning** - n/a
4. **Legal –** The governance arrangements support the implementation of the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014.
5. **Property/Assets –** property remains in the ownership of the parent bodies.
6. **Information Technology –** An agreed information sharing protocol and supporting agreements are being developed fo the Partnership
7. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be publised on the Council's website.
8. **Health & Safety –** health and safety processes and procedures are being reviewed to in order to support safe and effective joint working
9. **Procurement** – procurement activity will remain within the operational arrangements of the parent bodies.
10. **Risk –** None.
11. **Privacy Impact** – n/a.

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**List of Background Papers –** none

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## Appendix 1: Legal requirements and commitments

The tables below detail Renfrewshire's legal requirements and commitments in relation to Health and Social Care Integration as set out in the Public Bodies (Joint Working) (Scotland) Act 2014 Act and its Integration Scheme.

| Requirement / commitment source: | Key |
|---|---|
| Act & supporting Regulations | Act |
| Renfrewshire Integration Scheme | IS |
| Scottish Government guidance | SG |
| Established governance arrangements for parent bodies | Gov |

| 1. Governance (non-financial) arrangements | | | | |
|---|---|---|---|---|
| **Legal requirement /commitment** | **Type** | **Legal deadline** | **Target date** | **RAG** |
| Integration Scheme approved, published and Integration Joint Board (IJB) legally established | Act | 27/06/15 | - | ✔ |
| The 1st meeting of the legally constituted IJB | Act | - | 18/09/15 | ✔ |
| Ratify the remit and constitution of the IJB including its voting and non members, chair and vice chair. | Act | - | 18/09/15 | ✔ |
| The Procedural Standing Orders of the IJB agreed | Act | - | 18/09/15 | ✔ |
| IJB ratify the appointment of the Chief Officer, Chief Finance Officer and establish the Strategic Planning Group (including governance arrangements and Terms of Reference) | Act | - | 18/09/15 | ✔ |
| Risk policy, strategy, procedures and list of key strategic risks approved by IJB | IS | 27/09/15 | 18/09/15 | ✔ |
| Arrangements for Hosted Services agreed amongst the IJBs in the GG&C area. | IS | 31/03/16 | 18/03/16 | ● |
| Health and Safety policy and procedures in place | IS | 31/03/16 | 18/03/16 | ● |
| Complaints policy and procedures in place | IS | 31/03/16 | 18/03/16 | ● |
| FoI policy and procedures in place and Publications Scheme in place | Act | 31/03/16 | 18/03/16 | ● |
| Business continuity arrangements in place | IS | 31/03/16 | 18/03/16 | ● |
| Equalities scheme and EQIAs completed for Partnership (in line with IJB requirements under the Equalities Act) | IS | 31/03/16 | 18/03/16 | ● |
| Parent organisations agree the provision of support services for the IJB | IS | 31/03/16 | 18/03/16 | ● |
| CO confirms all governance arrangements in place (IJB Report) for functions to be delegated from parent organisations to the IJB | IS | 31/03/16 | 18/03/16 | ● |
| Functions delegated to IJB | Act | 01/04/16 | 01/04/16 | ● |

| Key: | ✔ | Complete | ● | On target | ▲ | Risk of delay | ● | Significant Issues |
|---|---|---|---|---|---|---|---|---|

| 2. Communication and engagement | | | | |
|---|---|---|---|---|
| **Legal requirement /commitment** | **Type** | **Legal deadline** | **Target date** | **RAG** |
| IJB agrees its participation and engagement strategy | IS | 27/12/15 | 20/11/15 | ✔ |

| 3. Strategic Plan (the order of Strategic Plan activities are prescribed in the Act but not specific individual deadlines for each stage) | | | | |
|---|---|---|---|---|
| **Legal requirement /commitment** | | **Legal deadline** | **Target date** | **RAG** |
| IJB agree its proposals for the Strategic Plan | Act | - | 18/09/15 | ✔ |
| SPG feedback on the proposals for the Strategic Plan content | Act | - | 23/09/15 | ✔ |
| IJB agree its first draft of Strategic Plan, taking account of SPG feedback | Act | - | 20/11/15 | ✔ |
| SPG feedback on the first draft of the Strategic Plan content | Act | - | 27/11/15 | ✔ |
| IJB agree its second draft of Strategic Plan, taking account of SPG feedback | Act | - | 15/01/16 | ● |
| Formal consultation with prescribed stakeholders including SPG, Health Board and Council (commences 18/01/16) | Act | - | 07/02/16 | ● |
| Update report on consultation and final draft of Strategic Plan prepared for the IJB | Act | - | 15/02/16 | ● |
| Health Board updated on the outcome of the consultation and the draft Strategic Plan | Gov | Not legal req't | 16/02/16 | ● |
| Council updated on the outcome of the consultation and the draft Strategic Plan | Gov | | 25/02/16 | ● |
| IJB approve their final version of the Strategic Plan | Act | 31/03/16 | 18/03/16 | ● |
| Strategic Plan published along with financial statement and statement of action taken by IJB under section 33 (consultation and development of the Strategic Plan). | Act | 31/03/16 | 31/03/16 | ● |

| 4. Performance Management | | | | |
|---|---|---|---|---|
| **Legal requirement /commitment** | | **Legal deadline** | **Target date** | **RAG** |
| Parties prepare a list of targets and measures in relation to delegated and non delegated functions | IS | 27/06/15 | 27/06/15 | ✔ |
| Council and Health Board develop proposals on targets and measures for 2015/16 'interim' performance framework to be submitted to an early meeting of the IJB | IS | - | 18/09/15 | ✔ |
| IJB agree its reporting arrangements and supporting plan to develop 2016/17 performance framework with the Council and Health Board | IS | - | 18/09/15 | ✔ |
| IJB agree 2016/17 performance framework, taking account of localities, reporting arrangements and plans to publish the annual performance report. | IS | 27/06/16 | 27/06/16 | ● |

## 5. Delivering for Localities

| Legal requirement /commitment | | Legal deadline | Target date | RAG |
|---|---|---|---|---|
| IJB agree locality arrangements (in line with SG guidance), based on stakeholder engagement, which will be reflected in the Strategic Plan (**must align with timeline for Strategic Plan) | IS | - | 20/11/15 | ✔ |

## 6. Workforce

| Legal requirement /commitment | | Legal deadline | Target date | RAG |
|---|---|---|---|---|
| Workforce plans and agreed management / governance structures approved by Health Board | IS | 31/03/16 | 16/02/16 | ✔ |
| Workforce plans and agreed management / governance structures approved by Council | IS | 31/03/16 | 25/02/16 | ✔ |
| Parent organisations formal structures established to link the Health Board's area partnership forum and the Council's joint consultative forum with any joint staff forum established by the IJB. | IS | 31/03/16 | 18/03/16 | ✔ |
| IJB note the approved Workforce plans and agree management / governance structures | Gov | Not legal req't | 18/03/16 | ✔ |
| Chief Officer implements Workforce governance arrangements between the IJB and parent organisations | IS | 31/03/16 | 31/03/16 | ✔ |

## 7. Clinical and Care Governance

| Legal requirement /commitment | | Legal deadline | Target date | RAG |
|---|---|---|---|---|
| IJB approve draft Quality, Care & Professional Governance Framework and implementation plan, including approach to working with parent organisations | Gov | Not legal req't | 18/09/15 | ✔ |
| The Parties and the IJB implement appropriate clinical and care governance arrangements for their duties under the Act. | IS | 31/3/16 | 18/03/16 | ✔ |
| IJB Quality, Care & Professional Governance Framework in place | IS | 31/03/16 | 18/03/16 | ✔ |
| Health and Care Governance Group established | IS | 31/03/16 | 18/03/16 | ✔ |
| Chief Social Work Officer provides annual report to IJB (Section 5.15 of IS) | IS | - | 31/10/16 | ✔ |

## 8. Finance and Audit

| Legal requirement /commitment | | Legal deadline | Target date | RAG |
|---|---|---|---|---|
| IJB Audit arrangements agreed | IS | 31/03/16 | 18/09/15 | ✔ |
| Insurance arrangements (claims handling) in place | IS | 31/03/16 | 31/12/15 | ✔ |
| IJB agree procedure with other relevant integration | | 31/03/16 | 18/03/16 | ✔ |

| | | | | |
|---|---|---|---|---|
| authorities for any claims relating to Hosted Services | | | | |
| IJB sign off financial governance arrangements as per the national guidance | IS | 31/03/16 | 20/11/15 |  |
| IJB report on due diligence on delegated baseline budgets moving into 2016/17 | IS | 31/03/16 | 18/03/16 |  |
| Draft proposal for the 2016/17 Integrated Budget based on the Strategic Plan approved by IJB | IS | 31/03/16 | 18/03/16 |  |
| Draft proposal for the Integrated Budget based on the Strategic Plan presented to the Council and the Health Board for consideration as part of their respective annual budget setting process | IS | 31/03/16 | 31/03/16 |  |
| Parent organisations confirm final IJB budget | IS | 31/03/16 | 31/03/16 |  |
| Financial statement published with the Strategic Plan | Act | 31/03/16 | 31/03/16 |  |
| Resources for delegated functions transferred to IJB from parent organisations | Act | 31/03/16 | 31/03/16 |  |
| Audit Committee established with agreed Terms of Reference | IS | 31/03/16 | 31/03/16 |  |

## 9. Information sharing and ICT

| Legal requirement /commitment | Type | Legal deadline | Target date | RAG |
|---|---|---|---|---|
| Information Sharing Protocol ratified by parent organisations | IS | 31/03/16 | 25/02/16 |  |
| Information Sharing Protocol shared with IJB | Gov | Not legal req't | 18/03/16 |  |
| Appropriate Information Governance arrangements are put in place by the Chief Officer | IS | 31/03/16 | 31/03/16 |  |

In addition to these legal milestones, regular progress reports will be brought to the IJB to provide reassurance that the Renfrewshire Health and Social Care Partnership is on track to deliver on its commitments.

The legal milestones will be reviewed and, where appropriate, revised in light of further guidance which is expected to be issued by the Scottish Government.
Further to this statutory work to progress these key areas, additional work is also underway to support the establishment of the Partnership including

- Regular, and meaningful, communication and engagement with our staff and key stakeholders, in particular community partners, outwith the formal prescribed consultation on the Strategic Plan;
- Organisational development activities for our Senior Leadership Group, IJB, Strategic Planning Group and workforce during 2015/16;
- Addressing the ICT and information sharing barriers which can be tackled in the short term, and start identifying the key ICT developments which will enable more seamless integrated working in future.

**To:** **Renfrewshire Integration Joint Board**

**On:** **15 January 2016**

**Report by:** **Chief Officer**

**Heading:** **Integrated Care Fund (ICF): Mid-year Report to the Scottish Government**

## 1. Summary

1.1. The IJB is invited to note the mid-year report on the Integrated Care Fund submitted to the Scottish Government.

1.2. The Integrated Care Fund is a three-year programme of funding made available by the Scottish Government to support the integration of health and care services.

1.3. Its implementation in Renfrewshire is managed by the Interim Integrated Care Fund Sub Group which has representation from the Partners and which reports its recommendations to the HSCP Chief Officer.

1.4. The Mid Year Report was prepared by the Interim Integrated Care Fund Sub Group and signed by all the Partners, as required by the Scottish Government.

## 2. Recommendation

2.1. The IJB is asked to note the report submitted to the Scottish Government by the Renfrewshire HSCP.

## 3. Background

3.1. The Scottish Government allocated in 2015/2016 an award of £3.49m to the Renfrewshire HSCP under the Integrated Care Fund Programme. This has been supplemented by a contribution of £650,000 by Renfrewshire Council.

3.2. In December 2014 The Renfrewshire Partmers submitted a detailed Plan for 2015/2016, prepared by the Interim Integrated Care Fund Sub Group, and confirmed to the Scottish Government its main priorities for the implementation of the Integrated Care Fund for 2015/2016 viz.

- The roll-out of successful rehabilitation, reablement and technology-enabled models of service to all adult care groups, building on the successful application of such models through the four year Change Fund Programme (Reshaping Care for Older People)
- The delivery of a community capacity building plan, engaging a wide range of stakeholders in its development and delivery, with a view to third sector organisations or partnerships leading on a number of the work areas.

3.3. The Mid Year Report outlines progress to date in 2015/2016 and sets out actions proposed to address the issues identified for the future implementation of the Integrated Care Fund Plan in Renfrewshire.

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**Implications of the Report**

**1. Financial –**

The three-year Integrated Care Fund provides funding to support action on integration and is additional to mainstream budgets.

**2. HR & Organisational Development -**

**3. Community Planning –**

**4. Legal -**

**5. Property/Assets -**

**6. Information Technology -**

**7. Equality & Human Rights -** The recommendations containted within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be publised on the Council's website.

**8. Health & Safety -**

**9. Procurement -**

**10. Risk -**

**11. Privacy Impact -**

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**List of Background Papers –**

**Mid Year Report and appendices as attached to this report.**

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**INTEGRATED CARE FUND**
**2015/2016**
**MID YEAR REPORT**
**To**
**MINISTERIAL STRATEGIC GROUP ON HEALTH AND COMMUNITY CARE**

**9 November 2015**

## 1 Introduction

The Renfrewshire Health and Social Care Partnership is pleased to submit its Mid Year report on progress with the Integrated Care Fund (ICF) programme 2015/2016.

## 2 Summary Report

2.1 The HSCP and its partners have proceeded with its ICF Plan as approved by the Scottish Government in February 2015, with some proposed amendments arising from early reviews of progress and responses to partners engaging in the Integration and Localities development process.

2.2 The Partnership is rolling out the service developments initiated under the previous Change Fund project to all adult care groups, with adjustments where appropriate to ensure a close fit with ICF outcomes, priorities and criteria.

2.3 The Partnership is pleased with progress and would draw the Ministerial Strategic Group's attention to two major developments and one proposed adjustment to the existing ICF budget plan:

- Proposed review of Home Care resource plan
- Implementation of strategic programme of community capacity-building Infrastructure Investment Projects
- Proposed enhancement of resources for Integration and Localities partnership-building

## 3 Proposed review of Home Care resource plan

3.1 The ICF budget is monitored and analysed at a monthly financial monitoring officer group led by the Chief Finance Officer.

3.2 The Partnership is currently undertaking a review of Home Care processes. The findings of this review may lead to proposals to realign the ICF budget allocations within the overall £1.52million ICF allocation to Home Care service development. This would not result in a change to the overall planned allocation of ICF to the development of Home Care services but may result in recommendations to realign budget headings in pursuit of the continuing transformational change to home care for adults and to ensure close realignment with ICF outcomes, priorities and criteria.

3.3 Justification for the proposed review and realignment of the ICF's home care budgets may be reflected in the current reporting of underspend in some home care budget lines.

3.4 Proposals for realignment, should they emerge, will be considered by the Partnership's ICF Sub Group as part of its budget planning process for 2016/2017 and finalised by the HSCP's Integrated Joint Board before submission to the Scottish Government.

**4. Implementation of strategic programme of community capacity-building Infrastructure Investment Projects**

4.1 The 2015/2016 Integrated Care Fund plan included an outline of the community capacity building plan being developed.

4.2 A third sector steering group (community capacity building) has been established and four infrastructure investment projects were approved by the HSCP ICF Sub Group in August 2015. These projects are now in their set-up phase. The partners will agree a strategic evaluation framework in January 2016 following the set-up phase and will engage a range of stakeholders in the process.

4.3 These infrastructure investment projects are being developed as pilots in different localities in Renfrewshire, with each project being led by a third sector partner.

**Community Health Champions Programme** - recruiting, training and supporting local people in their communities to become community health champions, supporting local health and well-being activity and developing links between communities and local health and care services (partnership initiative being led by third sector health and well being organisation)
**GP Social Prescribing –** a pilot setting up a Social Prescribing scheme in a number of GP practices to link patients with non-medical supports in their own communities (partnership initiative being led by third sector mental health organisation)
**Lifestyle management programme** - support for people with long term conditions, setting up a pilot to test referrals from GPs, the Social Prescribing Scheme and other health and care providers into a structured self-management course embedded in local community supports (partnership initiative to be led by the Thistle Foundation)
**Housing and Health Information Access Points** – piloting the delivery of easy access points of information for people about health and well being and health-related housing issues in local communities in points with a lot of public footfall (Partnership initiative being led by Linstone Housing Association)

4.4 It is anticipated that the monitoring and evaluation of the impact of these Infrastructure Investment projects will include measures of impact on individuals' self-management of mental health and well being.

5 **Proposed enhancement of resources for Integration and Localities partnership-building**

5.1 The original ICF plan submitted to the Scottish Government in February 2015 included resources for "Localities and Care and Repair service". This project was originally described as "localities and care and repair" but, on review, the Sub Group agreed to recommend to the HSCP that the primary focus of this workstream be partnership-focused relationship-building in the new localities being developed in the Renfrewshire HSCP.

Current developments being supported are:

- GP support for engagement in localities planning
- Business Admin support for Localities and Integration

5.2 The HSCP's input to the Care and Repair service will be considered as part of a wider consideration of the development of the aids and adaptations services in partnership with the Council's Housing service.

## 6. Outcomes monitoring

6.1 The Partnership monitors regularly the delivery of the ICF projects in pursuit of Integrated Care Outcomes on an operational basis through the Senior Management Monitoring group, which meets monthly, and the Interim Integrated Care Fund Sub Group, which meets on a 6 weekly cycle, in partnership with the Third Sector Steering Group (Community Capacity-building).

6.2 The strategic Community Capacity-building outcomes will be monitored through a strategic evaluation framework, the design of which is currently underway and which is expected to go live in early 2016 (see fig 1 below). The Framework will be developed using a Contribution Analysis model.

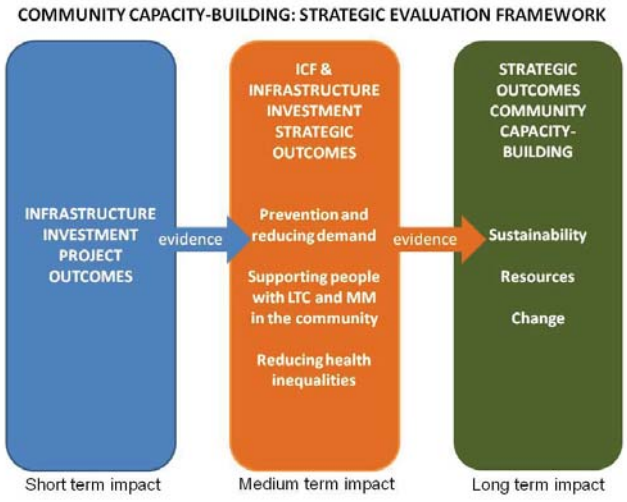


fig 1

## 7. Proposed Action on Potential Slippage

7.1 As the report at Annex B part (i) shows, some slippage is expected in the 2015/2016 budget as a result of:

a) The anticipated need to realign the home care budgets as a result of a major service review as described above;
b) The need to step up action on recruiting into posts as a result of additional ICF funding being made available in key pressure areas; and
c) The need to match resources to the pace of development in integration and localities development in Renfrewshire

7.2 Significant interest is being raised in the third and community sectors around the implementation of the four infrastructure investment projects and it is anticipated that interest in engagement activities in local communities will rise significantly over the next 12 – 18 months as these projects roll out.

7.3 The HSCP's IJB considers is prudent to hold over some of the capacity-building resources until a period in 2016/2017 when the four infrastructure projects begin to bear fruit and stimulate interest in engagement and the need for seed corn funding for a range of third sector-led, community-based activities.

7.4 It is proposed, therefore, that a portion of the ICF community capacity-building funds be carried forward into the next financial year to be allocated, with the agreement of the stakeholders, as part of the process of localities development, community capacity building and the development of local networks.

## 8. Closing remarks

8.1 The IJB would welcome the thoughts of the Ministerial Strategic Group on the Renfrewshire HSCP's progress to date and its plans for future development.

Renfrewshire HSCP ICF 2015/2016 annex B (i)

| WORKSTREAM | allocation 2015/2016 | spend April to Sept 2015 | forecast spend Oct to end March 2016 | projected over/underspend |
|---|---|---|---|---|
| home care | £ 1,512,441.00 | £ 432,895.00 | £ 640,875.00 | £ 438,671.00 |
| Mental Health Officers - Adults With Incapacity | £ 171,565.00 | £ 56,502.00 | £ 98,987.00 | £ 16,076.00 |
| Rehab and Enablement | £ 974,000.00 | £ 453,000.00 | £ 321,000.00 | £ 200,000.00 |
| hospital-based services | £ 322,480.00 | £ 175,415.50 | £ 147,064.50 | £ - |
| care homes service development | £ 74,694.00 | £ 7,150.00 | £ 67,544.00 | £ - |
| housing and housing-linked supports | £ 56,000.00 | | £ 35,500.00 | £ 20,500.00 |
| carers respite | £ 70,000.00 | £ 14,119.00 | £ 55,881.00 | £ - |
| community support and capacity-building | £ 522,500.00 | £ 85,105.00 | £ 287,395.00 | £ 150,000.00 |
| localities and integration partnership development | £ 380,000.00 | £ - | £ 322,936.00 | £ 57,064.00 |
| enablers | £ 56,238.00 | £ 22,560.00 | £ 26,056.00 | £ 7,622.00 |
| total | £ 4,139,918.00 | £ 1,246,746.50 | £ 2,003,238.50 | £ 889,933.00 |
| | | | | |

**Workstream Projects**

home care
further development of reablement
reablement rapid response
extra care home care staff
dementia and palliative care
telecare and telehealth

Mental Health Officers - Adults With Incapacity
MHO posts - increasing capacity to meet demand

Rehab and Enablement (RES)
staff
equipment

carers respite (older people)
home-based respite service

Community Support and Capacity-building

| | |
|---|---|
| ROAR | older people's social and well being clubs |
| Food Train | shopping service for older people |
| Alzheimer's Scotland | community connections |

Capacity Building
housing and health support (3rd sector)
multi morbidities innovation
community capacity building

enablers
project manager post
info and networking support (third sector)

hospital-based services
IN Reach Nurses (RES employees)

additional AHP staff to Acute, orthopaedics, stroke
outreach and unscheduled care service
out of hours physio and OT at RAH
community geriatrician

care homes service development
increase CPN input to care homes
Scottish Care Development Officer support
GP input into palliative care

housing and housing-linked supports
handyperson service (committed to March 2016)
options advice (older people) (committed to end March 16)

localities and integration partnership building

GP engagement
business and admin support
Adults with Incapacity - Financial Welfare Assistant (2015/2016)

**WORKSTREAMS AND PROJECTS, INTEGRATED CARE FUND 2015/2016**

**RENFREWSHIRE**

| Work Streams | ICF Outcomes and Approaches to Service Development 2015/16 | Progress towards outcomes | Sources of data used to monitor progress | Action taken in relation to under-performance |
|---|---|---|---|---|
| **Home care**<br><br>Comprising:<br>• Further development of reablement<br>• Reablement rapid response<br>• Extra care home care staff<br>• Dementia and palliative care<br>• Technology-enabled care | outcomes: reducing future demand; supporting people with multi-morbidities<br><br>service dev: personalised service; asset-based service model; increasing use of technology-enabled care | Despite demand for services continuing in an upwards direction as a result of demographics, the Partnership has managed to sustain the improvements made during the last 5 years in terms of reducing delayed discharge from hospital to extremely low levels (excluding AWI cases) through the provision of a flexible and responsive home care service, supported by technology enabled care approaches.<br><br>Bed Days Lost due to delayed discharge in August 2015 totalled 284 of which 217 were due to AWI issues.<br><br>The reablement rapid response service works closely with the hospital- based discharge services and the "front door" developments at the RAH designed to divert cases to appropriate services in the community wherever possible, reducing avoidable admissions and maintaining performance in low levels of delayed discharge.<br><br>A major review of the Home Care service is currently underway and will inform future development of the reablement service.<br><br>The ICF is supporting the home care services to develop and deliver support for people with dementia to live at home for longer, helping reduce or defer demand on care home placements. This has been primarily through the provision of extra care homes, the upskillling of staff to deliver care for people with dementia and a comprehensive technology enabled care programme. | Monthly performance reports to Senior Managers' monitoring group with data from the EDISON and SWIFT information management systems | Meeting monthly, the Senior Managers' monitoring group adopts a Service Improvement Plan approach to identified underperformance or potential difficulties in key service areas or pathways.<br><br>A major review of the Home Care service planning is currently underway. This may result in recommendations on the realignment of budgets within global "home Care" ICF budget to take account of developments in service in the last 5 years; demand continues to climb but the impact of Change action under the Change Fund is likely to require a shift of resources from some budget areas to others to maintain direction of travel in reducing future demand and supporting people with multi-morbidities in the community and in further developing personalised services across all adult care groups. |
| | | | | |

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|---|---|---|---|---|
| **AWI assessment – MHO capacity**<br><br>Comprising:<br>• MHO staffing<br>• Financial Welfare Assistant | outcomes: reducing future demand<br>service dev: personalised service | Demand levels on the MHO service continues to climb as a result of demographics.<br><br>The Renfrewshire Partnership continues to take a service improvement action on AWI, enhancing capacity in the MHO services, having recently created an MHO Resource worker post from one-off resources made available from Scottish Government.<br><br>A post of Financial Welfare Assistant is being funded in 2015/2016 to assist families deal with AWI issues and is expected to be mainstreamed in 2016/2017.<br><br>Action is being taken to facilitate and speed up connections between the various parties involved in AWI cases but, as the Scottish Government representatives acknowledge, more significant improvements in performance in dealing with AWI in Renfrewshire will rely on longer term work at a national level, taking into account legal and policy matters.<br><br>The use of nursing home facilities with full NHS support for patients with AWI has helped reduce pressures on EMI beds in the RAH.<br><br>Good progress is being made in working with local solicitors to facilitate the legal aspects of AWI cases. | Monthly performance reports to Senior Managers' monitoring group with EDISON and SWIFT information management systems data from the | Monthly Senior Managers' monitoring group adopts a Service Improvement Plan approach to identified underperformance or potential difficulties in key service areas or pathways. There is no underperformance in the MHO service, but prioritisation of hospital cases does lead to delays in the private and new cases simply due to the pressure of demand and the capacity available to meet demand.<br><br>The impact of the recent additional resources will be monitored by the Senior Managers' Monitoring Group and the information will contribute to future resource planning.<br><br>The MHO team leader reports on progress to the group and the group takes a co-productive approach to identifying ways of enhancing the service e.g. there is now MHO/SW input to regular hospital-based multi-disciplinary case reviews. |
| **Rehabilitation and Enablement Service (RES) and District Nursing Service**<br><br>Comprising:<br>• Staff<br>• Equipment | Outcomes: Reducing future demand; supporting people with multiple morbidities<br><br>Service development: personalised services, increasing use of technology | Despite demand for services continuing in an upwards direction as a result of demographics, the Partnership has managed to sustain the improvements made during the last 5 years in terms of reducing delayed discharge from hospital to extremely low levels (excluding AWI cases) through the provision of a flexible and responsive community-based rehabilitation and enablement service that works closely with the home care service.<br><br>The RES rapid response service works closely with the hospital- based discharge services and the "front door" developments at the RAH designed to divert cases to appropriate services in the community wherever possible, reducing avoidable admissions and maintaining performance in | Monthly performance reports to Senior Managers' monitoring group with data from the EDISON and SWIFT information management systems | Monthly Senior Managers' monitoring group adopts a Service Improvement Plan approach to identified underperformance or potential difficulties in key service areas or pathways.<br><br>Recent action has included reviews of the OT services and pathways to identify closer working between the former Community Health, former SW OT services and Acute services to be more person-centred and streamlined. There is also close monitoring of the physiotherapy service which is facing increasing demand as a permanent feature with limited permanent capacity to meet demand. Recent action arising from the Service Improvement |

| | | | | |
|---|---|---|---|---|
| | | delayed discharge. | | approach has been to shift resources on a temporary basis to provide additional hours of service to address waiting list priorities. |
| | | | | |
| **Hospital-based services**<br><br>Comprising:<br><br>• In Reach District Nurses on wards<br>• AHP staff in key hospital wards<br>• Physiotherapy and OT weekend working<br>• Community Geriatrician | Outcomes: reducing future demand, supporting people with multi-morbidities<br><br>Service development: personalisation of services | The hospital-based services supported by the Integrated Care Fund are designed to improve "front door" services at the hospital and to streamline pathways for patients, both within the hospital and between the hospital and community health and care services.<br><br>Targeting the ICF on developing more flexible work patterns, out of hours services and "in reach" teams to link acute services with community services, has been further developed by the Renfrewshire Development Programme (CSR) which built on the work of the previous Change Fund.<br><br>The RES In Reach nurses work closely with patients, families, ward staff and SW staff to facilitate people's discharge home from hospital.<br><br>The community geriatrician makes significant contribution to the development of rapid access clinics and day hospitals, helping to avoid admissions to acute wards through closer working with GPs and the community health services.<br><br>The community geriatrician has made a crucial contribution to the Renfrewshire Development Programme's Older Adults Assessment Unit at the "front door" of the Royal Alexandra Hospital.<br><br>The April 2015 Status Report indicated that the **Older Adult Assessment Unit (OAAU) was delivering a** Fast track service to best care for older adults, providing access to Comprehensive Geriatric Assessment.<br>Early results were encouraging:<br><br>o Up to 6 patients per day<br><br>79% discharged directly from OAAU (29% same-day, 52% within 24hours, 66% within 72 hours)<br><br>o Positive feedback from patients/carers & physicians. | Extracts from GGCNHS on performance against targets reported to the Senior Management Monitoring Group | Service Improvements at the RAH are managed by the GGCNHS Board and by hospital management.<br><br>Where appropriate, the Senior Managers' monitoring group may contribute to changes in pathways or interfaces to support hospital-based improvements e.g. using the rapid response teams to support delivery of out of hours discharge service. |

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|---|---|---|---|---|
| | | | | |
| **Care Homes**<br><br>Comprising:<br>• Increase in CPN input to care homes<br>• GP input to palliative care<br>• Scottish Care Development Officer | Outcomes: reducing future demand; supporting people with multi-morbidities<br><br>Service development: asset-based model; personalised services, co-production | The Integrated Care Fund makes a contribution to service developments in the care home services, working with care homes in the public and private sector: increasing liaison between GPs, the community geriatrician and SW services and upskilling care home staff and supporting collaborative approaches to training and development. The ICF contributes to the development of ACP in care homes and the development of palliative care skills to allow people who choose to die in their (care) homes rather than hospital.<br><br>The Scottish Care post funded through the ICF contributes to the liaison between care homes and the various agencies and services in the statutory public health and care services and facilitates links with developments in the third and independent sectors.<br><br>The ICF contributes to enhanced CPN input to care homes, to train and offer guidance to staff in dealing with mental health issues affecting residents. The key aim is to enable people with dementia and other mental health issues to stay in their own care homes for as long as possible, receiving appropriate care and avoiding unnecessary admissions to hospital.<br><br>The innovative work initiated under the RCOP programme continues under the ICF and has proved a foundation for mainstream developments currently underway to enhance care provision in care homes, making links between hospital EMI services and care homes | Monitoring of care home developments are undertaken by SW contracts team and by HSCP operational managers working with liaison nurses and mental health staff; reports are made to the Senior Managers' Monitoring group | Monthly Senior Managers' monitoring group adopts a Service Improvement Plan approach to identified underperformance or potential difficulties in key service areas or pathways. |
| | | | | |
| **Housing and Housing-linked supports**<br><br>Comprising:<br><br>• Handy person service<br>• Options advice service<br><br>Also new pilot (see below) Housing | Outcomes: reducing future demand<br><br>Service development: asset-based models | The ICF currently contributes to some services delivered to older and vulnerable people under management by a third sector housing association.<br><br>Lessons have been learned from the delivery of these 3 year projects, funded under the Change Fund, and future opportunities will be considered by the Interim Integrated Care Fund Sub Group at its budget planning session for 2016/2017 | Service delivery projects supported by the ICF are monitored through Service Level Agreements managed by the Council on behalf of the HSCP | |

| | | | | |
|---|---|---|---|---|
| and Health Community Information Hubs | | and recommendations will be made to the IJB.<br><br>The future development of the care and repair services (which includes the handy person service) will be considered by the HSCP as part of a wider consideration of care and repair, aids and adaptations and OT services.<br><br>There is also a Housing Association-led "Housing and Health" community hubs pilot being implemented as part of the Infrastructure Investment Projects development (third sector) which seeks to provide a single point of access to information and advice within localities and to facilitate people's engagement in health and well-being activity and in locality-focused planning and decision making on health and care services. | | |
| | | | | |
| **Carers' Support (home based respite)** | Outcomes: reducing future demand; supporting people with multi-morbidities<br><br>Service development: asset-based model | The service has been welcomed by older people and their carers as a means of supporting carers in their caring role. | The contract with the provider is monitored by the HSCP's SW service. | The contract manager manages the contract and liaises with the provider in relation to any service improvements required. |
| | | | | |
| **Community support and capacity-building:**<br><br>• Third sector service development:<br><br>o ROAR (reaching older adults in Renfrewshire)<br>o The Food Train<br>o Alzheimer's Scotland Community Connections<br><br>• Capacity-building:<br><br>o GP Social Prescribing pilot<br>o Community Health Champions<br>o Housing and Health Community Information Hubs (see above)<br>o Live Well, Stay Well (self-management programme using technology-enabled care for people with multi morbidities and long term | Outcomes: reducing future demand; addressing health inequalities; supporting people with multi-morbidities<br><br>Service development: asset-based model | The four infrastructure investment pilots are currently in the set- up phase. Staff have been recruited and working relationships are being established with GP services in the pilot areas as well as with local community-based groups and organisations.<br><br>It is anticipated at this early stage that key target groups will be:<br><br>people with mental health issues or identified by GPs as being in danger of developing mental health problems<br><br>people with a range of life issues which impact, or which will potentially impact on their physical and mental health e.g. poor housing, poor nutrition, loneliness and isolation<br><br>People with multiple morbidities who may benefit significantly in terms of being able to access a range of community based supports for their self management of their conditions | Service delivery projects supported by the ICF are monitored through Service Level Agreements managed by the Council on behalf of the HSCP<br><br>A third sector steering group (community capacity-building) works with the HSCP Interim Integrated Care Fund Sub Group to monitor progress in infrastructure investment projects.<br><br>The Infrastructure Investment projects are currently being implemented by the third sector project leads collaboratively through a project implementation steering group. | Close self-monitoring by the project leads and by the third sector steering group, reporting to the Sub Group (6 weekly basis) with input from HSCP officers, will monitor progress. Should underperformance or difficulties be identified at an early stage, a service improvement plan will be adopted by the project leads, supported by the third sector steering group and the HSCP. |

| | | | | |
|---|---|---|---|---|
| conditions | | | Each project lead will report on performance to the Sub Group<br><br>A Strategic Evaluation Framework is under development and will go "live" in January following the three month set up phase for the pilot projects.<br><br>Each Infrastructure Investment pilot has an individual performance monitoring plan which is reported to the ICF Sub Group. | |
| | | | | |
| **Localities and Integration Partnership Development (formerly known as "Localities and Care and Repair)**<br><br>Note: this project was originally described as "localities and care and repair" but, on review, the Sub Group agreed to recommend to the HSCP that the focus of this workstream be partnership-building in the new localities being developed in the Renfrewshire HSCP<br><br>Current developments being supported are:<br><br>• GP support for engagement in localities planning<br><br>• Business Admin support for Localities and Integration partnership-building | Outcomes: addressing health inequalities; reducing future demand | This support activity is still in early stages. It is, in part, responding to feedback from GPs about their interest in localities development and addressing their concerns about their capacity to release relevant staff to engage fully in planning and development activity. | Implementation of projects approved under this programme will be monitored by senior managers and/or the Sub Group as appropriate | |
| **Enablers** | | | | |
| Project Management | service dev: co-production | The project manager post funded through ICF supports the ICF Sub Group, the Third Sector steering group and partners in their development planning, delivery, monitoring and strategic reporting. | The Project Manager reports to the Sub Group and to the interim heads of service (adult services and Primary and Community Health) | |

**INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16**

**Integrated Care Fund - Indicators of progress**

| Question | Comment |
|---|---|
| How has ICF funding allowed links to be established with wider Community Planning activity? | Engage Renfrewshire, the Third Sector Interface, is engaged both at the ICF Sub Group and the Third Sector Steering Group in the delivery of the community capacity building projects. Engage and HSCP staff report to the CPP's thematic board, Community Care, Health and Well-being, on a regular basis on progress in community capacity building on health and well being and on the progress of the Infrastructure Investment projects, helping identify potential future partnership links in locality-based activity.<br><br>Previous area-based planning workshops, a joint initiatives with CPP staff, Engage, other third sector and independent sector parties and reps from the statutory services, produced information and materials which are now being used to support wider stakeholder partnership work e.g. local action research or transport, the development of the ICF infrastructure pilot, housing and health information hubs. This activity was supported by the Geographic Information System, helping the HSCP and the CPP to develop a user friendly technology to support locality-based planning. |
| What progress has been made linking ICF activity to work being taken forward through Strategic Commissioning more broadly? | The Infrastructure Investment projects will be evaluated using a strategic evaluation framework, currently under development, to be launched in January 2016, which will include evaluation of the projects' impacts on long term strategic commissioning models and processes, with particular reference to preventative and support services. A member of the Council's Strategic Commissioning Team supports the third sector steering group in this work and will help coordinate the management of the Strategic Evaluation Framework over the life of the ICF Infrastructure Investment projects. |
| How has ICF funding strengthened localities including input from Third Sector, Carers and Service Users | Previous area-based planning workshops produced information and materials which are now being used to support wider stakeholder partnership work. The four third sector-led Infrastructure Investment pilot projects are being developed and delivered on a localities basis in a number of localities. The lessons learned will be used to help localities-based planning groups to consider the potential to roll out or adapt the pilots to suit their own local needs. |

| | |
|---|---|
| What evidence (if any) is available to the partnership that ICF investments are sustainable | Part of the strategic evaluation of the pilots will be to assess the potential for sustainability of new services developed. A positive approach has been adopted at the start by the four third sector leads of the infrastructure investment projects who were able to contribute resources other than ICF to the package of funding for the pilot projects, a recognition of the need to be more strategic in the preparation of business plans and funding packages for new service development. |
| Where applicable - what progress has been made in implementing the National Action Plan for Multi-Morbidity | One of the Infrastructure Investment pilots, to be based initially in Renfrew, is focused on developing a programme of support, in partnership with GP practices, for self management for people with long term conditions and multi-morbidities, with reference to the use of technology-enabled care where possible. The other three infrastructure investment projects, focusing on Linwood and Johnstone, will also be encouraging people with multi-morbidities to engage in the community-based action on self management of conditions and of general health and well-being. There will be strong links between the Renfrew project and the Linwood and Johnstone projects. |

**INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16**

PARTNERSHIP DETAILS

| | |
|---|---|
| Partnership name: | |
| Contact name(s) | |
| Contact Telephone | |
| Email | |
| Date Agreed | |

The content of this template has been agreed as accurate by:

…….. (name) for NHS Board

…….. (name) for Local Authority

…….. (name) for Third Sector

…….. (name) for Independent Sector

When complete and signed please return to:

Brian Nisbet
GE-18, St Andrew House,
Regent Road,
Edinburgh,
EH1 3DG

Or send via e-mail to IRC@gov.scot

**To:** **Renfrewshire Integration Joint Board**

**On:** **15 January 2016**

**Report by:** **Chief Officer, Renfrewshire Health and Social Care Partnership**

**Heading:** **Audit Scotland Report on Health and Social Care Integration**

## 1. Summary

1.1 Audit Scotland have published a report outlining progress towards the integration of health and social care in Scotland. The report focuses on the transition year 2015/16.

1.2 Auditors have highlighted a number of risks and issues which integration authorities should be aware of as they move towards full delegation of functions from 1st April 2016.

1.3 The report also makes recommendations for the Scottish Government, for integration authorities, and jointly for integration authorities, Councils and Health Boards.

1.4 This report details the main findings from the Audit Scotland report and outlines some areas of local progress which show how work in Renfrewshire is addressing national issues raised by Audit Scotland.

1.5 The full Audit Scotland report is attached at Appendix 1 for information.

## 2. Recommendations

2.1 Members are asked to:

- Note the contents of the Audit Scotland report
- Note the progress to date to establish the Renfrewshire Health and Social Care Partnership
- Note that the content of future Audit Scotland reports on health and social care integration will be brought to this Board for consideration.

## 3. Background

3.1 Audit Scotland have undertaken the first of three planned audits examining progress with the integration of health and social care. The report on this first audit, which looked at progress during the transitional year, was published in December 2015. Subsequent audits will look at progress after the first year of establishment, and the longer-term impact of integration in shifting resources towards community-based services and preventative interventions and in improving outcomes for people who use services.

3.2 Fieldwork to inform the report was carried out in October 2015 and the findings are based on evidence which includes documents published by integration authorities (integration schemes, strategic plans etc), the work of local auditors, the Care Inspectorate and Healthcare Improvement Scotland, surveys completed by integration authorities, and interviews with key stakeholders. Renfrewshire was not one of the areas included in the sample for detailed review.

### Findings of the Report

3.3 Audit Scotland found that there is widespread support for the principles of integration within the organisations implementing the changes, and that progress is being made with implementation arrangements. However, the report notes that there are still concerns about the practicalities of integration. The report identifies a number of risks and issues which need to be addressed if there is to be a fundamental shift in the way health and social care services are delivered.

3.4 Potential risks and issues in relation to governance include:

- The size of Integration Joint Boards, specifically that larger boards may find it difficult to reach agreement and make key decisions. One example of a board deemed too large has 23 members.
- The potential for conflicts of interest to arise, as voting members of IJBs have a dual function, since they continue to serve as members of either a Council or a Health Board. There is also the potential for conflict of interest for senior managers, who must support the needs of the IJB but also have responsibilities to their employer.
- The need to establish clear scrutiny arrangements, which include mechanisms for linking back to Councils and Health Boards
- The establishment of clear procedures for clinical and care governance
- The need for a clear understanding, not only within the partnership but beyond, of lines of accountability. The IJB is responsible for planning and commissioning services, but the responsibility for delivering services lies with Councils and Health Boards.

3.5 In relation to planning for integration, Audit Scotland highlight the following issues and potential risks:

- Strategic plans already published tend to be aspirational and high level, and lack important detail about how resources will be utilised and how integration will improve services.
- The performance measurement systems proposed by the Scottish Government will not provide sufficient information to demonstrate that integration is delivering the change expected.
- The role of localities in planning and delivery of services is not well developed
- There is a pressing need for detailed workforce planning which links resources to service developments and strategic priorities.
- In many areas, supporting strategies (data sharing plans, risk management plans etc) are still to be produced.

3.6 The report raises concerns about the funding for integration authorities and notes the challenges in agreeing budgets. Audit Scotland also believe that there may be difficulty in evidencing that savings are being delivered as a result of integration.

3.7 More generally, it is noted that guidance issued by the Scottish Government has not been timeous in relation to the legislative requirements on integration authorities. A number of authorities had already prepared strategic plans and/or made arrangements for locality planning before guidance was issued in 2015. Similarly, guidance on performance frameworks has not yet been issued.

3.8 Based on these risks and issues, Audit Scotland indicate that there may be limited scope for integration authorities to have an immediate impact on reshaping local services.

**Audit Scotland Recommendations**

3.9 The report makes a number of recommendations not only for integration authorities but for the Scottish Government and jointly for integration authorities, Councils and Health Boards. These are summarised below.

3.10 The Scottish Government should:

- Work with integration authorities to help them develop performance monitoring in order to demonstrate impact of integrated services
- Monitor and publicly report on national progress on the impact of integration
- Provide ongoing support to integration authorities, including leadership development, and sharing of good practice.

3.11 Integration authorities should:

- Provide clear and strategic leadership to take forward the integration agenda, establishing a culture of openness, respect and support

- Set out clear and practical governance arrangements which include arrangements for managing complex accountabilities and potential conflicts
- Ensure a constructive working relationship between Integration Joint Board members, the Chief Officer, Chief Finance Officer and the public
- Be rigorous and transparent in their decision making, demonstrating evidence-based decisions, effective risk management and audit procedures, and a willingness to response to constructive scrutiny
- Develop strategic plans which do more than set out the local context for reforms
- Develop financial plans clearly showing a shift towards community-based services and preventative spend
- Demonstrate a shift in resources towards community-based health and preventative interventions.

3.12 Integration authorities should work jointly with Councils and NHS Boards to:

- Recognise and address the practical risks arising from complex accountability arrangements
- Review clinical and care governance arrangements to ensure consistency for each integrated service and alignment with arrangements in local authorities and Health Boards
- Urgently agree budgets for integration authorities
- Establish effective scrutiny arrangements to ensure Councillors and non-executive NHS Board members who are not on the Integration Joint Board are kept fully informed of the impact of integration on people who use services
- Put data-sharing agreements in place.

**Local progress**

3.13 Many of the risks and issues identified by Audit Scotland have been recognised locally in Renfrewshire and work has been ongoing throughout the transition year to address these.

3.14 Renfrewshire HSCP has ambitious plans for development but recognises that much of this work will take place in 2016/17 and beyond. Staff and stakeholder engagement has been a central element in work to date and this will continue.

3.15 Good progress has been made in terms of developing a number of key supporting plans, and some of these have already been approved by the IJB. Clinical and care governance arrangements have been established and ensure strong links with other Council and NHS services and clear professional leadership for practitioners.

3.16 A Strategic Plan first draft was approved in November 2015 and our consultation draft is being considered at the January 2016 IJB. The plan has been drafted in consultation with the Strategic Planning Group. A performance framework has already been developed and the final draft will include a financial framework.

3.17 Renfrewshire Health and Social Care Partnership will use the findings from the Audit Scotland report to guide and support its wider organisational development.

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**Implications of the Report**

1. **Financial** – *None.*

2. **HR & Organisational Development** - *None*

3. **Community Planning – None**

4. **Legal** - None

5. **Property/Assets** - None

6. **Information Technology** - *None*

7. **Equality & Human Rights** - The Recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement of individuals' human rights have been identified arising from the recommendations contained in the report because for example it is for noting only. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.

8. **Health & Safety** - None
9. **Procurement** – None.
10. **Risk** - *None*
11. **Privacy Impact** - *None*

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**List of Background Papers -** *None*

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Health and social care series

# Health and social care integration

ACCOUNTS COMMISSION

AUDITOR GENERAL

**Prepared by Audit Scotland**
December 2015

# The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about/ac

# Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about/ags

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

# Contents

# Key facts

Over **£8 billion**

Health and social care resources will be delegated to integration authorities in 2016/17

**18-29** per cent

Scottish Government estimate of the increase in the need for health and social care services between 2010 and 2030

**31**

Integration authorities are required to be operating by April 2016

**£138-£157m**

Scottish Government estimates of annual savings from integration

**9**

National outcomes that integration authorities are required to contribute towards

# Summary

## Key messages

1 The Public Bodies (Joint Working) (Scotland) Act 2014 introduces a significant programme of reform affecting most health and care services and over £8 billion of public money. The reforms aim to ensure services are well integrated and that people receive the care they need at the right time and in the right setting, with a focus on community-based and preventative care. The reforms are far reaching, creating opportunities to overcome previous barriers to change.

2 We found widespread support for the principles of integration from the individuals and organisations implementing the changes. The Scottish Government has provided support to partnerships to establish the new arrangements, including detailed guidance on key issues and access to data to help with strategic planning. Stakeholders are putting in place the required governance and management arrangements and, as a result, all 31 integration authorities (IAs) are expected to be operational by the statutory deadline of 1 April 2016.

3 Despite this progress, there are significant risks which need to be addressed if integration is to fundamentally change the delivery of health and care services. There is evidence to suggest that IAs will not be in a position to make a major impact during 2016/17. Difficulties in agreeing budgets and uncertainty about longer-term funding mean that they have not yet set out comprehensive strategic plans. There is broad agreement on the principles of integration. But many IAs have still to set out clear targets and timescales showing how they will make a difference to people who use health and social care services. These issues need to be addressed by April 2016 if IAs are to take a lead in improving local services.

4 There are other important issues which also need to be addressed. The proposed governance arrangements are complex, with some uncertainty about how they will work in practice. This will make it difficult for staff and the public to understand who is responsible for the care they receive. There are significant long-term workforce issues. IAs risk inheriting workforces that have been organised in response to budget pressures rather than strategic needs. Other issues include different terms and conditions for NHS and council staff, and difficulties in recruiting and retaining GPs and care staff.

there are significant risks which need to be addressed if integration is to fundamentally change the delivery of health and care services

## Recommendations

Stakeholders have done well to get the systems in place for integration, but much work remains. If the reforms are to be successful in improving outcomes for people, there are other important issues that need to be addressed:

- Partners need to set out clearly how governance arrangements will work in practice, particularly when disagreements arise. This is because there are potentially confusing lines of accountability and potential conflicts of interests for board members and staff. There is a risk that this could hamper the ability of an IA to make decisions about the changes involved in redesigning services. People may also be unclear who is ultimately responsible for the quality of care. In addition, Integration Joint Board (IJB) members need training and development to help them fulfil their role.

- IAs must have strategic plans that do more than set out the local context for the reforms. To deliver care in different ways, that better meets people's needs and improves outcomes, IAs need to set out clearly:
  - the resources, such as funding and skills, that they need
  - what success will look like
  - how they will monitor and publicly report on the impact of their plans.
- NHS boards and councils must work with IAs to agree budgets for the new IAs. This should cover both their first year and the next few years to give them the continuity and certainty they need to develop and implement strategic plans. IAs should be clear about how they will use resources to integrate services and improve outcomes.

Integration authorities need to shift resources, including the workforce, towards a more preventative and community-based approach. Even more importantly, they must show that this is making a positive impact on service users and improving outcomes.

A more comprehensive list of recommendations is set out in (Part 4).

## Background

**1.** The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) sets out a framework for integrating adult health and social care services. Social care services include supporting people to live their daily lives and helping them with basic personal care like washing, dressing and eating. People are living longer and the number of people with long-term conditions such as diabetes, and complex needs, such as multiple long-term conditions, is increasing. Current health and social care services are unsustainable; they must adapt to meet these changing needs. This means shifting from hospital care towards community-based services, and preventative services, such as support to help prevent older people from falling at home or to encourage people to be more active.

**2.** Integrating health and social care services has been a key government policy for many years. Despite this, there has been limited evidence of a shift to more community-based and preventative services. The Act sets out an ambitious programme of reform affecting most health and social care services. The scale and pace of the changes anticipated are significant, with a focus on changing how people with health and social care needs are supported.

**3.** The Act creates new partnerships, known as IAs, with statutory responsibilities to coordinate local health and social care services. The Act puts in place several national outcomes for health and social care and IAs are accountable for making improvements to these outcomes. The Act also aims to ensure that services are integrated, taking account of people's needs and making best use of available resources, such as staff and money. Each IA must establish at least two localities, which have a key role, working with professionals and the local community to develop services local people need.

**4.** IAs are currently at various stages in their development; all are required to be operational, that is taking on responsibility for budgets and services, by April 2016. The Scottish Government has estimated that IAs will oversee annual budgets totalling over £8 billion, around two-thirds of Scotland's spending on health and social work.

## About this audit

**5.** This is the first of three planned audits of this major reform programme. Subsequent audits will look at IAs' progress after their first year of being established, and their longer-term impact in shifting resources to preventative services and community-based care and in improving outcomes for the people who use these services.

**6.** This first audit provides a progress report during this transitional year. We reviewed progress at this relatively early stage to provide a picture of the emerging arrangements for setting up, managing and scrutinising IAs as they become formally established. This report highlights risks that need to be addressed as a priority to ensure the reforms succeed. The audit is based on fieldwork that was carried out up to October 2015. We hope that the issues raised in the report are timely and helpful to the Scottish Government and local partners as they continue to implement the Act.

**7.** We gathered audit evidence by:

- reviewing documents available at the time of our work, including integration schemes, strategic plans, and local progress reports on integration arrangements[1]
- drawing on the work of local auditors, the Care Inspectorate, and Healthcare Improvement Scotland
- issuing a short questionnaire to IAs on their timetable for reaching various milestones

- interviewing stakeholders who included, board members, chief officers and finance officers from six IAs, and representatives from the Scottish Government, the British Medical Association, the voluntary sector, the Convention of Scottish Local Authorities and NHS Information Services Division.[2]

Appendix 1 provides further information on our audit approach.

**8.** This work builds on previous audits that have examined joint working in health and social care. For example, our *Review of Community Health Partnerships* [PDF] highlighted the organisational barriers to improving partnership working between NHS boards and councils, and the importance of strong, shared leadership across health and social care.[3] Our subsequent report *Reshaping care for older people* [PDF] found continuing slow progress in providing joined up health and social care services.[4] This lack of progress in fundamentally shifting the balance of care from hospital to community settings, coupled with the unsustainability of current services, mean that there is a pressing need for this latest reform programme to succeed.

**9.** The Accounts Commission and Auditor General are currently conducting two other audits which complement this work:

- *Changing models of health and social care* examines the financial, demographic and other pressures facing health and social care and the implications of implementing the Scottish Government's 2020 vision for health and social care. We will publish the report in in spring 2016.

- *Social work in Scotland* will report on the scale of the financial and demand pressures facing social work. It will consider the strategies councils and integration authorities are adopting to address these challenges, how service users and carers are being involved in designing services, and leadership and oversight by elected members. We will publish the report in summer 2016.

# Part 1

## Expectations for integrated services

### Integration authorities will oversee more than £8 billion of NHS and care resources

**10.** The Public Bodies (Joint Working) (Scotland) Act 2014 sets out a significant programme of reform for the Scottish public sector. It creates a number of new public organisations, with a view to breaking down barriers to joint working between NHS boards and councils. Its overarching aim is to improve the support given to people using health and social care services.

**11.** These new partnerships will manage more than £8 billion of resources that NHS boards and councils previously managed separately. Initially, service users may not see any direct change. In most cases, people seeking support will continue to contact their GP or social work services. But, behind the scenes, IAs are expected to coordinate health and care services, commissioning NHS boards and councils to deliver services in line with a local strategic plan. Over time, the intention is that this will lead to a change in how services are provided. There will be a greater emphasis on preventative services and allowing people to receive care and support in their home or local community rather than being admitted to hospital.

### Change is needed to help meet the needs of an ageing population and increasing demands on services

**12.** Around two million people in Scotland have at least one long-term condition, and one in four adults has some form of long-term illness or disability. These become more common with age (Exhibit 1, page 10). By the age of 75, almost two-thirds of people will have developed a long-term condition.[5] People in Scotland are living longer. Combined life expectancy for males and females at birth has increased from 72 to 79 years since 1980, although there are significant variations across Scotland, largely linked to levels of deprivation and inequalities.[6] The population aged over 75 years is projected to increase by a further 63 per cent over the next 20 years.[7]

**13.** The ageing population and increasing numbers of people with long-term conditions and complex needs have already placed significant pressure on health and social care services. The Scottish Government estimates that the need for these services will rise by between 18 and 29 per cent between 2010 and 2030.[8] In the face of these increasing demands, the current model of health and care services is unsustainable:

- The Scottish Government has estimated that in any given year just two per cent of the population (around 100,000 people) account for 50 per cent of hospital and prescribing costs, and 75 per cent of unplanned hospital bed days.

the significant changes under way will have an impact on everyone who needs to access, provide or plan health and social care services

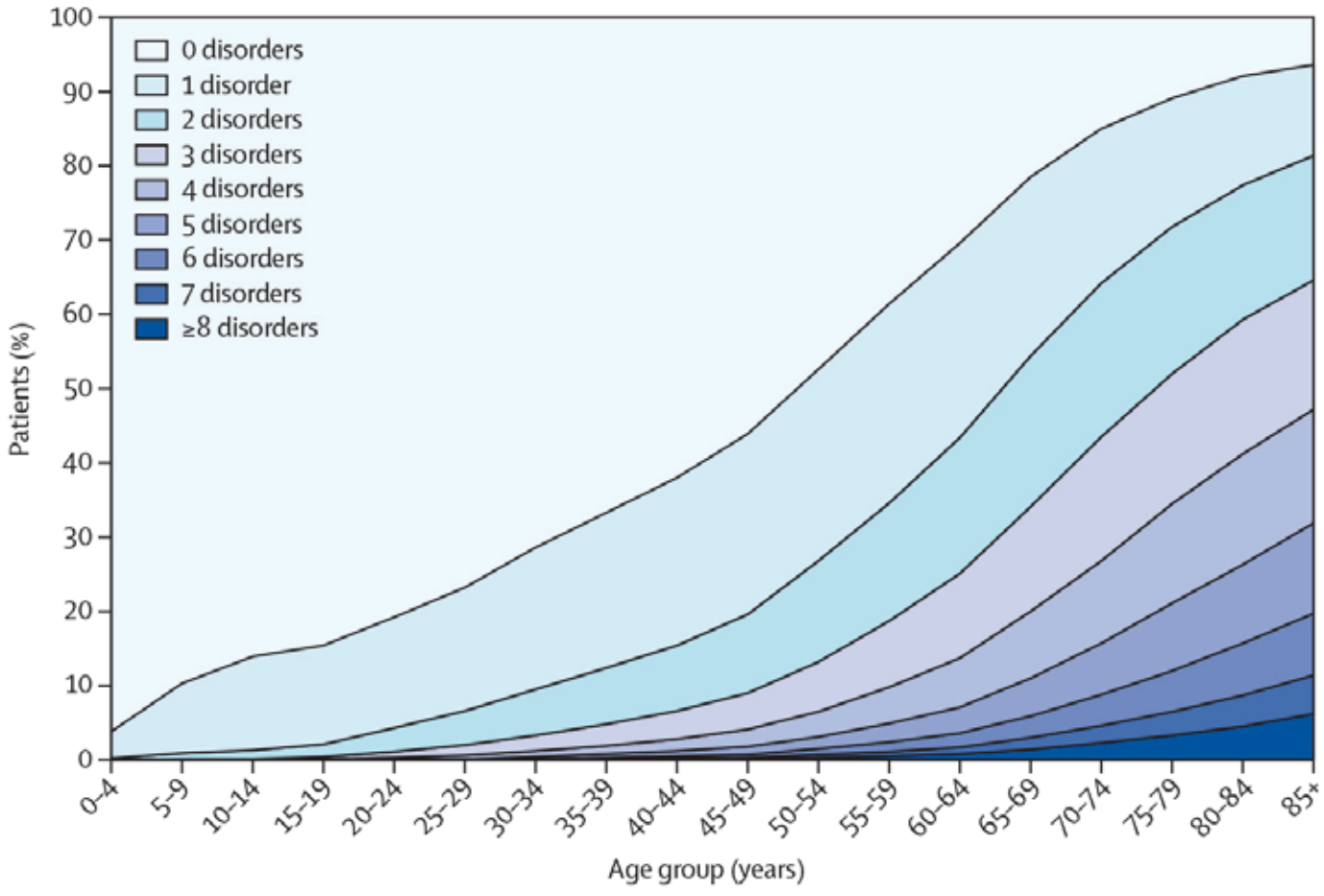
- A patient's discharge from hospital may be delayed when they are judged to be clinically ready to leave hospital but unable to leave because arrangements for care, support or accommodation have not been put in place. In 2014/15, this led to the NHS in Scotland using almost 625,000 hospital bed days for patients ready to be discharged.[9]

**14.** As a result of these pressures, there is widespread recognition that health and social care services need to be provided in fundamentally different ways. NHS boards, councils and the Scottish Government have focused significant efforts on initiatives to reduce unplanned hospital admissions and delayed discharges, yet pressures on hospitals remain. There needs to be a greater focus on anticipatory care, helping to reduce admissions to hospitals. There also needs to be better support to allow people to live independently in the community.

## Exhibit 1

### Long-term conditions by age

The number of long-term conditions that people have increases with age.




Source: Reprinted with permission from Elsevier (*The Lancet*, 2012, 380, 37-43)

**15.** None of this is unique to Scotland. Other parts of the UK and Europe face similar challenges. There have been various responses across the UK, but all try to deal with the changing needs of an ageing population, putting more emphasis on prevention and anticipatory care and seeking to shift resources from hospitals to community-based care.

**16.** A series of initiatives in Scotland over recent years has aimed to encourage a more joined-up approach to health and social care (Exhibit 2). Perhaps the most significant of these was creating Local Health Care Cooperatives (LHCCs) in 1999 and replacing them with Community Health Partnerships (CHPs) in 2004. While these reforms led to some local initiatives, LHCCs and CHPs lacked the authority to redesign services fundamentally. As a result, they had limited impact in shifting the balance of care, or in reducing admissions to hospital or delayed discharges.[10]

## Exhibit 2

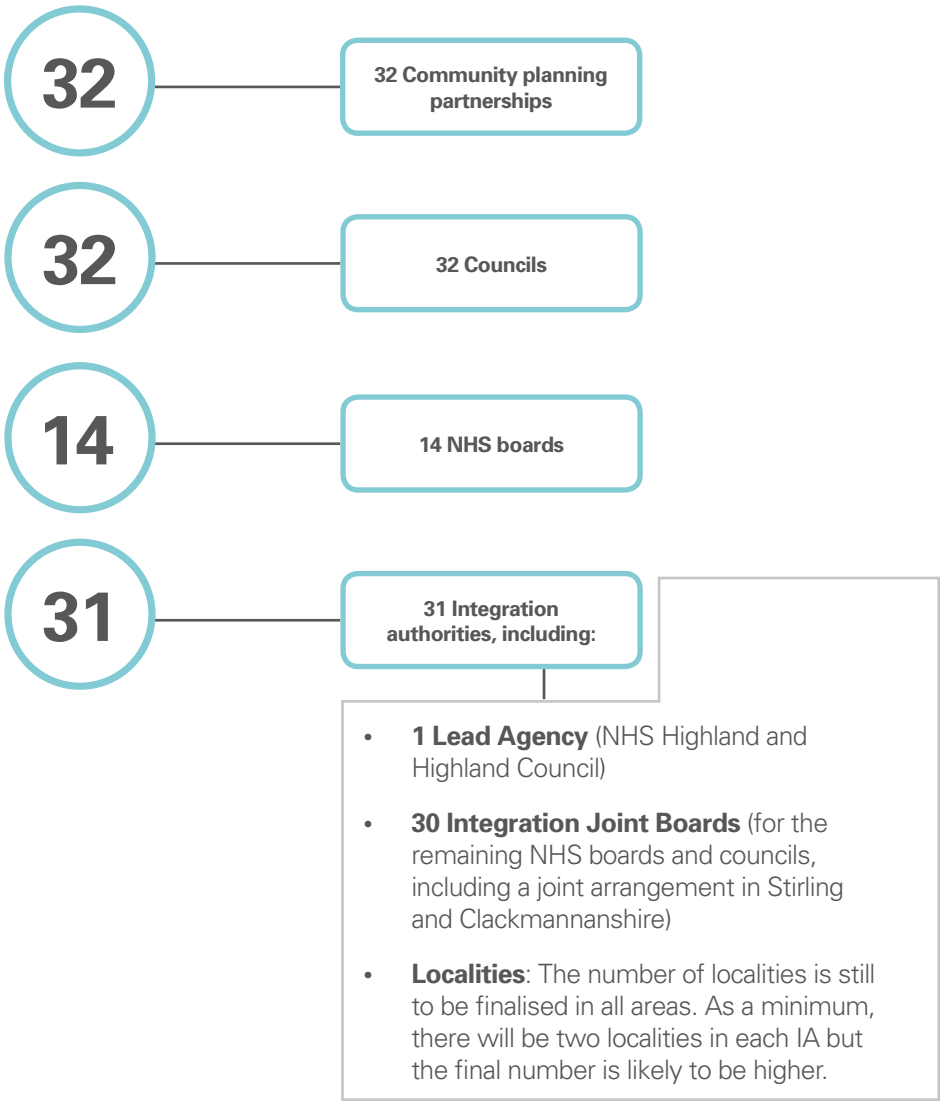
### A brief history of integration in Scotland

| | |
|---|---|
| **1999** | Seventy-nine **Local Health Care Cooperatives (LHCCs)** established, bringing together GPs and other primary healthcare professionals in an effort to increase partnership working between the NHS, social work and the voluntary sector. |
| **2002** | **Community Care and Health (Scotland) Act** introduced powers, but not duties, for NHS boards and councils to work together more effectively. |
| **2004** | **NHS Reform (Scotland) Act**, required health boards to establish CHPs, replacing LHCCs. This was a further attempt to bridge gaps between community-based care, such as GPs, and secondary healthcare, such as hospital services, and between health and social care. |
| **2005** | **Building a Health Service Fit for the Future: National Framework for Service Change**. This set out a new approach for the NHS that focused on more preventative healthcare, with a key role for CHPs in shifting the balance of care from acute hospitals to community settings. |
| **2007** | **Better Health, Better Care** set out the Scottish Government's five-year action plan, giving the NHS lead responsibility for working with partners to move care out of hospitals and into the community. |
| **2010** | **Reshaping Care for Older People Programme** launched by the Scottish Government. It introduced the Change Fund to encourage closer collaboration between NHS boards, councils and the voluntary sector. |
| **2014** | **Public Bodies (Joint Working) (Scotland) Act** introduced a statutory duty for NHS boards and councils to integrate the planning and delivery of health and social care services. |
| **2016** | All integration arrangements set out in the 2014 Act must be in place by 1 April 2016. |

Source: Audit Scotland

**17.** The relative lack of progress of earlier attempts at integration led to the Public Bodies (Joint Working) (Scotland) Act 2014. This is the first attempt in the UK to place a statutory duty on the NHS and councils to integrate health and social care services. The Act abolished CHPs, replacing them with a series of IAs (Exhibit 3, page 12). These bodies will manage budgets for providing all integrated services. Most will not initially employ staff, but instead direct NHS boards and councils to deliver services in line with a strategic plan.

## Exhibit 3
The public sector bodies overseeing health and social care services




Note: See Exhibit 4 for details of Integration Joint Board and lead agency approaches.
Source: Audit Scotland

## The Scottish Government has set out a broad framework that allows for local flexibility

**18.** The Public Bodies (Joint Working) (Scotland) Act 2014 sets out a broad framework for creating IAs. The Act and the supporting regulations and guidance give councils and NHS boards a great deal of flexibility, allowing them to develop integrated services that are best suited to local circumstances. The main aspects of this flexible framework follow below.

### Timing for establishing the new integration authorities
**19.** Scottish ministers must formally approve integration schemes for IAs: these set out the scope of services that are to be integrated and broad management and governance arrangements, including the structures and processes for

decision-making and accountability, controls and behaviour. Within this overall framework, IAs can choose when they become operational but all IAs must be established and operational, with delegated responsibility for budgets and services, by 1 April 2016.[11] Subject to the approval of their integration scheme, they can take on delegated responsibility for budgets and services at any time between April 2015 and 1 April 2016.

### Scope of services to be integrated

**20.** Councils and NHS boards are required to integrate the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. The hospital services included in integration are the inpatient medical specialties that have the largest proportion of emergency admissions to hospital. These include:

- accident and emergency services
- general medicine
- geriatric medicine
- rehabilitation medicine
- respiratory medicine
- psychiatry of learning disability
- palliative care
- addiction and substance dependence service
- mental health services and services provided by GPs in hospital.

Other, non-integrated, hospital services continue to be overseen directly by NHS boards. The Act also allows NHS boards and councils to integrate other areas of activity, such as children's health and social care services and criminal justice social work.

### How IAs are structured

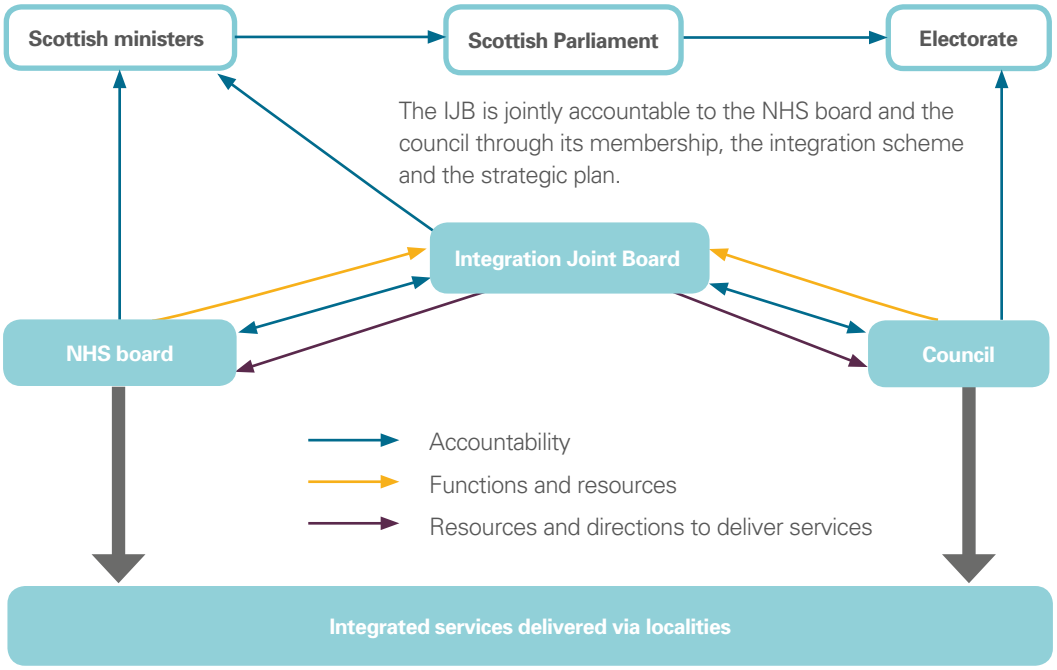
**21.** IAs will be responsible for overseeing certain functions that are delegated from the local NHS board and council(s). IAs can follow one of two main structural models (Exhibit 4, page 14).

**22.** All areas, apart from Highland, are planning to follow the body corporate model, creating an Integration Joint Board to plan and commission integrated health and social care services in their areas. IJBs are local government bodies, as defined by Section 106 of the Local Government (Scotland) Act 1973. Partners will need to understand the implications of differences between how councils and NHS boards carry out their business, so they are able to fulfil their duties. For example:

- IJBs must appoint a finance officer. The finance officer, under the terms of Section 95 of the Local Government (Scotland) Act 1973, has formal responsibilities for the financial affairs of the IJB.

## Exhibit 4
Integration authorities will follow one of two main models

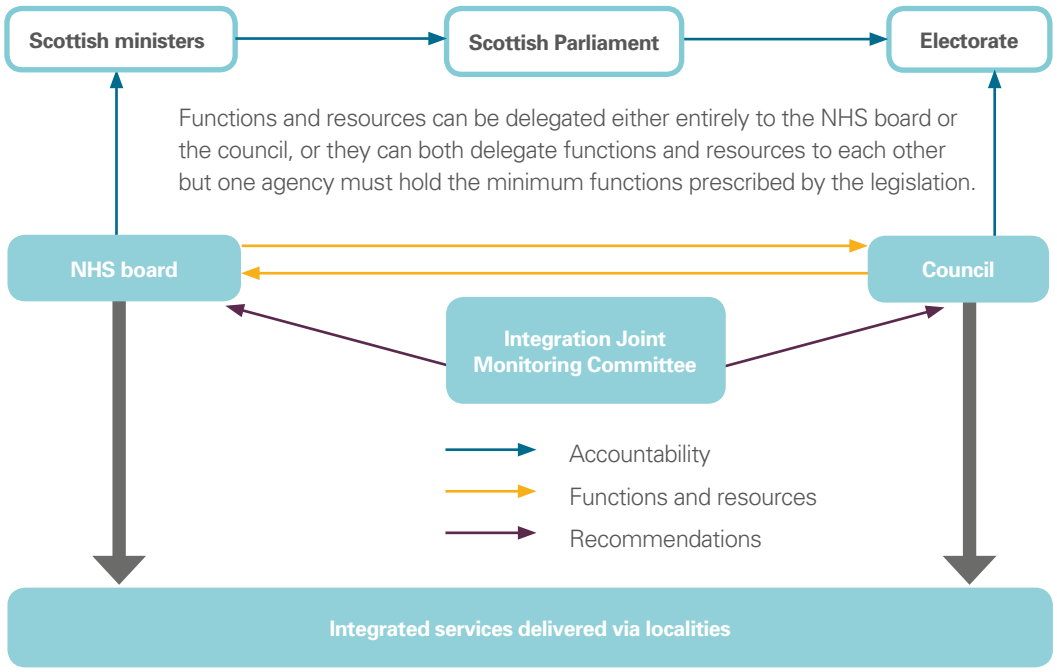
### Body corporate or Integration Joint Board model




**Body corporate**

- NHS boards and councils delegate health and social care functions to an Integration Joint Board (IJB)
- The Act allows for partners to work jointly, for example, for two councils to work with their local NHS board to create a single IJB

### Lead agency model




**Lead agency**

- NHS boards and councils delegate some of their functions to each other
- Carrying out of functions is overseen and scrutinised by an Integration Joint Monitoring Committee

Source: Audit Scotland

- The way local government bodies make decisions differs to NHS boards. Local government bodies in Scotland must take corporate decisions. There is no legal provision for policies being made by individual councillors.

- A statutory duty of Best Value applies to IJBs.

**23.** NHS boards and councils delegate budgets to the IJB. The IJB decides how to use these resources to achieve the objectives of the strategic plan. The IJB then directs the NHS board and council to deliver services in line with this plan. Only Highland has chosen the lead agency model, continuing arrangements established in earlier years for integrated services.[12] Under powers first set out in the Community Care (Scotland) Act 2002, NHS Highland is the lead for adult health and care services, with Highland Council the lead for children's community health and social care services. This provides continuity with lead agency arrangements in place in Highland since 2012. The council and the NHS board cannot veto decisions taken by the lead agency. Instead, as required by the legislation, they have established an integration joint monitoring committee (IJMC). The IJMC cannot overturn a decision made by the council or NHS board, but it can monitor progress in integrating services and make recommendations.

**24.** Whichever model is chosen, the underlying objective remains the same. The IA is expected to use resources to commission coordinated services that provide care for individuals in their community or in a homely setting and avoid unnecessary admissions to hospital.

### Membership of Integration Joint Boards (IJBs)

**25.** For the IAs that follow the body corporate model, board members of IJBs are a mix of voting and non-voting members. Councils and NHS boards are each required to nominate at least three voting members. The NHS board and council can nominate more members, but both partners need to agree to this and the number from each body needs to be equal. The NHS board nominates non-executive directors to the IJB, and the council nominates councillors. Where the NHS board is unable to fill their places with non-executive directors, it is able to nominate other members of the NHS board. At least two of the NHS members should be non-executive directors. The IJB should also include non-voting members, including a service user and a representative from the voluntary sector (Exhibit 5, page 16).[13]

**26.** Initially, IJBs are not expected to directly employ staff, operating only as strategic commissioning bodies.[14] This may change over time as the Act allows IJBs to employ staff, but this needs to be approved by Scottish ministers, rather than decided locally. A chief officer and finance officer provide support for the IJB, but they are employed by either the council or NHS board and seconded to the IJB. The finance officer, under the terms of Section 95 of the Local Government (Scotland) Act 1973, has formal responsibilities for the financial affairs of the IJB.

### Scrutinising integrated health and social care

**27.** Various scrutiny bodies have an interest in the integration of health and social care:

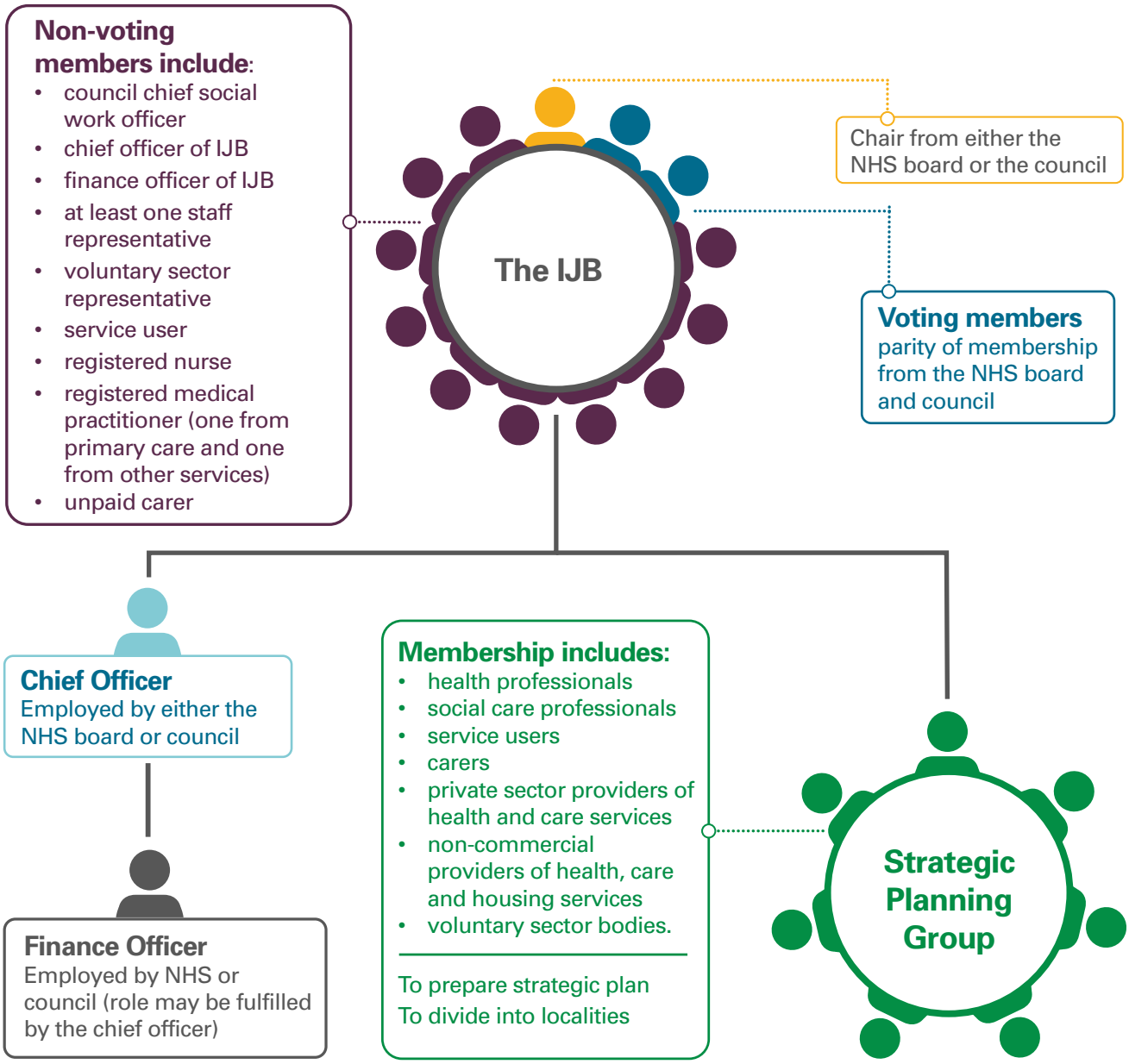
- The Accounts Commission is responsible for appointing auditors to IJBs and so has an interest in financial management and governance arrangements. As local government bodies, IJBs are also covered by the duty of Best Value as set out in the Local Government in Scotland Act 2003. The Accounts Commission has the power to audit the extent to which local government bodies are discharging their Best Value duty.

- Health and social integration is a significant national policy development. Therefore, the Auditor General for Scotland (alongside the Accounts Commission) has an audit interest in the extent to which it is being implemented at a national and local level, and in its impact on NHSScotland.

- The Care Inspectorate and Healthcare Improvement Scotland are responsible for scrutinising and supporting improvement in health and care services. Both organisations inspect individual services and work together to perform joint inspections of health and care services. These organisations will inspect the planning, organisation or coordination of

## Exhibit 5

Organisation chart for a typical IJB




Source: Audit Scotland

integrated health and social care services. From April 2017, the Care Inspectorate and Healthcare Improvement Scotland are required by legislation to assess progress in establishing joint strategic commissioning and the early impact of integration.

### Implications for the public, voluntary and private sectors

**28.** The significant changes under way will have an impact on everyone who needs to access, provide or plan health and social care services. Integration is part of the Scottish Government's focus on developing person-centred care. This is aimed at improving services, ensuring people using health and social care services can expect to be listened to, to be involved in deciding upon the care they receive and to be an active participant in how it is delivered. The aim is that this will result in improved outcomes for people, enabling them to enjoy better health and wellbeing within their homes and communities.

**29.** Health and social care integration is complex and it is important that IAs engage with the public on an ongoing basis so that they understand the purpose of integration and are able to influence the way services change. People may not see a significant difference in the services they receive immediately, but the reforms are focused on making better use of all health and social care services. Therefore there are implications for how people use services, for example GP, A&E and community-based services. If the reforms are to be successful, IJBs, NHS boards and councils need to involve people in decisions about the implications for local services. To help with this, there is a requirement that a service user and unpaid carer are members of the IJB and that IJBs consult and engage with local people as they develop their strategic and locality plans. It is also important that IAs are clear about how they link into the wider community planning process.

**30.** It is not only statutory services that need to change, other providers need to be involved. Voluntary and private sector providers employ two-thirds of the social services workforce and provide many social care services across Scotland. They are significant partners in developing integrated services, with the voluntary sector represented on the IJB as a non-voting member. Our previous report *Self-directed support* [PDF] highlighted some of the ways that councils have started to change how they work with the voluntary and private sectors.[15] There are lessons here for IJBs.

### Localities

**31.** The Act requires IAs to divide their area into at least two localities, but they can choose to create more. Localities have an important role in reforming how to deliver services. They bring together local GPs and other health and care professionals, along with service users, to help plan and decide how to make changes to local services. A representative from each locality is expected to be part of the IA's strategic planning group, helping to ensure that specific local needs are taken into account. Localities also have a consultative role. When an IA is planning a change that is likely to affect service provision in a locality significantly, it must involve representatives of the local population in that decision.

**32.** As part of their role in planning services, localities are expected to plan expenditure on integrated health and social care services in their area, based on local priorities and to help shift resources towards preventative and community-based health and care services.

### Outcomes and performance measures

**33.** IAs are required to contribute towards nine national health and wellbeing outcomes (Exhibit 6). These high-level outcomes seek to measure the quality of health and social care services and their impact in, for example, allowing people to live independently and in good health, and reducing health inequalities. This is the first time that outcomes have been set out in legislation, signalling an important shift from measuring internal processes to assessing the impact on people using health and social care services. IAs are required to produce an annual performance report, publicly reporting on the progress they have made towards improving outcomes.

## The Scottish Government is providing resources to help support integration

**34.** The integration of health and social care is a complex reform and the Scottish Government is providing support to help organisations as they establish the new arrangements. The Scottish Government will provide more than £500 million over the three years from 2015/16 to 2017/18 to help partnerships establish new ways of working that focus on prevention and early intervention in a bid to reduce

## Exhibit 6

### National health and wellbeing outcomes

IAs are required to contribute to achieving nine national outcomes.

| | |
|---|---|
| **1** | People are able to look after and improve their own health and wellbeing and live in good health for longer. |
| **2** | People, including those with disabilities 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. |
| **3** | People who use health and social care services have positive experiences of those services, and have their dignity respected. |
| **4** | Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. |
| **5** | Health and social care services contribute to reducing health inequalities. |
| **6** | People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing. |
| **7** | People who use health and social care services are safe from harm. |
| **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. |
| **9** | Resources are used effectively and efficiently in the provision of health and social care services. |

Source: National Health and Wellbeing Outcomes, Scottish Government

long-term costs. This money is not directly to support integration, but to continue initiatives that were already under way to improve services. The money is made up as follows:

- £300 million is an integrated care fund to help partnerships achieve the national health and wellbeing outcomes and move towards preventative services
- £100 million to reduce delayed discharges
- £30 million for telehealth
- £60 million to support improvements in primary care
- £51.5 million for a social care fund.

**35.** The Scottish Government has provided guidance to partnerships, covering issues such as strategic commissioning of health and care services, clinical and care governance, and the role of housing services and the voluntary sector. The timescales to implement the Act are tight. For some partnerships, guidance came too late. For example, the Scottish Government issued its guidance on localities in July 2015, yet localities play an important part in strategic plans and many partnerships had already begun the strategic planning process by then. The Scottish Government plans to issue further guidance on performance reporting late in 2015. However, for some areas this is coming too late – the three Ayrshire IJBs will present their first performance reports on or before 2 April 2016 and are developing these in advance of the guidance being issued.

**36.** The Scottish Government is supplementing this formal guidance with a series of support networks for IJB chairs and finance officers, such as regular learning events, and through the work of the Joint Improvement Team (JIT), including support for IJBs in developing their strategic plans.[16] Healthcare Improvement Scotland and the Care Inspectorate are currently developing a support programme for IAs, tailoring training and development events to fit local needs.

**37.** IAs are also being supported by the Information Services Division (ISD) of NHS National Services Scotland. ISD is creating a single source of data on health, social care and demographics. It is making this information available to NHS boards, councils and IAs to help them to gain a better understanding of:

- the needs of their local population
- current patterns of care
- how resources are being used.

**38.** This is the first time this detailed information on activity and costs will be routinely available to partnerships to help them with strategic planning. It will also help inform decisions on how to better use resources to improve outcomes for service users and carers. ISD is also providing data and analytical support through a Local Intelligence Support Team initiative, where partnerships can have an information specialist from ISD working with them in their local area.

# Part 2

## Current progress

### Integration authorities are being established during 2015/16

**39.** Thirty-one IAs are being established, with one for each council area and a shared one between Clackmannanshire and Stirling. All partners submitted their draft integration schemes to Scottish ministers by the April 2015 deadline. Some, such as East Dunbartonshire, already plan to extend the scope of services being integrated and will resubmit their integration scheme for approval. By October 2015, 25 integration schemes had been formally approved, with the remainder expected to be agreed by the end of 2015.

**40.** By October 2015, six IAs had been established and taken on operational responsibility for budgets and services (Exhibit 7, page 21). The remaining IAs plan to be operational just before the statutory deadline, in March and April 2016.

### Most integration authorities will oversee more than the statutory minimum services, and their responsibilities vary widely

**41.** The Act requires councils and NHS boards to integrate adult health and social care services. But it also allows them to integrate other services, such as children's health and social care services and criminal justice social work services.

**42.** The scope of the services being integrated varies widely across Scotland. Almost all the IAs will oversee more than the minimum requirement for health services, mainly by including some aspects of children's health services. But there is a wide range in responsibilities for other areas, such as children's social work services, criminal justice social work services, and planned acute health services (Exhibit 8, page 22). These differences in the scope of services included create a risk of fragmented services in some areas. Good clinical and care governance arrangements will be important to ensure that vulnerable people using integrated and non-integrated services experience high standards of care.

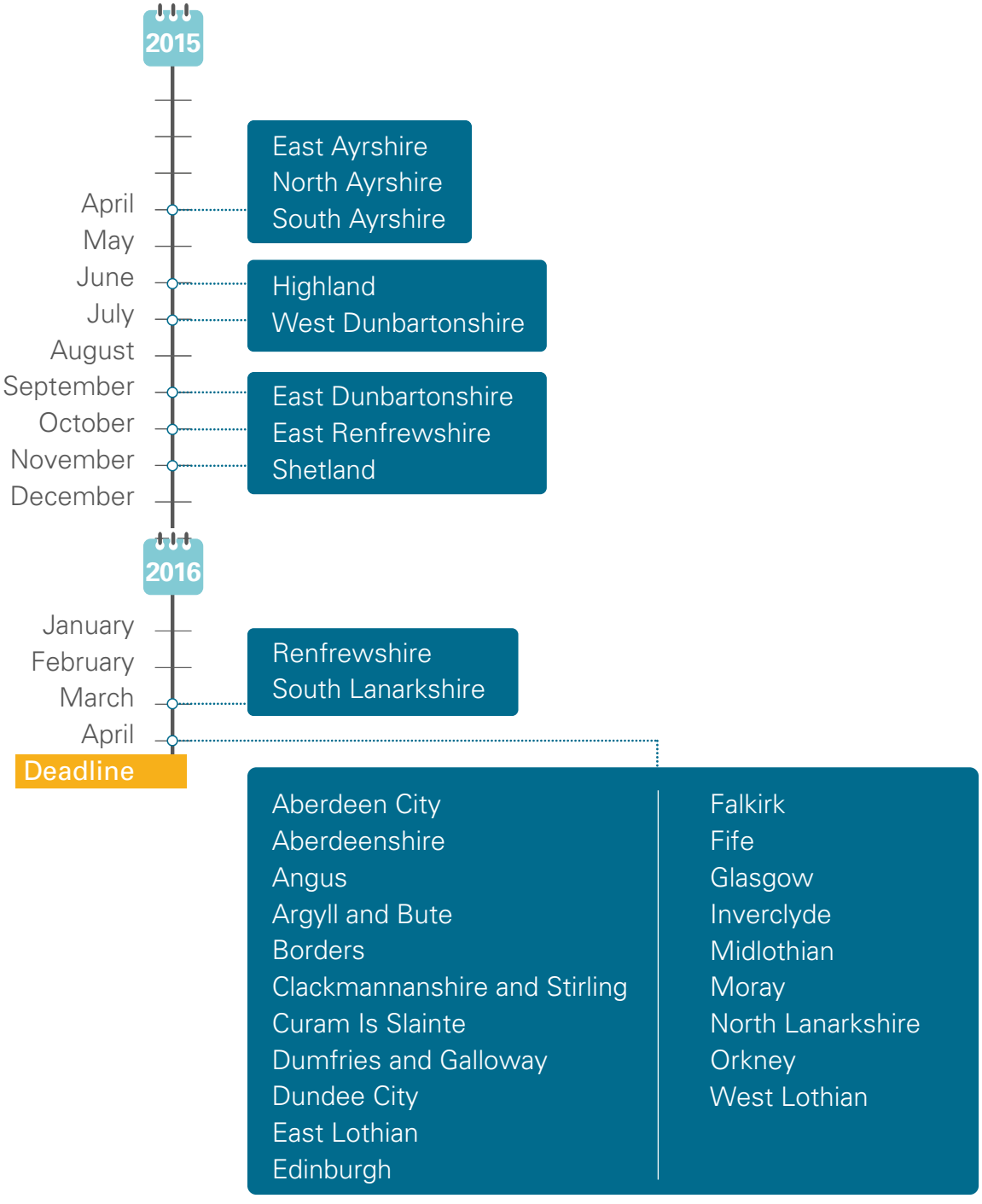
the scope of the services being integrated varies widely across Scotland

**43.** Among the variations the most notable are in Argyll and Bute IJB and Dumfries and Galloway IJB. These IJBs will oversee all NHS acute services, including planned and unplanned hospital services. In theory, this should allow these IJBs to better coordinate all health and care services in their area.

**44.** Various 'hosting' arrangements are also being implemented across the country. Where the area covered by an NHS board has more than one IJB it is often not practical or cost-effective to set up separate arrangements to deliver services for individual IJBs. This is particularly the case for specialist services, such as certain inpatient mental health services with small numbers of patients or staff. For example, North Ayrshire IJB hosts the following services on behalf of East Ayrshire and South Ayrshire IJBs:

## Exhibit 7

Services will be delegated to IAs throughout 2015/16 with most delegating in April 2016




Notes:
1. The date of becoming operational is still to be agreed in Perth and Kinross.
2. Curam Is Slainte is the name for the partnership between NHS Western Isles and Comhairle nan Eilean Siar.

Source: Audit Scotland

## Exhibit 8

### Additional integrated services

Partnerships are integrating a wider range of services in addition to the statutory minimum.

| | Children's social work services | Criminal justice social work services | Children's health services | Planned acute health services |
|---|---|---|---|---|
| Argyll and Bute | ✓ | ✓ | ✓ | ✓ |
| East Ayrshire | ✓ | ✓ | ✓ | – |
| East Renfrewshire | ✓ | ✓ | ✓ | – |
| Glasgow | ✓ | ✓ | ✓ | – |
| Inverclyde | ✓ | ✓ | ✓ | – |
| North Ayrshire | ✓ | ✓ | ✓ | – |
| Orkney | ✓ | ✓ | ✓ | – |
| South Ayrshire | ✓ | ✓ | ✓ | – |
| West Dunbartonshire | ✓ | ✓ | ✓ | – |
| Aberdeen City | – | ✓ | ✓ | – |
| Aberdeenshire | – | ✓ | ✓ | – |
| Curam Is Slainte | – | ✓ | ✓ | – |
| East Lothian | – | ✓ | ✓ | – |
| Midlothian | – | ✓ | ✓ | – |
| Moray | – | ✓ | ✓ | – |
| Shetland | – | ✓ | ✓ | – |
| Highland | ✓ | – | ✓ | – |
| Dumfries and Galloway | – | – | ✓ | ✓ |
| Angus | – | – | ✓ | – |
| Borders | – | – | ✓ | – |
| Clackmannanshire and Stirling | – | – | ✓ | – |
| Dundee | – | – | ✓ | – |
| East Dunbartonshire | – | – | ✓ | – |
| Edinburgh | – | – | ✓ | – |
| Falkirk | – | – | ✓ | – |
| Fife | – | – | ✓ | – |
| North Lanarkshire | – | – | ✓ | – |
| Perth and Kinross | – | – | ✓ | – |
| Renfrewshire | – | – | ✓ | – |
| South Lanarkshire | – | – | ✓ | – |
| West Lothian | – | – | ✓ | – |

**Key**

- Children's social work services
- Criminal justice social work services
- Children's health services
- Planned acute health services

Notes:

1. Criminal justice social work services can include services such as providing reports to courts to assist with decisions on sentencing. Planned acute health services can include services such as outpatient hospital services.
2. The range of children's health services delegated varies by IA. They may include universal services (such as GPs) for people aged under 18, or more specialised children's health services such as school nursing or health visiting, or both universal and specialised services.
3. IAs may also be responsible for additional integrated services not listed here.
4. East Dunbartonshire plan to amend their integration scheme to include children's primary and community health services before 1 April 2016.
5. Where integration schemes have not yet been approved by ministers, the final integration scheme may vary from the information included here.

Source: Scottish Government, 2015 and Audit Scotland, 2015

- inpatient mental health services
- learning disability services
- child and adolescent mental health services
- psychology services
- community infant feeding service
- family nurse partnership
- child health administration team
- immunisation team.

## IJBs are appointing voting board members and most have chief officers in post

**45.** Most IJBs are currently appointing board members. Our review of the 17 IJB integration schemes that Scottish ministers had approved at the time of our audit shows the following:

- Thirteen IJB boards will initially be chaired by a councillor, with the remaining four chaired by a non-executive from the local NHS board.
- Only three areas have chosen to nominate the minimum of three voting members each from the council and NHS board.[17] In 13 schemes, councils and NHS boards have each nominated four voting members. In Edinburgh, the council and NHS board each have five voting members.
- There are also local variations in the number of additional non-voting members. For example, East Renfrewshire has appointed an additional GP member to help provide knowledge on local service needs. In most cases, these variations do not add significantly to the number of IJB board members. But some IJBs have very large boards. For example, Edinburgh has 13 non-voting members, in addition to its ten voting members. The IJB board for Clackmannanshire and Stirling is expected to be even larger, reflecting the joint arrangements between the two council areas, with 12 voting members and around 23 non-voting members.

**46.** Almost all IJBs have now appointed a chief officer.[18] Edinburgh and Falkirk expect to have their chief officers in post by the end of 2015.[19] Chief officers are employed by either the NHS board or the council and then seconded to the IJB. Terms and conditions of employment vary between councils and NHS boards, so successful candidates choose their preferred employer, based on the packages offered.

### Chief officer accountability

**47.** Accountability arrangements for the IJB chief officer are complex and while there may be tensions in how these arrangements will work in practice, we have attempted to set out the technical arrangements as clearly as possible. The chief officer has a dual role. They are accountable to the IJB for the

responsibilities placed on the IJB under the Act and the integration scheme. They are accountable to the NHS board and council for any operational responsibility for integrated services, as set out in the integration scheme.

### Accountability to the IJB

- The chief officer is directly accountable to the IJB for all of its responsibilities. These include: strategic planning, establishing the strategic planning group, the annual performance report, the IJB's responsibilities under other pieces of legislation (for example, the Equalities Act and the Public Records Act), ensuring that its directions are being carried out, recommending changes and reviewing the strategic plan.

- Integration schemes can pass responsibility for overseeing the operation of specific services from the NHS board or council to the IJB. In these circumstances, the chief officer is accountable to the IJB for establishing the arrangements to allow it to do this. This includes setting up performance monitoring, reporting structures, highlighting critical failures, reporting back based on internal and external audit and inspection. If the council or NHS board passes responsibility for meeting specific targets to the IJB, the IJB must take this into account during its strategic planning, and the chief officer is accountable for making sure it does so.

### Accountability to the NHS board and council

- All integration schemes should set out whether the chief officer also has operational management responsibilities. Where the chief officer has these responsibilities, they are also accountable to the NHS board and the council.

- Where the chief officer has operational management responsibilities, the integration scheme makes the chief officer the responsible operational director in the council and NHS board for ensuring that integrated services are delivered. The chief officer is therefore responsible to the NHS board and council for the delivery of integrated services, how the strategic plan becomes operational and how it is delivered. They are also responsible for ensuring it is done in line with the relevant policies and procedures of the organisation (for example staff terms and conditions).

- Although this is untested, the accountable officers for delivery should still be the chief executives of the NHS board and the council. But they must discharge this accountability through the chief officer as set out in their integration scheme. The chief executives of the NHS board and council are responsible for line managing the chief officer to ensure that their accountability for the delivery of services is properly discharged.

**48.** Although employed by one organisation only, most chief officers are line managed by the chief executives of both the council and the NHS board. This means that in some NHS board areas the chief executive is line managing several IJB chief officers. South Lanarkshire has adopted a more streamlined approach, where the chief officer reports to both the council and NHS board chief executive, but the organisation that employs the chief officer performs day-to-day line management.

# Part 3

## Current issues

### There is wide support for the opportunities offered by health and social care integration

**49.** Integrated health and social care offers significant opportunities. These include improving the services that communities receive, the impact these services have on people, improving outcomes and using resources, such as money and skills, more effectively across the health and care system. The Scottish Government expects integrated services to emphasise preventative care and reduce both the level of hospital admissions and the time that some patients spend in hospital. A measure of success will be the extent to which integration has helped to move to a more sustainable health and social care service, with less reliance on emergency care.

**50.** Because integrated services with a focus on improving outcomes should result in more effective use of resources across the health and social care system, the Scottish Government expects integration to generate estimated annual savings of £138 - £157 million. The savings are as follows:

- Annual savings of £22 million if IAs can meet the current target to limit the delay in discharging patients to no more than two weeks and £41 million if they can reduce this further, to no more than 72 hours.
- Annual savings of £12 million by using anticipatory care plans for people with conditions that put them at risk of an unplanned admission to hospital. These plans provide alternative forms of care to try to avoid people being admitted to hospital.
- Annual savings of £104 million from reducing the variation between different IAs in the same NHS board area. The Scottish Government expects that IAs will identify the inefficiencies that cause costs to vary and, over time, reduce them.[20]

**51.** The Scottish Government estimated the initial cost of making these reforms to adult services to be £34.2 million over the five years up to 2016/17, and £6.3 million after this. It has not estimated the additional costs, or savings, from integrating other services such as children's health and social care or some criminal justice services.[21] It is unclear whether these anticipated savings will release money that IJBs can invest in more community-based and preventative care or how the Scottish Government will monitor and report progress towards these savings.

widespread support for the policy of health and social care integration, but concerns about how this will work in practice

**52.** There have been previous attempts at integration, as listed in Exhibit 2 (page 11). Our *Review of Community Health Partnerships* [PDF] highlighted that CHPs had a challenging remit, but lacked the authority needed to implement the significant changes required.[22] We also found limited progress with joint budgets across health and care services. This latest reform programme contains important new elements to help partnerships improve care. The Act:

- provides a statutory requirement for councils and NHS boards to integrate services and budgets, in contrast to previous legislation that encouraged joint working with resources largely remaining separate
- provides, for the first time, a statutory requirement to focus on outcome measures, rather than activity measures
- introduces a requirement for co-production as part of strategic planning. Co-production is when professionals and people who need support combine their knowledge and expertise to make joint decisions
- has clear links to other significant legislation, including The Children and Young People (Scotland) Act 2014 and the Community Empowerment (Scotland) Act 2015, where similar principles of co-production, engagement and empowerment apply.

**53.** Throughout our audit, we found there is widespread support for the policy of health and social care integration, but concerns about how this will work in practice. In this part of our report, we summarise the most important risks and issues we have identified through our audit. These are significant and need to be addressed as a priority nationally and locally to integrate health and care services successfully.

## NHS boards, councils and IJBs need to be clear about how local arrangements will work in practice

### Sound governance arrangements need to be quickly established

**54.** Good governance is vital to ensure that public bodies perform effectively. This can be a particular challenge in partnerships, with board members drawn from a wide range of backgrounds. Previous audit reports on community planning partnerships (CPPs) and CHPs have highlighted the importance of issues such as:

- a shared leadership, which takes account of different organisational cultures
- a clear vision of what the partnership wants to achieve, with a focus on outcomes for service users
- a shared understanding of roles and responsibilities, with a focus on decision-making
- an effective system for scrutinising performance and holding partners to account.

### Members of IJBs need to understand and respect differences in organisational cultures and backgrounds

**55.** IJBs include representatives from councils, NHS boards, GPs, the voluntary sector, and service users. Everyone involved in establishing the new arrangements needs to understand, respect and take account of differences in organisational cultures so these do not become a barrier to progress. Members of the IJB need quickly to establish a shared understanding of their new role, how they will work together and measure success.

**56.** Voting members are drawn exclusively from councils and NHS boards and it is particularly important that they have a shared vision and purpose. There are important differences in how councils and NHS boards operate. Councils, for example, are accountable to their local electorate, while NHS boards report to Scottish ministers. There are also differences in how councils and the NHS work with the private sector. Councils have had many years of contracting services out to the voluntary and private sectors; for example, around 25 per cent of home care staff are employed in the private sector.

**57.** IJBs are aware of the need to establish a common understanding of the roles and responsibilities of board members. We found that many are planning opportunities for board development by providing training and support to board members. Other IJBs are also reinforcing this by developing codes of conduct to ensure that their board members follow the same standards of behaviour.

**58.** IJBs include representatives from a wide range of organisations and backgrounds. This inclusive approach has benefits, including a more open and inclusive approach to decision making for health and care services, but there is a risk that boards are too large. For example, the Edinburgh IJB will have 23 members and the Clackmannanshire & Stirling IJB will have around 35. As we have highlighted in previous audits of partnerships across Scotland, there is a risk that large boards will find it difficult to reach agreement, make decisions and ensure services improve.

### IJB members will have to manage conflicts of interest

**59.** The design of IJBs brings the potential for real or perceived conflicts of interest for board members. The NHS board and council nominate all voting members of the IJB. Their role is to represent the IJB's interests. Voting members will also continue in their role as an NHS board member or councillor. As a result, there is a risk that they may have a conflict of interest, particularly where there is a disagreement as part of IJB business.[23]

**60.** There is a similar potential for a conflict of interest for senior managers. IJB finance officers, for example, are required to support the needs of the IJB, but may also have responsibilities to support their employer – either the local NHS board or council. Similarly, legal advisers to the IJB will be employed by the council or the NHS board and, at a time of disagreement, may have a conflict of interest.

**61.** There is also a particular issue for NHS board members. Some NHS boards have to deal with several IJBs, and this places significant demands on their limited number of non-executive members. As a result, the Act and its associated regulations allow for NHS executive members to be appointed as voting members of the IJB. This means that there is the possibility of individuals acting as IJB board members who commission a service, and as NHS board members, responsible for providing that service. IJBs need to resolve this tension as part of their local governance arrangements.

**62.** IJBs are taking action to manage these tensions. For example, they are providing training to alert board members to the need to act in the IJB's interests when taking part in IJB meetings, and declaring conflicts of interest when they arise. But underlying conflicts of interest are likely to remain a risk, particularly at times of disagreement between local partners.

### Although IJBs will lead the planning of integrated services, they are not independent of councils and NHS boards

**63.** IJBs set out how they will deliver services in their strategic plans, which they develop through strategic planning groups. The legislation allows NHS boards and councils jointly to ask IJBs to change their strategic plans only if they think it hinders their work in achieving the national health and wellbeing outcomes. As such, NHS boards and councils cannot individually veto an IJB decision. However IJBs are not fully independent of NHS boards and councils which can influence them through the following:

- **Membership of IJBs**: Chairs, vice chairs and voting members are all nominated by NHS boards and councils.
- **The approval process to agree future budgets:** Guidance issued by the Scottish Government's Integrated Resources Advisory Group (IRAG) suggests that, for future years, each IJB develops a business case and budget request and submits this to the NHS board and council to consider.
- **Control of integration schemes:** NHS boards and councils can decide to resubmit their integration schemes, changing the terms under which the IJB operates, or replacing it with a lead agency approach.

**64.** IJBs may overcome the challenges of working with a large board, with different organisational cultures and tensions, but once difficult decisions have been made there are still complex relationships back to the NHS board and council to negotiate. As a result, it is not clear if IJBs will be able to exert the necessary independence and authority to change fundamentally the way local services are provided.

### Only a few IJBs will oversee the operation of acute services in their area, potentially limiting their impact

**65.** Regulations allow NHS boards and councils to choose what role IJBs will have in relation to operational management of services, in addition to commissioning and planning services. This flexibility allows, for example, NHS boards to remain solely responsible overseeing the operation of large hospital sites. The alternative is a more complex arrangement where responsibility for overseeing the operation of an A&E department is shared across several IJBs. Where the IJB has no operational management of hospital services, the IJB will receive regular performance reports from the NHS board on hospital services, so the IJB can assess whether the NHS board is delivering services in line with the IJB strategic plan. From the 17 schemes we reviewed that establish IJBs, we found the following:

- All 17 IJBs oversee the operation of non-acute integrated services, such as district nursing.
- To date, only Argyll and Bute, and Dumfries and Galloway IJBs will oversee the operation of the acute hospital integrated services in their areas, and

the chief officer will operationally manage these services. In Argyll and Bute, this continues an arrangement that existed previously and arises because the NHS board contracts most acute services from NHS Greater Glasgow and Clyde. Argyll and Bute CHP received information from the NHS board as part of the contract monitoring process. The IJB and NHS Greater Glasgow and Clyde are in the process of agreeing the information the chief officer and IJB board members will receive on the operational performance and delivery of these services.

- In Dumfries and Galloway, the IJB will oversee the operation of all integrated services, including all acute hospital services. The chief officer will be responsible for managing the operation of these integrated services, receiving regular information from the council Chief Social Work Officer and the NHS board acute services management team. The geographical circumstances in Dumfries and Galloway help to make this arrangement possible, as there is only one IA in the NHS board area, with only one acute hospital.

### There needs to be a clear understanding of who is accountable for service delivery

**66.** There is a risk that the complex interrelationship between IJBs and councils and NHS boards will get in the way of clear lines of accountability. Their respective roles appear to be clear: IJBs are responsible for planning and commissioning services; councils and NHS boards are responsible for delivering those services.

**67.** But this understanding of accountabilities could be tested when there is a service failure, either in the care of an individual or in meeting outcome targets. The consensus amongst those we spoke with during our audit is that responsibility would lie with the council or NHS board delivering the service. But it could also be argued that ultimate responsibility might lie with IJBs, which plan and direct councils and NHS boards in how services are to be delivered. All parties need to recognise this risk and set out clearly an agreed understanding of each other's roles and responsibilities. It is essential that the chief officer is clear about how this joint accountability will work in practice from the start.

**68.** Clear procedures also need to be in place for clinical and care governance. These are procedures for maintaining and improving the quality of services and safeguarding high standards of care. NHS boards use long-established clinical governance approaches within the NHS. Similarly, councils follow well-established approaches for social care. IJBs have a great deal of flexibility over this issue and are required only to consider what role they will have in supporting the councils' and NHS boards' clinical and care governance work and how integration might change some aspects of this.

**69.** The Act introduced a requirement that IJBs set out in their integration scheme how they will work with NHS boards and councils to develop an integrated approach to clinical and care governance. We found that, at present, most IJBs plan to retain existing arrangements, with NHS boards directly overseeing clinical governance and councils overseeing care governance. However, IJBs will need to have a role in monitoring clinical and care standards without duplicating existing arrangements. Perth and Kinross IJB has developed a new clinical and care governance framework that other IJBs are now considering. In addition, the Royal College of Nursing has developed an approach that helps IJBs, councils and NHS

boards review their clinical and care governance arrangements. The aim is to ensure consistent approaches within each integrated service, and that these are aligned to existing clinical and care governance arrangements in the NHS and councils.[24]

### IAs need to establish effective scrutiny arrangements to help them manage performance

**70.** IAs need to establish effective arrangements for scrutinising performance, monitoring progress towards their strategic objectives, and holding partners to account. Using the nine statutory outcome measures, listed at Exhibit 6, will help IAs to focus on the impact of health and care services. But as well as simply monitoring performance, IJB members will need to use these to help redesign services and ensure services become more effective.

**71.** There is also a need for regular reporting to partner organisations. This is particularly important where most members of the local council or NHS board are not directly involved in the IJB's work. Aberdeenshire Council, for example, has 68 councillors, with only five sitting on the IJB. Those not directly involved need to be kept informed on how the budgets provided to the IJB have been used and their effectiveness in improving outcomes for local people.

## Councils and NHS boards are finding it difficult to agree budgets for the new integration authorities

**72.** At this stage, IAs are establishing financial procedures that look to be sound. While there is a range of approaches to financial monitoring and dealing with overspends and underspends, the processes outlined in the integration schemes are reasonable.

**73.** There are, however, significant concerns about funding. Councils and NHS boards are having great difficulty in agreeing budgets for the new IAs. At October 2015, six months before they were required to be established and commissioning health and care services, the Scottish Government had only been informed of the agreed budgets for six IAs. This uncertainty about budgets is likely to continue until early 2016. The results of the UK spending review were not announced until November 2015, and the Scottish Government will only publish its financial plans on 16 December 2015.

**74.** NHS boards and councils have faced several years of financial constraints and this is expected to continue in the coming years. There is a risk that, if NHS boards and councils seek to protect services that remain fully under their control, IAs may face a disproportionate reduction in their funding, despite the focus on outcomes that all partners should have. We have reported previously on increasing pressures on health and care budgets. This risk of budget overspends is a significant risk for IJBs. Other specific factors add to these difficulties in agreeing budgets:

- **Set-aside budgets:** These relate to the budgets retained by NHS boards for larger hospital sites that provide both integrated and non-integrated services. There are difficulties in agreeing these set-aside budgets, despite the Scottish Government issuing specific guidance. The current difficulties relate to how to determine the integrated and non-integrated costs for these hospitals and how to allocate a fair share to each IJB within the NHS board area. More fundamentally, however, there is a risk that NHS

boards may regard this funding as continuing to be under their control, making it difficult for IAs to use the money to shift from acute hospital care to community-based and preventative services. As a result of these uncertainties, not all of the strategic plans published so far consider the set-aside budgets or plan for the level of acute services that will be needed in future years.

- **Different planning cycles:** NHS boards and councils agree budgets at different times. In North Ayrshire, for example, the council agreed its 2015/16 budget in December 2014, while the NHS agreed its budget in March 2015. NHS budgets and allocations can change during the financial year. This could bring further challenges for IJBs. Similar budget-setting cycles exist across Scotland. If councils and NHS boards continue with these cycles, then IJBs will be involved in protracted negotiations for budgets and ultimately cannot expect partners to approve their plans until just before the start of each financial year. In response, NHS Forth Valley has adapted its budgeting process to allow it to provide an earlier indication of the integrated health budget to its local IAs. In addition, as part of the community planning process, there is an expectation that community planning partners will share information on resource planning and budgets at an early stage, before formal agreement.[25] This should help IAs' financial planning.

## Integration authorities need to make urgent progress in setting out clear strategic plans

### Most IAs are still developing their overall strategic plans, but those that are in place tend to be aspirational and lack important detail

**75.** Strategic planning is central to the role that IAs will have in commissioning and helping redesign local health and care services. Scottish Government guidance emphasises the importance of localities in this process, and of strategic plans to reflect the different priorities and needs of local areas.

**76.** At the time of our audit, only six IAs had published their strategic plans. Some, such as Aberdeen City, Aberdeenshire and Moray, have developed draft plans in advance of the formal approval of the integration schemes. Difficulties with reaching agreement on budgets are an important factor hindering IAs from developing comprehensive strategic plans. This raises concerns about the readiness of IAs to make an immediate impact in reshaping local services. Our audit involved speaking to people involved with strategic planning, including IJB board members. Many of them felt it would be at least another year before most IAs have established plans that are genuinely strategic and can redesign future service delivery rather than simply reflect existing arrangements.

**77.** Even where strategic plans are in place, there tend to be weaknesses in their scope and quality. They often set out the broad direction of how to provide integrated health and social care services in their areas over the next three or so years, identifying local priorities for their area and for localities. But they can be unclear about what money and staff are available, particularly over the longer term, or how to match these to priorities. They lack detail on what level of acute services is needed in an area and how they will shift resources towards preventative and community-based care. They generally lack performance measures that directly relate to the national outcomes.

**78.** Strategic planning is even less developed at the locality level. There is a risk that strategic planning is not joined up with locality planning. Some IAs have completed strategic needs assessments, helping to identify the different needs and priorities of individual localities. They are using these to develop local priorities and budgets. There are also significant challenges in involving a wide range of service users, voluntary organisations, GPs and other clinicians and other professional staff in the planning process. These groups are represented at IJB board level, as non-voting members. But involving these groups more widely and actively at locality level is crucial to providing community-based and preventative health and social care services.

### Most IAs have still to produce supporting strategies

**79.** In addition to their overall strategic plans, IAs need to establish supporting strategies for important areas such as workforce, risk management, data sharing, and how they will work with people who use health and social care services. They are required to set out a broad timetable for producing these in their integration schemes.

**80.** We analysed the timetables in the approved integration schemes available at the time of our audit. This reveals some significant variations (Exhibit 9, page 33). Some risk management and workforce strategies have been developed and are scheduled to be agreed well in advance of the IA becoming operational. In others, however, it will be up to 12 months after the IA becomes operational before these strategies are due to be agreed and can start to contribute to progress with integrating services.

**81.** This raises questions about the effectiveness of some IAs, at least in the first year of their operation. It is important that IA strategies are well thought through, built on an analysis of local needs and resources and meaningful consultation, clearly setting out how the IA will deliver against the aspirations of the Act. We did not look in detail at the strategies produced at this early stage. But there is a risk that strategies produced quickly lack the detail needed to show how IAs will take practical steps that:

- improve outcomes
- integrate services
- make best use of the funds, skills and other resources available to them.

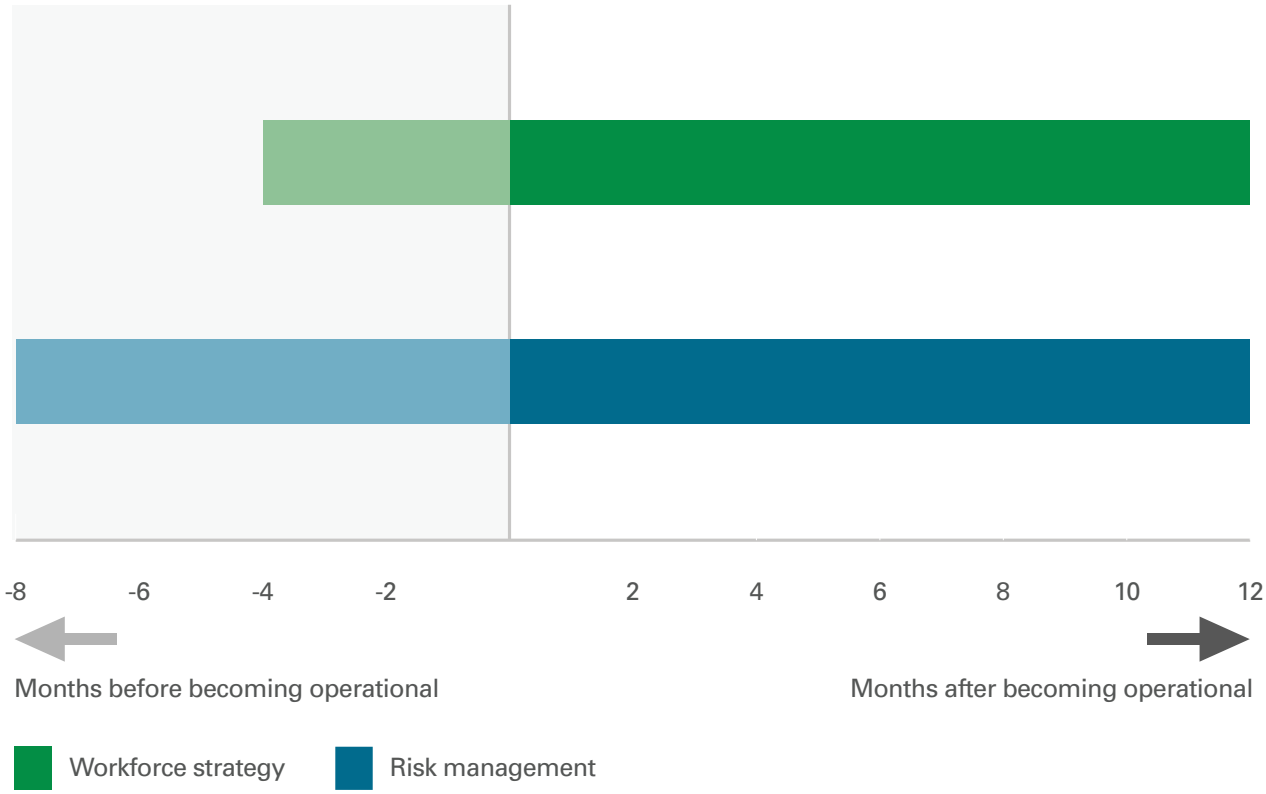
Equally, there are risks where the IA will not have plans in place until they have been operational for many months. It is important that IAs have clear strategic priorities and use these in developing:

- a workforce strategy, showing how they will redesign health and care services
- a risk management strategy to demonstrate that they are properly prioritising their work and their resources.

## Exhibit 9

### Range of timescales for supporting strategies

It will be up to a year before some IJBs have established workforce and risk management strategies.




Source: Audit Scotland analysis of available integration schemes

## There is a pressing need for workforce planning to show how an integrated workforce will be developed

**82.** The health and social care workforce is critical to the success of integration. Health and social care services are personal services; it is important that staff have the skills and resources they need to carry out their roles, including providing emotional and physical support and clinical care.

**83.** At present, few IAs have developed a long-term workforce strategy. Developing a suitably skilled workforce is crucial to the success of integrated health and social care services. This is particularly challenging, given the wide range of people involved and the size of the workforce. NHS Scotland employs around 160,000 staff.[26] Social services employ almost 200,000, both directly employed council staff and others from the private and voluntary sector.[27] Furthermore, an estimated 759,000 people in Scotland are carers for family members, friends or neighbours.[28] IJBs need to work closely with professional and regulatory bodies in developing their workforce plans.

**84.** IJBs do not directly employ staff, but they are responsible for coordinating services from this varied mix of staff and carers. There will be implications for the skills and experience that staff will need to deliver more community-based support as services change. Developing and implementing workforce strategies to meet these needs will be challenging.

**85.** The following will add to these difficulties:

- **Financial pressures on the NHS and councils.** NHS boards and councils continue to face pressures from tightening budgets and rising demand for services. Most councils have responded to these pressures in part by reducing staff numbers and outsourcing some services to the private and voluntary sectors. These changes are less evident in the health sector. As a result, there are concerns that any future changes to the workforce will not affect health and care staff equally.

- **Difficulties in recruiting and retaining social care staff.** Over many years, councils have had difficulties recruiting and retaining care home and home care staff. Organisations in areas such as Edinburgh and Aberdeen, with high living costs, have had particular difficulties. There is a need to develop a valued, stable, skilled and motivated workforce. We found examples of organisations developing new approaches to making careers in caring more attractive. For example in Dumfries and Galloway and Aberdeen City they are considering creating caring roles that are part of a defined career path, to encourage more people into these roles.

- **The role of the voluntary and private sectors.** Voluntary and private organisations play an important role in providing care and support, but there are particular challenges in how IJBs can involve these diverse organisations as part of a coordinated workforce plan. The introduction of the national living wage will have a significant impact on the voluntary sector and their ability to provide the same level of support for health and care services. We will comment on this further in our audit of Social Work in Scotland.

**86.** GPs have a particularly important role but there are concerns over GPs having time available to contribute actively towards the success of integrated services. Most GPs are independent contractors, not employed by the NHS. GPs have a crucial role in patient referrals and in liaising with other health and care services. Ultimately, if there are concerns about the quality or availability of community-based services, there is a risk that GPs will refer patients to hospital to ensure they receive the care they need.

**87.** Throughout Scotland, there are difficulties in recruiting and retaining GPs. As a result, GPs are facing increasing pressures, at a time when a planned shift to community care and support can be expected to increase their workload. The Scottish Government has recognised this issue and has announced £2.5 million to fund a three-year programme to improve recruitment and retention of GPs and improve the number of people training to be GPs. It also has plans to revise GP contracts, to allow GPs to delegate some services to other healthcare professionals, freeing up GPs' time. However, it will be many years before these measures will have a significant impact.

## The proposed performance measurement systems will not provide information on some important areas or help identify good practice

**88.** There is wide support for the Scottish Government's focus on health and wellbeing outcomes (set out earlier at Exhibit 6). In addition to the nine national outcomes, the Scottish Government developed core integration indicators to measure progress in delivering the national health and wellbeing outcomes and to allow national comparison between partnerships. These 23 measures, listed in Appendix 2, cover a mixture of outcome indicators – based on people's perception of the service they received – and indicators based on system or organisational information, such as people admitted to hospital in an emergency or adults with intensive care needs receiving care at home.

**89.** The Scottish Government has provided further support through the Information Services Division (ISD) of NHS National Services Scotland. It provided access to local data and technical support to help partnerships understand and plan for their areas' health and social care needs. The ISD data brings together health, social care and demographic information for the first time and is a significant step forward in providing partnerships with the information they need to plan locally and to measure the impact of their activity. Much of the data is already available for partnerships to use, and ISD plans to develop the data further including analysing the cost of end-of-life care.

**90.** Some IAs have been unable to make use of this resource as data-sharing agreements are not yet in place. ISD has access to health data but requires permission from councils to access the social work data they hold for their areas. Before councils can grant access they need to ensure they are not breaching data protection legislation and are doing this by agreeing data-sharing procedures. Most councils and NHS boards are making progress with this, but where information sharing has not been agreed IAs are having to plan without it.

**91.** National care standards were created in 2002 to help people understand what to expect from care services and to help services understand the standard of care they should deliver. Given the way that services have changed since then, in June 2014, the Scottish Government issued a consultation on new national care standards. The consultation proposed developing overarching standards, based on human rights, setting out the core elements of quality that should apply across all health and social care services.

**92.** The standards are an important part of integrating and scrutinising health and care services and it is important that they are in place quickly and publicised widely. However, overarching principles will not be finalised until April 2016; this will be followed by a consultation on specific and generic standards, with a view to them being implemented from April 2017.

**93.** While all these developments are clearly a step in the right direction, all partners need to consider the following issues:

- **The core integration indicators do not fully take account of all the expected benefits of the reform programme.** Overall, the Scottish Government's reform programme is expected to shift the balance of care to community-based or preventative services. However, demographic pressure will create increased demand for both hospital and community-

based services. It is not clear how the proposed indicators will measure progress in transferring from hospital to community care. There may be central data that the Scottish Government can use to track some of these changes but these should be set out clearly as part of measures to publicly monitor and report on progress. It is also unclear how the Scottish Government will track expected savings. An example is the expected annual savings of £104 million from reducing some of the variation evident in the cost of providing health and social care services across different parts of Scotland.[29] The core set of integration indicators does not attempt to give a national measure of reductions in cost variation or the savings that arise from this. Anticipatory care plans are projected to yield savings of £12 million a year, but there are no proposed indicators to assess if IAs are using them, or what impact they have on releasing resources such as skills and equipment.[30] This means the Scottish Government will not know if integration has freed up resources for other uses, in line with its expectations, or if it has achieved a shift from institutional to community-based care.

- **The process of linking measures and outcomes is incomplete and it may be difficult to measure success.** This means that the Scottish Government will be unable to see what progress is being made nationally, or to compare the different approaches adopted by IAs to identify which are most effective. For example, one of the measures seen as indicating success is 'reducing the rate of emergency admission to hospitals for adults'. (A reduction in this is seen as evidence of a positive impact on outcomes 1, 2, 4, 5 and 7, as listed at Exhibit 6.) But hospital emergency admission rates can reduce for many reasons. At present, it is up to individual partnerships to decide which additional local measures they will adopt to explore why hospital emergency admission rates are changing.

  Councils and NHS boards are required to set out in their strategic plans which local measures they will use. We compared plans for North Lanarkshire and North Ayrshire IAs, both relatively advanced in their performance management arrangements at the time of our audit. We found the following:

  - They will use different measures from each other. This has the benefit of allowing IAs to focus on their local priorities. However, it will make it difficult for the Scottish Government to compare performance across IAs to identify what approaches are working best (Exhibit 10, page 37).
  - In various places, both IAs have associated a different mix of indicators to an outcome from that set out in Scottish Government guidance. This occurs more frequently in North Ayrshire which developed its plans before the Scottish Government published its approach. But North Lanarkshire also has taken a different view on which indicators it will use to measure progress on some of the national outcomes, making it difficult for the Scottish Government to measure progress at a national level.
  - We have provided a more detailed comparison of the approaches used by North Lanarkshire and North Ayrshire IAs in a supplement to assist other IJBs when developing their plans (Exhibit 10, page 37).

## Exhibit 10

Integration authorities can use different information to measure progress towards national outcomes

| National Outcome | Core integration indicator | | | Number of additional local indicators mapped to national outcome | |
|---|---|---|---|---|---|
| | Mapped to national outcome by both | Not mapped to national outcome by both | | North Ayrshire | North Lanarkshire |
| People are able to look after and improve their own health and wellbeing and live in good health for longer | Percentage of people who say they are able to look after their health very well or quite well | • Premature mortality rate | NL | 5 | 19 |
| | | • Emergency admission rate | AL | | |
| 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 | None | • Percentage of staff who say they would recommend their workplace as a good place to work | NA | 8 | 8 |
| Resources are used effectively and efficiently in the provision of health and social care services | None | • Percentage of adults supported at home who agree that their health and care services seemed to be well coordinated | NL | 10 | 31 |
| | | • Readmission to hospital within 28 days | NL | | |
| | | • Proportion of last six months spent at home or in community setting | NL | | |
| | | • Falls rate per 1,000 population aged 65+ | NL | | |
| | | • Number of days people spend in hospital when clinically ready to be discharged per 1,000 population | NL | | |

NL = North Lanarkshire map this to outcome

NA = North Ayrshire map this to outcome

AL = Neither map this to outcome

Source: Audit Scotland analysis of performance frameworks

- **It is important that there is a balance between targeted local measures and national reporting on impact.** This has the benefit of providing flexibility so that local partnerships can focus their efforts on priority areas. It is important that local partnerships set ambitious targets. The reforms bring the opportunity to have local outcome measures that local people recognise as responding to specific issues in their community. However, the Scottish Government and IAs need to resolve tensions between introducing better local measures and the need for clarity at national level about the impact that IAs are having. An increasing focus on local measures means it is timely to review whether existing national measures are fit for purpose.

## The role of localities still needs to be fully developed

**94.** Localities are intended to be the key drivers of change, bringing together service users, carers, and health and care professionals to help redesign services. The Act requires IAs to establish at least two localities within their area. Scottish Government guidance, issued in July 2015, suggests that localities should be formed around natural clusters of GP practices. Naturally, the number and size of localities vary. Edinburgh, for example, has established four localities, with an average population of around 120,000. By contrast, Shetland has seven localities, each with an average population of around 4,000. Under the Act, localities need to be involved in both planning services and play a consultative role about service change in their local area. This raises an issue about the scale and size of localities – the optimal scale for locally planning services may not be the same as that for consulting on service change.

**95.** With IAs still focusing on their overall budgets and governance arrangements, the arrangements for localities are relatively underdeveloped. Some have now agreed priorities and budgets for individual localities, but in most cases, work at locality level has initially focused on networking with stakeholders and on needs assessments. Localities are key to the success of integration, therefore IJBs must focus on how localities will lead the integration of health and care.

**96.** We found that GPs are becoming involved in locality planning. But, in many areas, there are concerns about their ability to remain fully involved in locality planning. Some GPs are also sceptical, given earlier experiences with LHCCs and CHPs, which failed to provide a fundamental shift towards preventative and community-based services. In response, the Scottish Government is piloting a new approach in ten health centres across the country. These centres will form 'community care teams' and test different ways of delivering healthcare. It is important that there is a clear link between the work of these teams and locality planning arrangements to avoid confusion.

## There will be a continuing need to share good practice and to assess the impact of integration

**97.** The 31 IAs are putting different arrangements in place to deliver integrated health and social care services. This high level of variation is permitted by the Act and, in allowing IAs to respond to their local context and priorities, has many advantages. However, at some point, the Scottish Government and individual IAs will need to review their initial arrangements and consider how these might evolve to reflect good practice in other parts of Scotland. We hope that this report, and our subsequent audits, will contribute towards this wider review.

# Part 4

## Recommendations

We have made recommendations to help organisations address potential risks to the success of health and social care integration. We will monitor progress as part of our future work on integration.

### The Scottish Government should:

- work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this:
  - work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system
- monitor and publicly report on national progress on the impact of integration. This includes:
  - measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans
  - reporting on how resources are being used to improve outcomes and how this has changed over time
  - reporting on expected costs and savings resulting from integration
- continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.

### Integration authorities should:

- provide clear and strategic leadership to take forward the integration agenda; this includes:
  - developing and communicating the purpose and vision of the IJB and its intended impact on local people
  - having high standards of conduct and effective governance, and establishing a culture of openness, support and respect
- set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny.

This includes:

- setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice
- ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB

- ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes:
  - setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required.
  - ensuring relationships between the IJB, its partners and the public are clear so each knows what to expect of the other

- be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including:
  - developing and maintaining open and effective mechanisms for documenting evidence for decisions
  - putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice
  - developing and maintaining an effective audit committee
  - ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints
  - ensuring that an effective risk management system in in place

- develop strategic plans that do more than set out the local context for the reforms; this includes:
  - how the IJB will contribute to delivering high-quality care in different ways that better meet people's needs and improves outcomes
  - setting out clearly what resources are required, what impact the IJB wants to achieve, and how the IA will monitor and publicly report their progress
  - developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils
  - making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act

- develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes:
  - developing financial plans for each locality, showing how resources will be matched to local priorities
  - ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively
- shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.

### Integration authorities should work with councils and NHS boards to:

- recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early on in the relationship and that a shared understanding of the roles and objectives is maintained
- review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils
- urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners
- establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and care services
- put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.

# Endnotes

1 This included reviewing 18 approved integration schemes, 17 of which were for integration joint boards following the body corporate model and one of which was for Highland's lead agency model.

2 Clackmannanshire and Stirling, Dumfries and Galloway, East Renfrewshire, Edinburgh City, North Ayrshire and North Lanarkshire.

3 *Review of Community Health Partnerships* [PDF], Audit Scotland, June 2011.

4 *Reshaping care for older people* [PDF], Audit Scotland, February 2014.

5 *Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland,* Scottish Government, 2012.

6 *Scotland Performs*, Scottish Government, 2015.

7 *Projected Population of Scotland (2014-based),* National Records Scotland, 2015.

8 *Finance Committee. 2nd Report, 2013 (Session 4): Demographic change and an ageing population*. Scottish Parliament, 11 February 2013.

9 *Bed days occupied by delayed discharge patients*, ISD Scotland, May 2015.

10 *Review of Community Health Partnerships* [PDF], Audit Scotland, 2011.

11 After approval of its integration scheme, an IJB is established by parliamentary order. An IJB is operational when it has delegated responsibility from the NHS board and council for integrated budgets and services.

12 The lead agency is between Highland Council and NHS Highland. NHS Highland also has an IJB with Argyll and Bute Council.

13 Where the IJB spans across more than one council area, the minimum number of voting members is different. For IJBs of two council areas, at least two councillors from each council are required. For IJBs of more than two areas at least one councillor from each council is required. In both cases, the NHS board must nominate board members equal to the total number of councillors.

14 As IJBs have no plans to directly employ staff in this early stage of development, we are not commenting on related potential risks and issues. We are likely to return to this issue in more detail in future reports on integration.

15 *Self-directed support* [PDF], Audit Scotland, June 2014

16 The Joint Improvement Team is a partnership between the Scottish Government, NHSScotland, COSLA (Convention of Scottish Local Authorities) and the voluntary, independent and housing sectors.

17 East Dunbartonshire, Shetland and West Dunbartonshire.

18 Some areas, have a chief officer designate. This happens where, although recruitment for a chief officer is complete, until the IJB is established it cannot formally appoint the chief officer.

19 Falkirk currently has an interim chief officer in post and expects to make a permanent appointment to this role by the end of the year.

20 Public Bodies (Joint Working) (Scotland) Bill, Financial Memorandum, 2013.

21 Ibid.

22 *Review of Community Health Partnerships* [PDF], Audit Scotland, June 2011.

23 We explore these tensions more fully in our report *Arm's-length external organisations (ALEOs): are you getting it right?* [PDF], Audit Scotland, June 2011.

24 *RCN briefing 2: Clinical and care governance in an integrated world,* May 2015, Royal College of Nursing.

25 *Agreement on joint working on community planning and resourcing*, Scottish Government and COSLA, September 2013.

26 *NHS Scotland Workforce Information Quarterly update of Staff in Post, Vacancies and Turnover at 30 June 2015*, ISD Scotland, 2015. This figure refers to all staff in NHS Scotland, not just those working in integrated services.

27 *Scottish Social Service Sector: Report on 2014 Workforce Data*, Scottish Social Services Council, 2015.

28 *Scotland's Carers,* Scottish Government, March 2015.

29 Public Bodies (Joint Working) (Scotland) Bill, Financial Memorandum, 2013.

30 Ibid.

# Appendix 1

## Audit methodology

We reviewed a range of documents during our audit. Where available, this included:

- the Act and national guidance and regulations on implementing the Act
- 18 approved integration schemes[1]
- strategic and related financial plans
- minutes, papers and agendas for IJB meetings
- internal audit reports and local reports on integration arrangements
- financial audit information
- joint inspection reports from the Care Inspectorate and Healthcare Improvement Scotland.

We interviewed stakeholders in the following IA areas:

- Clackmannanshire and Stirling
- Dumfries and Galloway
- East Renfrewshire
- Edinburgh City
- North Ayrshire
- North Lanarkshire.

We drew on the work already carried out by:

- the Care Inspectorate
- Healthcare Improvement Scotland
- local auditors.

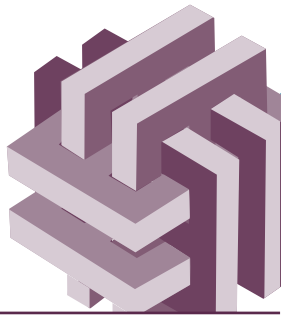
We also interviewed staff from:

- the Scottish Government
- the Joint Improvement Team
- the British Medical Association
- the Convention of Scottish Local Authorities
- NHS Information Services Division
- the Care Inspectorate
- Healthcare Improvement Scotland
- the voluntary sector.

Note: 1. We reviewed 17 integrations schemes establishing IJBs for Argyll & Bute, East Ayrshire, East Dunbartonshire, East Lothian, East Renfrewshire, City of Edinburgh, Eilean Siar, Inverclyde, Midlothian, North Ayrshire, North Lanarkshire, Renfrewshire, Shetland Isles, South Ayrshire, South Lanarkshire, West Dunbartonshire and West Lothian, and Highland's integration scheme setting out its lead agency approach.

# Appendix 2

## Scottish Government core integration indicators



Outcome indicators, based on survey feedback, available every two years, include:

- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well coordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good.
- Percentage of people with positive experience of care at their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of adults supported at home who agree they felt safe.
- Percentage of staff who say they would recommend their workplace as a good place to work.*

Outcome indicators derived from organisational/system data, primarily collected for other reasons, available annually or more often, include:

- Premature mortality rate.
- Rate of emergency admissions for adults.*
- Rate of emergency bed days for adults.*
- Readmissions to hospital within 28 days of discharge.*
- Proportion of last six months of life spent at home or in community setting.
- Falls rate per 1,000 population in over 65s.*
- Proportion of care services graded 'good' or better in Care Inspectorate Inspections.
- Percentage of adults with intensive needs receiving care at home.
- Number of days people spend in hospital when they are ready to be discharged.
- Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
- Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
- Percentage of people who are discharged from hospital within 72 hours of being ready.*
- Expenditure on end-of-life care.*

* Indicates indicator is under development.

# Health and social care integration

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**To:** **Renfrewshire Integration Joint Board**

**On:** **15 January 2016**

**Report by:** **Chief Officer**

**Heading:** **Draft Strategic Plan for Consultation**

## 1. Summary

1.1. The purpose of this report is to present members of the Integration Joint Board (IJB) the second draft of the Strategic Plan for approval, in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. Following approval, all prescribed stakeholders will be invited to comment on the plan through a formal consultation process.

1.2. The views of the Strategic Planning Group (SPG) have been taken into account in the preparation of the Strategic Plan.

1.3. The second draft of the Strategic Plan is attached in Appendix 1.

## 2. Recommendations

2.1. It is recommended that members of the IJB:

- note the approach and note the themes emerging from the views expressed by SPG members on the Strategic Plan Proposals,
- approve the second draft of the Strategic Plan, and
- agree to consult widely on the second draft Strategic Plan in line with legislative requirements and guidelines.

## 3. Background

3.1. At its meeting on 20 November 2015, the IJB approved the first draft of the Strategic Plan and agreed to seek the views of the SPG, in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

3.2. The second draft of the Strategic Plan has now been developed in line with legal requirements and reflecting national guidance on the joint strategic commissioning process.

3.3. The second draft of the Strategic Plan is attached in Appendix 1 for members' consideration.

## 4. Strategic Planning Group Views

4.1. One of the key legal requirements is for the IJB to seek the views of the SPG on the Strategic Plan. This has been carried out on an ongoing basis, and formally at the SPG meeting on 20 November 2015.

4.2. The SPG members were given copies of the first draft Strategic Plan and asked for views across a range of areas:

- Clarity around integration arrangements;
- Direction of travel for locality working; and
- Comment on strategic priorities and action plans.

4.3. The views expressed were captured and summarised. The detail of this is availble. A number of views were expressed multiple times and key themes emerged from the group discussions. These included:

- Integration arrangements: Members asked for information to be added about sensory impairment services, gardening assistance and the role of the voluntary sector. They also wanted further clarity about how the organisation will work with hospital services, the interface between Children's Services and the HSCP and the role of Primary Care Services. They asked for the role of housing to be expanded and requested that simple language be used where possible. Most felt that the role of the IJB and the SPG were clear.
- Localities: Generally, SPG members agreed with the direction of travel and with the delivery of services in the two geographical areas described. They asked for more details about the emerging cluster working model with GPs and other local services identifying new ways of working together.

- Priorities and Action Plans: The SPG members were satisfied that the priorities were informed by their views and built on existing work. They asked for clarity about community led health. Specifically, they asked for the action plans for learning and physical disabilities to be separated and to provide more detail. They wanted to see indicators developed for all action plans.

4.4. All the views expressed by SPG members have been captured and where possible incorporated in the plan. SPG members are updated on the progress being made in relation to their views at each meeting.

**5. Second Draft Strategic Plan**

5.1. The second draft of the Strategic Plan has been developed taking the SPG's views into account as outlined in 4.3 above.

5.2. The Strategic Plan sets out:

- An introduction and key messages from the Chair of the IJB and the Chief Officer;
- A description of the profile of Renfrewhsire, highlighting where we differ from other areas;
- Detail on the context within which we are working;
- The challenges facing health and social care services, based on the demographics, policy drivers and service demands;
- The resources available to us;
- Emerging priorities and action plans which read across to the 9 national outcomes;
- Appendices which provide details of our integration arrangements and case studies which demonstrate how integration can improve servies for people in Renfrewshire. A comprehensive glossary is provided.

**6. Strategic Planning Timeline and Next Steps**

6.1 In line with the process and timeline approved previously, the second draft of the Strategic Plan will now be taken through a formal consultation exercise to seek feedback from the prescribed consultees. The Act prescribes the stakeholders who must be consulted at this stage, including staff, service users, carers, the third sector providers, the Council and Health Board.

6.2 Six staff events have been organised throughout January 2016 and an event for Third Sector and public members will be held on 3rd February

in Paisley Town Hall. Consultation on the plan will also take place at several other planned meetings and fora over this period.

6.3 The consultation will be launched with a short video which will be available at www.renfrewshire.gov.uk/integration after IJB approval on 15th January 2016. Feedback from this wider consultation will then be taken into account when preparing the final draft.

6.4 Feedback can be submitted using a standard questionnaire (which is also available electronically).

6.5 At its meeting on the 18th March 2016, the IJB will agree their final draft of the Strategic Plan, taking account any feedback from the Council, Health Board and wider consultation. Following this, the Health Board and the Local Authority will delegate functions to the IJB.

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**Implications of the Report**

**1.** **Financial –**

**2.** **HR & Organisational Development –**

**3.** **Community Planning**

**4.** **Legal –**

**5.** **Property/Assets –**

**6.** **Information Technogloy –**

**7.** **Equality & Human Rights –** The recommendations containted within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be publised on the Council's website.

**8.** **Health & Safety –**

**9.** **Procurement –**

**10.** **Risk –**

**11.** **Privacy Impact –**

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**List of Background Papers – None.**

**Author** Fiona MacKay, Head of Strategic Planning and Health Improvement, Renfrewshire Health and Social Care Partnership.

# Renfrewshire Integration Joint Board (IJB)

# Strategic Plan 2016-2019 Consultation Draft


**15th January 2016**

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# 1. Introduction

1.1 This is the first Renfrewshire Strategic Plan for the delivery of health and social care services in Renfrewshire, produced by the Integration Joint Board under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014. It describes how we will move towards delivering on our organisational vision - it therefore sets out the context, challenges, priorities and action plans for the new Health and Social care Partnership for the period 2016-2019.

1.2 Renfrewshire Council and NHS Greater Glasgow and Clyde have a positive and proven track record of effective joint working to improve outcomes for people who use health and social care services in Renfrewshire. Bringing adult Social Work and all former Community Health Partnership functions into a Health and Social Care Partnership (HSCP) is a further step in these joint working arrangements and places a renewed, clear focus on putting the people who use services at the heart of what we do and how we work.

1.3 Whilst the Strategic Plan builds on the successes and experience of the past, it also focuses on how we can further join and, where appropriate, integrate our services. People who need health and/or social care rarely need the help of a single specialist, team or service and we believe that improved joint working and, where sensible, integration, is vital to improving our services.

1.4 So, this Strategic Plan outlines the context in which our health and social care services operate; the needs we are seeking to respond to, the challenges we are managing and the importance of optimising the benefits of our new organisational arrangements - to change how we work, get services working effectively together and focusing our resources to deliver services that we know work well in order to respond to those in greatest need. It also examines the evidence for our strategic decisions, it uses this evidence to identify local priorities and shape our action plans.

1.5 Because of growing demand on our resources, we know that more of the same is often not an option. If we continue to deliver services only in their current form, the health and social care system will be unable to deliver the high quality services the people of Renfrewshire need. We therefore have to plan, commission and deliver services that are focused on the outcomes we must achieve and make the best use of the resources available. It is an established feature of both national and local policy that more joined up care, more self care, and targeted anticipatory and preventative approaches, must be prioritised and shape our planning if we are to manage the growing demands we face. Linked to this we must ensure a clear and consistent focus in our resource prioritisation on home and community based care reducing demands on hospital and other more specialist services where appropriate.

1.6 Other partners play a central role in creating an effective and person-centred health and social care system. We will continue to work together with family doctors (GPs), hospital services, our communities, the independent sector and the voluntary (or third) sector to progress and achieve our aims. We will also continue and develop our work with Community Planning partners (for example Development and Housing in the Council and Police Scotland) to influence the wider determinants of health to create a healthier Renfrewshire.

1.7 From this, the Strategic Plan sets out clear Care Group Action Plans. These plans will be further developed over the next year as we develop and establish our ways of working and learn how to better join up and integrate services. Priorities from these emerging plans are contained in Section 8 and are framed with clear actions and are linked to the relevant national outcomes we need to deliver on. The Care Group Action Plans also link to our HSCP Performance Framework which will drive regular reports to our IJB on the progress we are making. We will also ensure that we are planning and working in a way to ensure staff, service users, patients and partner organisations are engaged in what we do and how we work.

1.8 So, we trust this Strategic Plan provides a sound and clear basis for our new HSCP to begin its work. We have launched this for consultation knowing that it needs to adapt and mature over time and importantly, knowing that it will benefit from your feedback.

Cllr Iain McMillan
IJB Chairman

David Leese
Chief Officer

*Our vision:*
*Renfrewshire is a caring place where people are treated as individuals and supported to live well*

## 2. Executive Summary

**The final plan will describe key priorities in an Executive Summary. These will be informed by the detail of the plan.**

## 3. Renfrewshire – Our Profile

3.1 Renfrewshire is a diverse area of towns, villages and countryside covering 270 square kilometres and situated 7 miles west of Glasgow City. The area has excellent transport connections to the rest of Scotland and has a major airport. Scotland's largest business park is situated in Hillington, and key campuses of the University of the West of Scotland and West College Scotland are located in Paisley town centre.

3.2 Just over 170,000 people live in Renfrewshire. Over the next 20 years, the number of people aged 16-64 living in Renfrewshire is likely to fall and the number of children will remain broadly the same. A major change will be that the number of older people (over 65) will rise by 40%. 2.8% of Renfrewshire residents are members of an ethnic minority group.

3.3 Life expectancy in Renfrewshire is lower than the Scottish average.

| | Males | % Change over 10 years | Female | % Change over 10 years |
|---|---|---|---|---|
| Renfrewshire | 75.9 | 4.0 | 80.6 | 2.4 |
| Scotland | 77.1 | 3.4 | 81.1 | 2.1 |

There are significant variations within Renfrewshire, with male life expectancy in some areas being over 15 years lower than that in other more affluent areas.

3.4 We know that the inequalities gap in life expectancy (and in other outcomes) is influenced by the pattern of deprivation in Renfrewshire. Many of Renfrewshire's datazones are found in the three most deprived deciles, but a significant number are also found in decile 9. The most deprived datazone in Renfrewshire is in the intermediate zone of Paisley Ferguslie, and it is ranked 1 in Scotland. Renfrewshire's share of the 15% most deprived datazones has increased slightly from 4.2% in 2004 to 4.9% in 2012.

3.5 39% of the adult population of Renfrewshire are receiving treatment for at least one illness/condition e.g. high blood pressure, arthritis, asthma, diabetes, depression, coronary heart disease. This figure increases with age (17% for those aged 16-24 and 83% for those aged over 75) and in our more deprived areas.

3.6 The number of smokers (19% of the population), and those reporting exposure to second hand smoke (26% of the population) has fallen in 2014 from similar studies done in 2008 and 2011. Renfrewshire also shows improvements with fewer people reporting exceeding recommended alcohol limits and more meeting physical activity recommendations. However, around 1 in 2 are overweight or obese, with men in the 45-64 age range being the most likely to be overweight or obese (68% of the population). Where data is collected

at locality level, Renfrewshire consistently shows wide variations, reflecting the more general inequalities in the area. For example, alcohol related hospital discharges are over 25 times higher in Paisley North West than in Bishopton.

3.7 In Scotland, at least one person in four will experience a mental health problem at some point in their lives, and one in six has a mental health problem at any one time. This means that today in Renfrewshire, around 20,000 adults are experiencing a mental health problem. The recent Renfrewshire Health and Wellbeing Survey (2014) confirmed that 77% of people living in Renfrewshire were positive about their general health in a recent survey. This is an improvement from a similar study carried out in 2008. In general, satisfaction was lower among older people and in our more deprived areas.

3.8 In relation to Addictions, almost 2,800 15-64 year olds in Renfrewshire are estimated to be problem drug users. The rate of alcohol related hospital discharges in Renfrewshire has reduced slightly but remains 31% higher than the national average (981.8 per 100,000 population in 2014/15, against a national average of 671.7).

3.9 From the work of the Renfrewshire Tackling Poverty Commission, we know that there are real local challenges with poverty. In Renfrewshire, there are 30,121 children aged 0-15 in Renfrewshire and 8,143 young people aged 16-19. More than 1 in 5 of our children are growing up in poverty. This ranges from 30% in Paisley North West to 13% in Bishopton, Bridge of Weir and Langbank. In Renfrewshire in 2014, 20.1% of the population reported difficulty in sometimes meeting fuel costs.

3.10 Carers in Renfrewshire are a valued and important contributor to healthcare provision. 12,868 people in Renfrewshire provide up to 50 hours of informal care per week and a further 4,576 people provide more than 50 hours of informal care per week. 10% of our population are carers in some form.

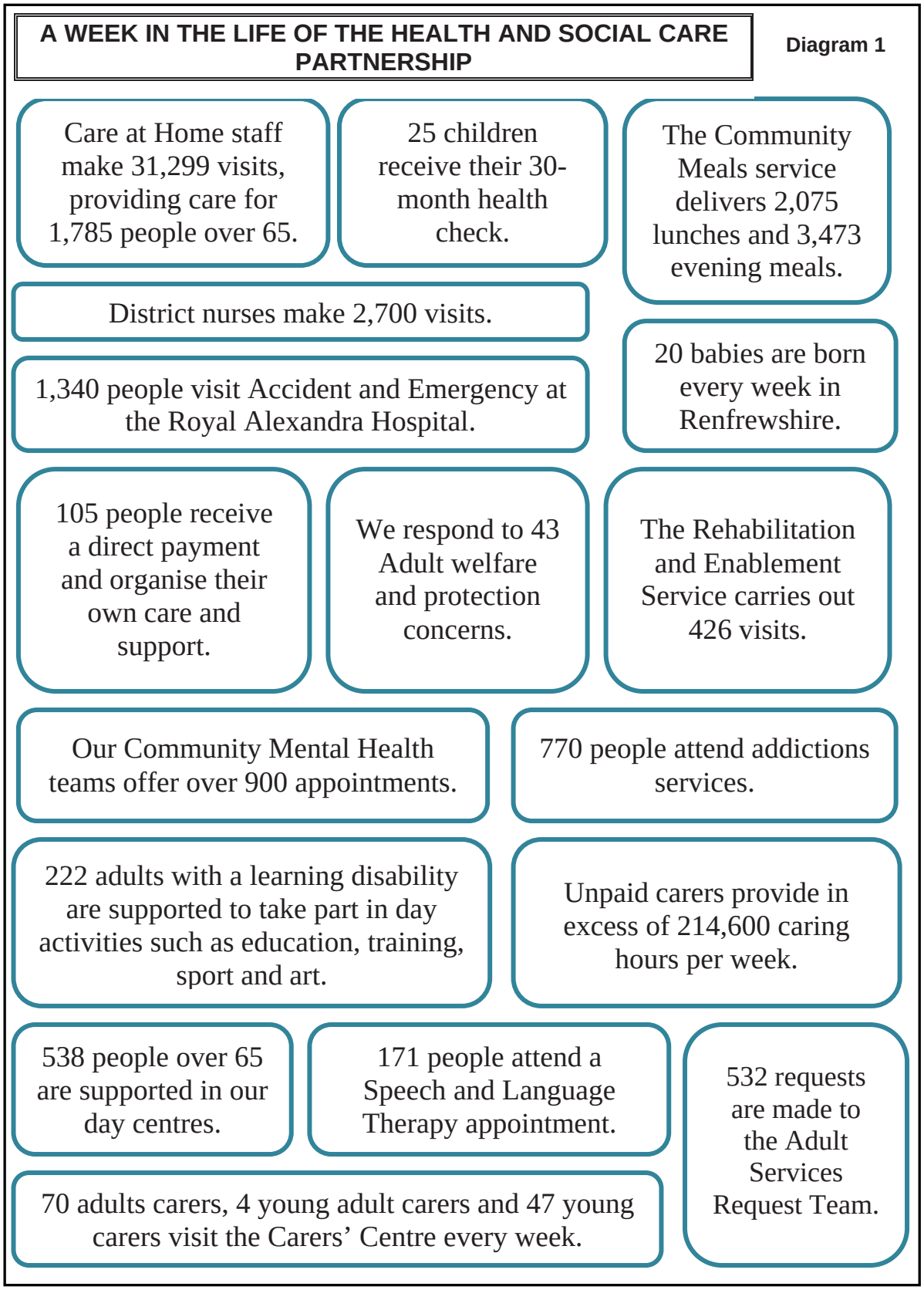
3.11 How individual and family circumstances are affected by such needs are difficult to describe but we know that our service and care responses when needed are vital to the care and support required – in our case study section of the Plan (see Appendix 1) we have attempted to describe a number of real life situations, all of which clearly show the need for highly effective and joined up community health and social care services.

3.12 We have a range of services in Renfrewshire that respond each day to the needs of local people. We have 29 GP practices, 44 community pharmacies, 19 community optometrists and 35 general dental practitioners. We also provide or commission a wide range of community based health and social care services and have a major acute hospital – the Royal Alexandra Hospital (RAH).

3.13 Also, the diagram below gives an indication of the level of activity carried out in a typical Renfrewshire HSCP week.

**A WEEK IN THE LIFE OF THE HEALTH AND SOCIAL CARE PARTNERSHIP**

**Diagram 1**



## 4. Renfrewshire – Our Demand and Demographic Challenges

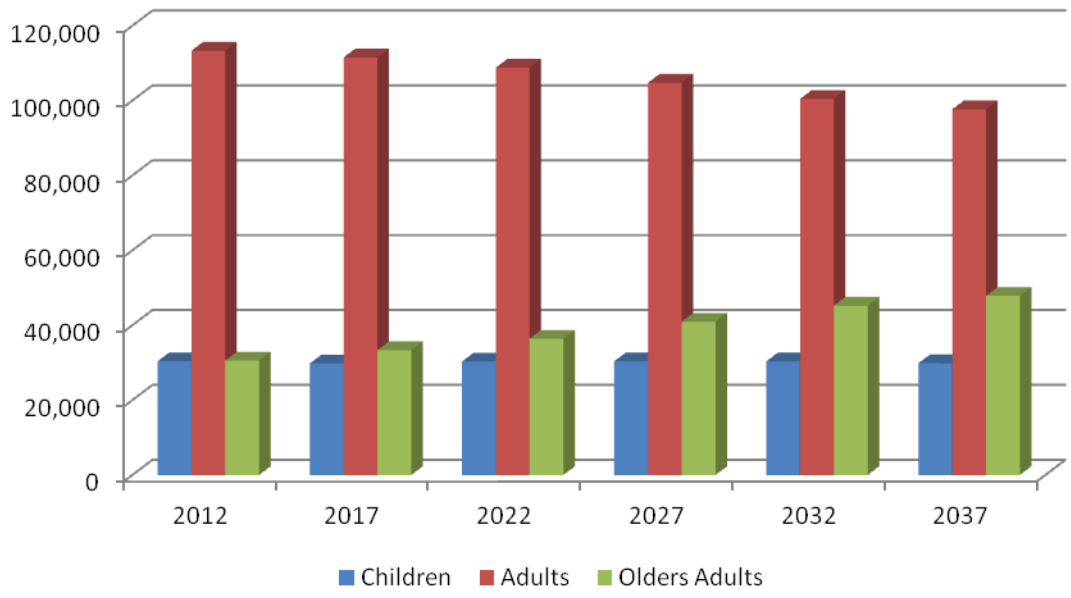
4.1 The profile, described in Section 3 above, presents a number of challenges for the services we manage. These are described in more detail below.

4.2 Older People

According to population projections published by National Records for Scotland, there will be almost 48,000 people in Renfrewshire aged 65 and over by 2037. This compares with 31,751 in 2014 and represents an increase of 51%. Over the same period, the number of people of working age is expected to fall by 13%, and the number of children will be almost unchanged over the same period.

***Diagram 2***

***Projected population of Renfrewshire, 2012-2037***




This change will have significant implications for health and social care, with demand increasing as a result of more people living into older age (when health and social care needs are likely to be more complex) whilst the number of people available to work in health and social care and/or provide unpaid care may decline.

Population projections also look at household composition. It is estimated that the number of people aged 65 and over and living alone will increase by 6% between 2015 and 2020, and by 36% between 2015 and 2035.

## 4.3 Learning Disabilities

In 2013, there were 819 adults with learning disabilities known to social care services in Renfrewshire. We know that:

- Over half (55%) are male;
- 65% are aged between 20 and 49.

Many people with a learning disability, particularly with a mild disability, will never come into contact with social care services and so this figure does not reflect the true number of people with learning disabilities in Renfrewshire.

- The prevalence of mental health conditions is much higher amongst people with learning disabilities than amongst the rest of the population. Diagnosable psychiatric disorders are typically present in 36% of children and young people with a learning disability, compared with a whole population rate of 8%.[1]

- People with learning disabilities are at greater risk of developing dementia than the rest of the population, and it tends to develop at a much younger age.

- There are a number of physical conditions which have been shown to be more common in people with learning disabilities than in other groups in the population. These include epilepsy, sensory impairment, respiratory disorder and coronary heart disease.

The age profile of current service users means that the next few years will see higher than usual numbers of people transferring from Children's Services to Adult Services.

Suitable accommodation to support people with learning disabilities or autism to live independently is limited. Supported accommodation, either in individual tenancies or in cluster flats, has proven to be effective but demand outstrips supply and mainstream housing is not always appropriate for this group of service users. Services providing day opportunities are running at near capacity. Resources may also be required in the future to support older people with learning disabilities and provide a specialist service.

## 4.4 Mental Health

It is estimated that 1 in 4 adults in the UK will experience a mental health disorder in the course of an average year and that 1 in 6 will experience one at any given time[2] . A person's mental health is not static; it may change over time in response to different life

[1] People with Learning Disabilities in England 2011 (Emerson et al)

[2] Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. Psychiatric Morbidity Among Adults Living In Private Households (2001)

stages and challenges. Using the 1 in 4 people estimation means that over 35,500 adults in Renfrewshire experience a mental health problem in an average year. In the 2011 Census, 5.2% of Renfrewshire's population (9,084 people) reported suffering a mental health problem. This suggests that almost three-quarters of people who may be experiencing mental health challenges either do not consider this a long-term condition or are reluctant to publicly acknowledge it.

The Scottish Public Health Observatory's profile of Renfrewshire states that 18.2% of Renfrewshire's population (30,580 people) were prescribed drugs for anxiety, depression or psychosis in 2013, against a Scottish average of 17.0%. The rate of hospitalisation for psychiatric conditions is 254.4 per 100,000 residents, which is below the Scottish figure of 291.6 per 100,000. Within Renfrewshire, there is a great deal of variation, with psychiatric admissions per 100,000 people ranging from 33.9 in Houston South to 514.7 in Paisley East.

The rate of deaths from suicide, which is strongly linked to mental health problems, is also higher than that of Scotland – 16.1 per 100,000 people, compared with 14.7 nationally. In some parts of Renfrewshire, it is considerably higher – 36.6 in Gallowhill and Hillington, and 53.3 in Paisley North West[3].

There is also a strong link between mental health problems such as depression and over-consumption of alcohol. In 2011, there were 1626 alcohol-related hospital discharges in Renfrewshire, which is a rate of 958.6 people per 10,000 of population[4]. This is significantly worse than the national rate of 748.6 people.

## 4.5 Physical Disability and Sensory Impairment

Disability may be defined as a physical or mental impairment that has a substantial and long term negative effect on the ability to do normal daily activities. The prevalence of disability is a direct measure of the level of need for services. Renfrewshire's prevalence of disability is shown below:

| | Renfrewshire | Greater Glasgow and Clyde | Scotland |
|---|---|---|---|
| Visual Impairment | 9.2% | 9.6% | 9.0% |
| Auditory Impairment | 26.1% | 26.3% | 25.4% |
| Physical Disability | 21.2% | 22.7% | 20.6% |

[3] ScotPHO 2014 Health and Wellbeing profile- insert source

[4] age-sex standardised rate per 100,000 population to ESP2013

## 4.6 Addictions

Excessive alcohol consumption is a major risk factor for mental and physical ill health. 13.2% of Renfrewshire's adult population reported drinking in excess of recommended limits in a given week. In the year to June 2014, the rate of alcohol related hospital admissions in Renfrewshire was 10.8 per 100,000 population, slightly higher than the Greater Glasgow and Clyde rate of 10.4. The rate of drug related hospital discharges has increased by 22% since 2009/10 in Renfrewshire.

## 4.7 Unpaid Care

Informal or unpaid care represents an important form of health care provision. It is usually provided in the community by family members or friends.

The 2011 Census reported that 10% of people in Renfrewshire regularly provide unpaid care, with 3% providing more than 50 hours of unpaid care each week. Research published by Carers UK[5] suggested that unpaid carers save the UK government £119 billion every year by providing care that might otherwise be delivered by statutory services.

The Scottish Government is currently progressing legislation which gives local authorities new duties in relation to carer support. The legislation has a significant financial impact, as it requires additional resources for assessment and care planning, and waives the right of local authorities to charge for services which provide support to a carer.

## 4.8 Care at Home Service

Since 2011/12, the introduction of a reablement approach to Care at Home services has increased the number of people receiving a service and the number of hours of care provided. At present, in a typical week the service delivers around 15,500 hours of care to almost 1,800 people aged 65 and over. More than 200 of these service users will need two or more workers to attend to their needs.

Recruitment and retention of staff is a considerable concern for Care at Home services. The sector has relatively low levels of pay and the care sector has struggled with staffing issues.

All community-based services report additional demand pressures arising from the success locally in reducing delayed discharges from hospital. Supporting prompt discharge often requires a package of community-based care and support to be available, and Care at Home are consequently required to deliver service to a greater number of people. To date,

[5] Carers UK (2012) In Sickness and in Health

there has been no direct resource transfer from the acute sector to the community sector to mitigate these pressures.

4.9 Residential and Nursing Homes

In the last two to three years, there has been an emerging over capacity in the local care home market. National and local policy has been focused on supporting people to remain in their own home as long as possible and consequently there has been a steady reduction in the number of care home placements in Renfrewshire. Demand for residential places is particularly low, since service developments now contribute to many more people being able to remain at home with complex care needs. As such, most people who require full-time bed based care have needs substantial enough to require nursing care. There are also growing numbers of people requiring specialist dementia care and an under-supply of this type of care in the local market.

4.10 Adult Protection

The volume of referrals to social work teams has steadily increased in each quarter of the last few years. The number of contacts in June 2015 was around 10% higher than 12 months previous. The staffing complement of the team has not increased in recent years and staff continue to manage increasing workloads.

The increasing workloads have included a significant rise in the number of adult protection concerns received. In July 2105, there were 149 Adult Welfare Concerns raised and 88 Adult Protection Concerns. Each of these requires initial investigation by frontline staff and many will progress further. Changes in the approach taken by Police Scotland means that, on a like for like basis, the annual volume of referrals rose from 1734 in 2013/14 to 2522 in 2014/15, an increase of 45%.

Adult services teams are generally completing between 250 and 300 assessments each month, but recent data indicates this is increasing, with 330+ per month becoming more usual.

4.11 Impact of Self-directed Support

The Social Care (Self-Directed Support) Act 2014 requires local authorities (and now the HSCP) to offer service users more choice and control over the package of care put in place to address their assessed needs. Included within this is the option for service users to choose who provides their service or to opt for a direct payment. More than half of service users who have completed the process to date have requested that the Council choose and arrange their care for them but in the longer term it is expected that more people will want

services not provided by the council or their framework providers. This could result in falling demand for services (including building-based services such as day centres) higher unit costs.

4.12 Supporting the Reduction in Delayed Discharges

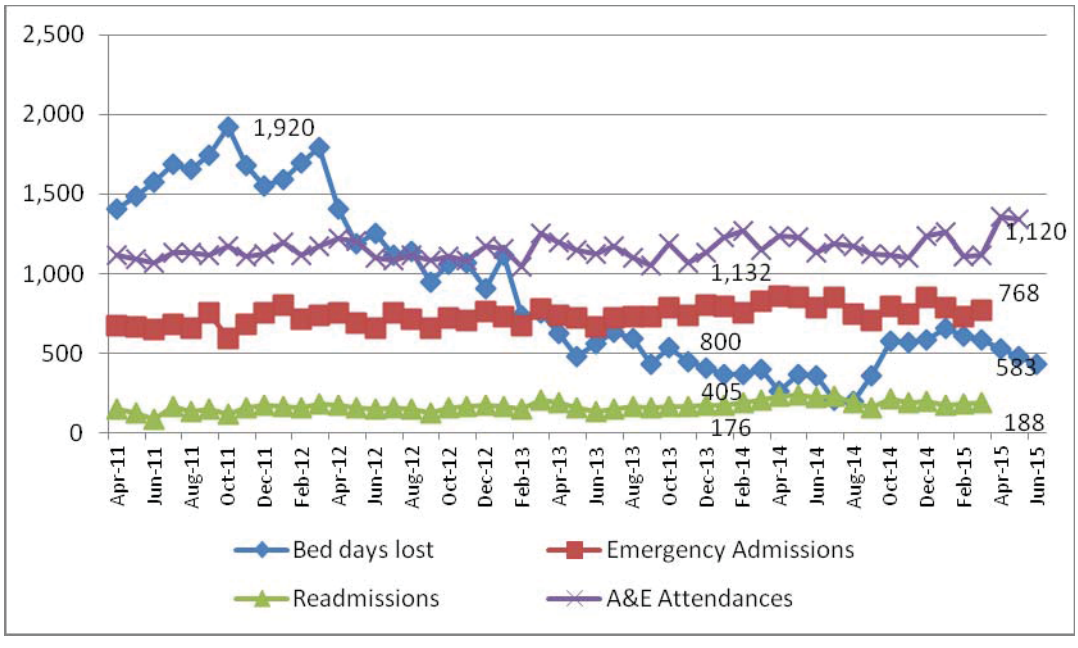
Renfrewshire has made significant progress in reducing hospital bed days lost due to delayed discharges (where a person is medically fit to leave hospital but services and supports are not in place to allow a safe discharge).

- The numbers of bed days lost per annum has reduced from 19,792 in 2011/12 to 5,835 in 2014/2015 – the equivalent of 38 beds.
- There is limited scope for further improvement since the majority of remaining delays are individuals subject to Adults with Incapacity legislation, meaning they cannot be moved until guardianships are established by the courts. This issue is considered separately below.

As noted above, supporting a reduction in delayed discharge has created additional demands in community based services, particularly care at home services. This has not seen a release of resource from the Acute hospital budgets as there has been no reduction in admissions or in attendances at Accident and Emergency (see Diagram 3 below). It is vital that we work effectively at this interface and where we can we agree how resources are used to best effect, and how more self care, anticipatory and preventative approaches can reduce demands on all services.

***Diagram 3***

***Hospital Activity, April 2011 to June 2015***



4.13 Adults with Incapacity

As noted earlier, the majority of delayed discharges are people impacted by Adults with Incapacity legislation, meaning decisions about their ongoing care cannot be made until the Courts appoint a guardian. There are also increasing numbers of people supported in the community who are subject to the same legislation. Where there is no appropriate person to act as guardian, the local authority can apply to Courts for the Chief Social Work Officer (CSWO) to be appointed as guardian. In these cases, the CSWO will delegate the day to day management to a Mental Health Officer (MHO). Renfrewshire Council has invested significantly in additional MHOs to support this work but the volume of work continues to grow. In 2014/15, the CSWO had responsibility for 89 guardianships, up from 70 in 2013/14 and 47 in 2012/13. There has been a 91% increase in such guardianships in Renfrewshire since 2002.

In addition to increasing volumes, this area of work is subject to complex and lengthy legal processes which impact on workloads. It is highly specialised work that requires an MHO to undertake.

## 5. Renfrewshire – Our Planning and Delivery Context

5.1 This Strategic Plan begins our journey to developing more joint and integrated services and marks a key milestone in our progress towards achieving the Scottish Government's 2020 Vision.

That vision is clear on what we must work to achieve - namely that everyone is able to live longer, healthier lives at home or at a homely setting we will have a health and social care system where:

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

5.2 In pursuit of this vision we must ensure we deliver on the agreed 9 national health and social care outcomes. These are set out below:

| | |
|---|---|
| **Outcome 1:** | People are able to look after and improve their own health and wellbeing and live in good health for longer |
| **Outcome 2:** | People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community |
| **Outcome 3:** | People who use health and social care services have positive experiences of those services, and have their dignity respected |
| **Outcome 4:** | Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services |
| **Outcome 5:** | Health and social care services contribute to reducing health inequalities |
| **Outcome 6:** | People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing |
| **Outcome 7:** | People using health and social care services are safe from harm |

| | |
|---|---|
| **Outcome 8:** | People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide |
| **Outcome 9:** | Resources are used effectively and efficiently in the provision of health and social care services |

5.3 In working to deliver on the 2020 Vision and to make real progress to deliver on the 9 outcomes we need to recognise and plan based upon a number of demands and drivers.

Increasing Demand

- Many of our services are facing year on year increases in demand.
- Many of the growing demands are characterised by complexity, vulnerability and the need to provide support to people in their own homes and communities at the earliest possible point.
- Further evidence of increasing demand is set out in section 5. Given this and the national 2020 Vision and health and social care outcomes we are working to deliver, it is important that investment in community based health and social care services is sustained in real terms and ideally increased. This presents a real challenge when set in the context of reducing budgets and increasing levels of demands for services.

Improving Quality

- There must continue to be a clear focus on the quality of services we provide and the evidence upon which we plan, design and deliver our services. We therefore need to focus our resources on what works in order to deliver high quality care and high quality outcomes.

Utilising Resources

- We need to prioritise how we use our resources. This may mean that we need to target our spend more effectively into what we know to work in order to support those with greatest need.
- We also need to make further progress to optimise how our health and social care staff work. We are in the very early stages of developing a health and social care organisational development and workforce strategy and also exploring how to further develop staff and our teams to work together to generate real benefits from effective joint working.
- We must continue to develop a system wide, joined up, multi-disciplinary team and service working approach to best address the needs of the local population. We need therefore to be working smartly with Community planning partners in Renfrewshire, with local GPs and other community based service providers and with other HSCPs and Acute Hospital services across NHS GG&C.

Planning in Localities

- We must continue to develop our approach to how we plan based on localities within our HSCP. At this point most of our services are delivered within the two geographical areas (or localities) that are well known – Paisley and West Renfrewshire.
- In 2016/17 we will work to build a dialogue within 'clusters' or 'sub localities' across Renfrewshire and through this test how our services can work better together with local GPs and others.
- Through this we will also develop a clearer view of the geographical/locality planning required for Paisley and West Renfrewshire. Our focus is to develop our approach to locality planning and to make local joint working central to what we do over the next three years. It is vital that we nurture and develop this approach as it is through better local multi disciplinary team and service working that we believe real improvements in care for service users and patients will be secured.

Partnership Working

- How our services work with others is vital and we must further develop effective interfaces which are defined by true collaboration, mature relationships and a shared understanding, ownership and agreement of the challenges we face and shared agreement on the ways forward.
- A key interface will be how we work with Acute Hospital Services – particularly with the RAH which provides the majority of Acute care for our Renfrewshire population.
- How we work with other Council services, particularly Children's Services is also key. There is a very positive track record of joint working and this will be built upon as we develop more effective preventative and evidence based approaches to support children and families.
- General Practice is central to highly effective, joined up health and social care. As the new GP contract comes into operation from April 2016, we must renew how our staff and teams work with GPs and the wider primary care based professionals, to optimise benefits to patients and service users. The Royal College of General Practice (RCGP) Strategy for safe, secure and strong general practice in Scotland provides a helpful framework for this.
- It is also important that Renfrewshire HSCP continues to be a dynamic partner with the 5 other HSCPs across the NHS Greater Glasgow and Clyde area. Working collaboratively with other HSCPs is central to effective whole system working – and this is essential if we are to optimise how we plan, learn and deliver best practice and the highest quality, most effective services.

Equalities Focus

- Our services must also take into account diverse groups of service users irrespective of race, age, gender, sexual orientation, disability, religion, marital status, gender reassignment and/or pregnancy/maternity.

- In April 2015 the Scottish Government added Integration Joint Boards (IJBs) to the Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2015. This places a duty on our IJB to consult on how the policies and decisions made affect the people who are protected under the Equality Act. This amendment requires our IJB to publish a set of equality outcomes and a report on progress it has made to mainstream the equality duty by the 30 April 2016.

- We will produce a set of equality outcomes and a mainstreaming report to meet the requirements of the legislation. We will consult with a variety of stakeholders to identify equality issues and develop our equality outcomes to complement the priority themes and care group action plans indicated in our Strategic Plan. In order to meet our equality outcomes we will produce a set of actions and indicators to ensure that our performance is transparent to all our service users and other stakeholders.

- We will also ensure new or revised policies, strategies and services are equality impact assessed to identify any unmet needs, and to provide a basis for action to improve services where appropriate. It is also an important tool in our overall endeavours to improve effectiveness and efficiency in responding to health inequalities and improving health. An equality impact assessment has been undertaken for this Plan.

- To measure our performance we will publish our equality outcomes and information in an accessible format for the public, to show that we have complied with the Equality legislation.

# 6. Our Resources

## 6.1 Context

As set out earlier, this Strategic Plan provides the framework for the development of health and care services over the next few years and lays the foundation for us to work with partners in developing a focused approach to delivering on our priorities. In order to do this we need an agreed, clear financial framework which will support the delivery of the Plan and its associated programmes within the agreed resources available.

The functions delegated from Renfrewshire Council to the Integration Joint Board represent all Adult Social Care functions of the Council, along with the budget for these functions. In addition the Council must also delegate Housing Adaptations and Gardening Assistance budgets to the IJB. A similar range of health functions, along with the budget for these, are delegated to the Integration Joint Board by NHS Greater Glasgow and Clyde.

## 6.2 Budget Pressures

Renfrewshire, in common with all other HSCP areas throughout Scotland, has faced significant financial challenges in recent years, with further pressures anticipated in future years. The overall picture is one of reducing resources and increasing demands in delivering the delegated functions above. The key issues for us are:

- Reducing levels of funding from Scottish Government to parent organisation over recent years and this trend is expected to continue to 2020.
- The real effects on services of the demographic changes outlined earlier- mainly as a result of an ageing population.
- Health inequalities with large differences in life expectancy between affluent and more deprived areas, and higher than average rates of hospitalisation for a number of chronic conditions, particularly those linked to unhealthy lifestyles such as smoking, excessive alcohol consumption and drug misuse.
- We continue to face increasing costs of medications and purchased care services.
- An ageing population with a corresponding increase in co-morbidities and individuals with complex needs.
- Increasing rates of dementia.
- Increases in hospital admissions, bed days and delayed discharges.
- Increased demand for equipment and adaptations to support independent living.
- Increases in National Insurance contributions for employers.

- The increasing minimum wage and move to a living wage, leading to increased employer costs and requests for uplifts from contractors.
- Superannuation increases and the impacts of automatic pension enrolment.

NHS Greater Glasgow and Clyde is reporting significant financial challenges, particularly driven by demands on Acute hospital services along with further cost pressures pension and other pay pressures. Renfrewshire Council is facing similar pressures of demand and staff costs. In December 2015, Audit Scotland published a national report highlighting financial risks being faced by the NHS in Scotland and the consequential need for the Scottish Government and the NHS to accelerate the delivery of change and modernisation as a key response to mitigating the impact brought about by cost pressures.

## 6.3 Meeting the Financial Challenges Ahead

Current service provision is not sufficient to meet the future health and social care needs of the population, with the predicted rise in long term conditions and health problems associated with an ageing population. We must therefore embed new ways of working and seek to focus resources away from expensive bed based models of care into community based services. We need to critically appraise and challenge our current models of service delivery to ensure our combined resources are focused on areas of greatest need delivering the best outcomes to our service users and patient.

Over recent years, the Council's Social Work services has managed a number of demographic and financial pressures through a range of demand and cost mitigation measures in order to minimise the level of additional investment by the Council going forward. The strategy for the HSCP will adopt this approach, building on ongoing proactive work within the partnership with a focus on shifting the balance of care to community based settings.

Building on what has been set out earlier in this Plan our focus will be on:

- Linking with the 'Better Council' efficiency programme we will develop more efficient methods of service delivery focusing on outcomes and needs of patients and service users.
- Developing models of service and ways of working that support people to live longer in their own homes and communities, with less reliance on hospital and residential care.
- Continue our programme of reducing delayed discharges.
- Developing service models which are focussed on prevention and early intervention promoting community based support over residential settings.

Service reviews prioritised for the next two years reflect the national policy direction to shift the balance of care and promote independent living and person centred care. This will ensure that service users can live as independently as possible in their own homes and communities for as long as possible. Key areas proposed include reviewing:

- The approach to the way we deliver and commission care at home services to ensure that services provided are modern, flexible and efficient.
- Care home provision - in light of the changing needs of current residents and the local population with increased demand for specialist nursing and dementia placements.
- Occupational Therapy services and provision of equipment and adaptations.
- Self Directed Support.
- Embedding the requirements of the new Carer's legislation.

6.4 **Budgets**

The total financial resource available to the partnership for 2016/17 has not yet been finalised. The 2015/16 budget is summarised below.

| | £m |
|---|---|
| Social Work Net Expenditure | 55.5 |
| Health Net Expenditure | 147.6 |
| | 203.1 |

The Acute set aside budget and an allocation from housing services will be added.

**The final strategic plan will give an updated budget position for 2016/17 and show an analysis of this by care group.**

## 7. Our Strategic Priorities

7.1 This section of the Strategic Plan describes the themes and high level priorities which will direct the HSCP over the next three years. Detailed action plans by care groups, informed by previous plans and consultations will be updated and finalised by March 2016 (see Section 8). In summary our strategic priorities are set out in the following.

7.2 **Improving Health and Wellbeing**

Prevention, Anticipatory Care and Early Intervention

- We will support and advise people to take greater control of their own health and wellbeing so they maintain their independence and improve self care wherever possible.
- We will develop systems to identify people at risk of inappropriate hospital admission, and to provide them with the necessary support to remain in their own community safely for as long as possible.
- We will focus on improving Anticipatory Care planning.
- We will support the wellbeing of children and young people and provide parenting support to families.
- We will drive up the uptake of the 30-month assessment and use the information from this to maximise readiness for school and support parents.
- We are progressing toward full implementation of GIRFEC by August 2016 to improve early identification of need.

Active Participation in Community Life

- We will enable people to become better connected with each other and encourage co-operation, mutual support and caring within their communities.
- We will continue to support and signpost patients and clients into employment services to allow them to meaningfully contribute to their community.
- We will support them to prosper by improving their financial wellbeing and ensuring there is access to appropriate financial services and support.
- We will work with third sector partners to build community capacity and to increase the local opportunities available to our population.

Addressing Inequalities

- We will target our interventions and resources to narrow inequalities and to build strong resilient communities.
- We will carry out Equalities Impact Assessments (EQIAs) on new policies and

services to remove barriers which prevent people from leading healthy independent lives.

Support and Protection

- We will work to deliver on our statutory duty to protect and support adults at risk of harm.
- Harm can be physical, sexual, emotional or financial or it can be neglect. It can also take the form of forced marriage, radicalisation or gender based violence, or can be related to harmful behaviours. It can be intentional or unintentional.
- We will continue to build on our progress to date to ensure services work to protect children. We will continue to work closely with the Council's Children's Services Directorate and with others to develop our child protection services and keep Renfrewshire's children safe.

7.3 **The Right Service, at the Right Time, in the Right Place**

Pathways through and between Services

- We will build on the local work to test new pathways between primary, secondary and community based services through the Renfrewshire Development Programme. This learning will be used to make more permanent improvements.
- For those with dementia, post diagnostic support is available and, in learning disabilities, the transition into adult services is being improved.

Appropriate Accommodation Options to Support Independent Living

- Our 10 year plan for older people services highlights the need to respond to the rising demand for smaller properties and for homes which are fully accessible. The HSCP offers the opportunity to work in partnership to influence Renfrewshire's local Housing Strategy. We will continue to improve services and systems for those who are homeless or at risk of homelessness.

Managing Long-term Conditions

- We will take the opportunities offered by emerging technology to support people to manage their own long term conditions.
- We will also focus on self management and partnership with specialist services.

7.4 **Working in Partnership to Treat the Person as well as the Condition**

Personalisation and Choice

- Self directed support offers people the opportunity to have greater choice and

control in the care they receive. We will continue to use the Patient Experience process and other patient feedback systems to improve services and respond to issues raised by the people who use our services.

- We will continue to adapt and improve how our services work by learning from all forms of patient and service users feedback and from significant events and incidence

Support for Carers

- Carers are key partners in contributing to many of the priorities above. We will progress the issues raised by local carers: accessing advocacy, providing information and advice and involving them in service planning.
- We will also help support the health and wellbeing of carers to allow them to continue to provide this crucial care.

## 8. Our Action Plans

Progress against these action plans will form the basis of our performance management arrangements and regular reports will be taken to the IJB.

| 1. Population Health and Wellbeing | | | | |
|---|---|---|---|---|
| | **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 1.1 | Support a defined number of people from the 40% most deprived areas to quit smoking for 12 weeks. | Smoking cessation - non smokers at the 3 month follow up in the 40% most deprived areas | 171 | 5 |
| 1.2 | Meet national targets for cancer screening for breast, bowel and cervical. | % uptake of breast screening<br>% uptake of bowel screening<br>% uptake of cervical screening (age 21-60 years) | 70%<br>60%<br>80% | 1 |
| 1.3 | Work with partners to develop a range of physical activity options to reduce barriers to access and target less active people. | Identify and test programmes for people with mental health problems.<br><br>Plan a physical activity programme for older people as a legacy. | Complete by March 2017.<br><br>Complete by March 2017. | 5 |
| 1.4 | Test a social prescribing model in three practices. | Number of community champions recruited.<br><br>Number of holistic needs assessments carried out.<br><br>Number of people seen at community hub. | 10<br><br>60<br><br>100 | 1 |
| 1.5 | Implement health and homelessness standards, and actions from previous homeless service users' consultation. | Self-evaluation of the Health and Homelessness Action Plan (HHAP) showing evaluation ratings. | 12 very good; 7 good<br>Achieved 14/15 | 5 |
| 1.6 | Increase referrals to financial inclusion and employability services. | Number of financial inclusion workshops delivered.<br><br>Number of attendees | 4<br><br>48 | 5 |

| 1. Population Health and Wellbeing | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| | Number of employability workshops delivered.<br><br>Number of attendees<br><br>Number of Healthier Wealthier Children (HWC) referrals and financial gains.<br><br>HWC financial gains<br><br>Increase uptake of Healthy Start | 4<br><br>48<br><br>400<br><br>£700,000<br><br>Establish local baselines | |
| 1.7 Implement a sexual health policy (with partners) for looked after and accommodated children. | Policy agreed and finalised.<br><br>LAAC staff to be invited to all sexual health training.<br><br>Specific LAAC training package to be offered. | Policy disseminated by June 2016.<br><br>A training calendar will be available to all LAAC workers/carers by June 2016.<br><br>Train 20 LAAC workers around sexual health and wellbeing. | 5 |
| 1.8 Reduce unintended pregnancies for those over 20 years of age. | No. of unintended pregnancies for those over 20 years of age: | 30 | 4 |
| 1.9 Lead the health and wellbeing actions from the Tackling Poverty Report, in particular establishing a school counselling service and a peer mentoring service across all Renfrewshire secondary schools. | Procure and oversee implementation of school counselling service.<br><br>Agree individual models of peer mentoring with all schools.<br><br>Establish target activity levels | April 2016<br><br>May 2016<br><br>June 2016 | 5 |

| 1. Population Health and Wellbeing | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| | for both initiatives. | | |
| 1.10 Raise awareness of mental health issues among the general population. | Understanding Mental Health:<br>– attendees<br><br>Scottish Mental Health first aid training for young people:<br>– sessions<br>– attendees | <br>200<br><br><br><br>4<br>12 | <br><br><br>1 |
| 1.12 Develop and monitor Eat Better Feel Better (EBFB) work. | Number of Renfrewshire EBFB Network meetings.<br><br>Number of EBFB interventions delivered.<br><br>Number of individuals/organisations trained to deliver cookery skills courses. | 2.11 per year<br><br>50<br><br>8 | 1 |

| 2. Child and Maternal Health | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 2.1 Continue to implement Family Nurse Partnership, as we move into year 2. | % full terms and low birth weight infants.<br><br>Breastfeeding at 6 weeks infancy, at all and exclusive<br><br>% clients reporting tobacco use in last 48 hours at 36 weeks gestation | 5%<br><br>10%<br><br>25% | 5 |
| 2.2 Increase uptake of the 30 month check and share information appropriately to maximise readiness for schools. | Percentage of children receiving 30 month check.<br><br>Establish a meaningful baseline and target from referrals to parenting programmes and speech and language therapy. | 85%<br><br>March 2017 | 4 |
| 2.3 Work in partnership to support more women to breastfeed and to focus on women from more deprived areas. | % exclusive breastfeeding in 15% most deprived areas.<br><br>Exclusive breastfeeding at 6-8 weeks. | 20.9% (15/16)<br><br>21.4% (15/16) | 5 |
| 2.4 Develop sustainable services for children who are overweight. | Number of child health weight interventions delivered. | New Mum, New You: 36<br>Mini Active 2-4 : 24<br>Children 5-16: 24 | 1 |
| 2.5 Continue to support a population based model of parenting programmes. | No. of staff trained in Solihull:<br><br>Number of attendees at Triple P seminars (Level 2).<br><br>Number of interventions at levels 3 and 4. | 90%<br><br>140<br><br>200 | 1 |

| 2. Child and Maternal Health | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 2.6 Deliver Autism Spectrum Disorder waiting times target | Referral to assessment time. | 18 weeks | 3 |
| 2.7 Deliver CAMHS referral to treatment waiting times HEAT target. | Referral to treatment time. | 18 weeks | 3 |
| 2.8 Reduce speech and language therapy waiting times in community paediatrics. | Percentage of paediatric Speech & Language Therapy wait times triaged within 8 weeks<br><br>Number waiting more than 18 weeks for paediatric Speech & Language Therapy assessment to appointment | 100%<br><br>0 | 3<br><br>3 |
| 2.9 Implement recommendations from multi-disciplinary Inspection Report | Action Plan developed | May 2016 | 7 |
| 2.10 Reduce conceptions in young people under 20 years old. | Teenage pregnancies (15-19) at conception (crude rate/1000). | 35 | 1 |
| 2.11 Support improvements in sexual health and relationships education in schools and community settings. | Use of sexual health DVD in schools<br><br>Support schools for children with ASN (additional support needs)<br><br>Training for school staff (local and NHS Board) | All 8 non denominational schools to evidence use.<br><br>All ASN schools to receive copies of 'All About Us' DVD and offer of training.<br>Direct training to 100 young people.<br><br>60 staff. | 5 |

| 2. Child and Maternal Health | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| | Awareness sessions/training in school and other settings. | 400 young people reached in school assemblies.<br><br>50 young people in community settings reached.<br><br>Support 2 Freshers' Week events | |
| 2.12 The commencement of health assessments for all children looked after at home and in kinship care. | % of health assessments carried out for all new referrals from April 2016. | 80% of all new referrals will have received a health check by March 2017. | 5 |
| 2.13 Work with partners in schools and Oral Health Directorate to improve child oral health in Renfrewshire. | Dental registration:<br><br>0-2 years:<br>3-5 years:<br><br>Dental decay:<br><br>Primary 1<br>Primary 7 | <br><br>60%<br>86%<br><br><br><br>60%<br>60% | 4 |
| 2.14 To ensure the establishment of a named person service for pre school children residing in Renfrewshire from August 2016.<br><br>To ensure agreed process for receipt of information related to wellbeing concerns by named person. | All pre school children are allocated a named person.<br><br>System is implemented for named person to receive information regarding well being concerns. | 100% of preschool children are allocated a named person.<br><br>August 2016. | 7 |

| 3. Primary Care & Long Term Conditions | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 3.1 Support GPs to implement and improve Anticipatory Care planning across Renfrewshire. | Number of nursing home residents who have an anticipatory care plan | 95% | 3 |
| 3.2 Support Primary Care staff to deliver target number of Alcohol Brief Interventions. | Number of Brief Interventions cumulative by year | 1,116 | 5 |
| 3.3 Address barriers to effective GP contributions to child protection case conferences. | GP reports received on time for Case Protection conferences. | 90% | 7 |
| 3.4 Work with GPs in clusters to pilot improved ways of working with community and social care staff. | Identification of practice clusters and key issues to be taken forward. | 2 practices identified by April 2016.<br><br>6-monthly progress report | 4 |
| 3.5 Develop the use of Practice Activity Reports and other data to support primary care. | Dissemination of PAR reports and production of Exception Report. | 2 per year | 4 |
| 3.6 Establish a single route into web based information about long term conditions. | Number of patients signed up to My Diabetes My Way<br><br>Revised A-Z directory under development | Baseline to be established in Year 1.<br><br>December 2016 | 2 |
| 3.7 Improve pathways between primary and secondary care for those with diabetes. | The implementation of a new referral system for Type 1 and 2 diabetics to the Royal Alexandra Hospital (RAH) diabetes clinic.<br><br>Reduced HbA1c levels for Type 1 diabetics attending RAH<br><br>Number of patients attending Conversation Maps. | June 2016<br><br>Baseline to be established in Year 1.<br><br>Baseline to be established in Year 1. | 4 |

| 3. Primary Care & Long Term Conditions | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 3.8 Support the respiratory early supported discharge initiative. | Number of patients supported. | 32 | 2 |
| 3.9 Implement home health monitoring through the Tec Programme in partnership with East Renfrewshire HSCP. | Number of people receiving home health monitoring. | 350 | 2 |

| 4. Older People | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 4.1 Increase the number of people benefiting from the Community Falls pathway.<br><br>Reduce the number of falls using the Smartcare online tools in with neighbouring Health and Social Care Partnerships and Health Boards. | Number of recorded Level 1 falls screenings completed in Renfrewshire.<br><br>Number of recorded Level 2 multi-factorial falls assessments completed in Renfrewshire.<br><br>Number of people evaluated as part of the Smartcare Project. | 50 screenings per month completed by March 2017<br><br>50 assessments per month completed by March 2017<br><br>60 | 2 |
| 4.2 Evidence the provision of 12 months post diagnostic support for people with dementia. | People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support (female & male) | 100% | 2 |
| 4.3 Support nursing homes through the LES and liaison nurses to prevent inappropriate hospital admissions. | Emergency admissions from care homes | 480 | 2 |
| 4.4 Maintain target levels of lost bed days. | Number of acute bed days lost to delayed discharges (inc AWI) | 8,104 | 2 |
| 4.5 Reduce number of bed days lost due to AWI | Number of acute bed days lost to delayed discharges for Adults with Incapacity. | 1,064 | 2 |
| 4.6 Increase the uptake of flu vaccinations in the over 65 age group. | % uptake of vaccinations in 65+ age group | 78% | 2 |
| 4.7 Promote the uptake of Power of Attorney. | Number of responses to Power of Attorney question within SSA.<br><br>Continue to promote the uptake and use of Power of Attorney across all services within RHSCP to assist with anticipatory care planning and ongoing care management. | 100 responses per month by March 2017.<br><br>15% increase in registration | 3 |

| 5. Learning Disabilities | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 5.1 Deliver agreed number of health checks to clients with learning disabilities. | Number of health checks. | 40 | 4 |
| 5.2 Improve oral health in this population. | Number of oral health checks. | 30 | 4 |
| 5.3 Relaunch Renfrewshire Autism Strategy. | Action plan developed and monitored. | September 2016 | 4 |
| 5.4 Work with the housing and care providers and service users/carers to review the existing service model for adults with learning disabilities and identify options for redesign. | Sufficient supply of housing to meet the needs of the local population, including input to local Housing Strategy. | March 2019 | 2 |

| 6. Physical Disabilities | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 6.1 Develop and implement joint commissioning plan for adults with a physical disability or sensory impairment. | Produce Joint Commissioning Plan | March 2017 | 4 |
| 6.2 Service improvements around rehabilitation services. | Revised Occupational Therapy pathways.<br><br>Reduced waiting times.<br><br><br><br><br>Personal assets approach. | March 2017<br><br><br>Urgent – 3 working days<br>Priority – 5 working days<br>Routine – 9 weeks<br><br>March 2017 | 4 |
| 6.3 Implementation of See Hear Sensory Impairment Strategy | Full implementation and recommendations from the Strategy taken forward. | March 2017 | 4 |
| 6.4 Implementation of Right To Speak Strategy, for the provision of communication equipment for people with physical disabilities and communication impairments. | Local implementation of Strategy recommendations.<br><br>Clear protocols, pathways and criteria established for support and provision of communication equipment | March 2017<br><br><br>March 2017 | 4 |
| 6.5 Implementation of Allied Health Professionals delivery programme | Renfrewshire AHP services are developed and sustained in line with the national objectives. | March 2017 | 4 |
| 6.6 Work with the housing and care providers and service users/carers to review the existing service model for adults with physical disabilities and identify options for redesign. | Sufficient supply of housing to meet the needs of the local population, including input to local Housing Strategy. | March 2019 | 2 |

| 7. Mental Health | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 7.1 Ongoing review of clinical pathways in community mental health to continue to provide access to psychological therapies within the agreed standard. | Percentage of patients who started treatment within 18 weeks of referral to Psychological Therapies | 90% | 3 |
| 7.2 Deliver waiting time targets for primary mental health services, ensuring equality of access for all (age, sex, SIMD). | Percentage of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks<br><br>Percentage of patients referred to first treatment appointment offered within 9 weeks | 100%<br><br>90% | 3 |
| 7.3 Deliver suicide awareness training to front line staff and implement suicide prevention policy for schools, with Children's Services. | Maintain level of 50% of staff trained. | 23 | 7 |
| 7.4 Demonstrate changed practice in mental health inpatient and community to reduce average lengths of stay and the requirement for out of area boarding of patients. | Achieve recommended target for bed occupancy rates for Renfrewshire patients in all acute wards.<br><br>All patients with length of stay over 3 months will receive Multi Disciplinary Team complex care review. | 95% occupancy<br><br>100% | 3 |
| 7.5 Support people in mental health and addictions services to access employment opportunities. | Total referrals:<br><br>Addiction referrals:<br><br>Mental health referrals: | 310<br><br>110<br><br>200 | 5 |
| 7.6 Demonstrate changed practice in inpatient and community services as a result of listening to patient feedback e.g. Charleston Centre upgrade. | Evidence change in practice from patient conversations. | 3 sessions per year | 3 |

| 8. Drugs and Alcohol | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 8.1 Influence the availability of alcohol through partnership working with the Licensing Forum, ADP and local communities. | Number of community representatives influencing licensing decisions.<br><br>Develop Joint Alcohol Policy Statement and organise Launch Event. | 100<br><br>June 2017 | 1 |
| 8.2 Reduce harm caused by misuse of drugs and alcohol. | Alcohol related hospital stays.<br><br>Drug related hospital stays.<br><br>Naloxone units issued.<br><br>Drug related deaths.<br><br>Alcohol related deaths. | 9.0<br><br>1.35<br><br>30% coverage of problem drug users.<br><br>13.0 per 100,000 population<br><br>27.5 per 100,000 population | 7 |
| 8.3 Deliver Alcohol Brief Interventions in primary care and in wider settings. | Number of Brief Interventions<br>(primary care)<br>(older people) | 1,116<br>40 staff trained<br>Establish baseline | 7 |
| 8.4 Maintain standard of access to services to ensure it continues to meet national waiting times targets. | % seen within 3 weeks | 91.5% | 3 |
| 8.5 Evidence user involvement in the development and monitoring of services. | Completion of client satisfaction surveys within all drug and alcohol services:<br><br>Renfrewshire Drug Service<br>Integrated Alcohol Team<br>Alcohol Problems Clinic | <br><br>60<br>30<br>80 | 3 |

| 8. Drugs and Alcohol | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| | Evidence of service change | One example from each service implemented as part of You Said – We Did. | |
| 8.6 Continue to monitor the use of the STAR Outcomes tool across drug and alcohol services. | Maintain % of individuals showing positive change across key dimensions:<br><br>Drug use<br>Alcohol use<br>Emotional health<br>Use of time | <br><br>40%<br>40%<br>40%<br>40% | 4 |
| 8.7 Implement Quality Principles in core drug and alcohol services. | Number of services that have implemented/evidenced Quality Principles | 6 | 4 |

| 9. Carers | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 9.1 Prepare for implementation of the new Carers' Act. | Action plan completed. | May 2016 | 6 |
| 9.2 Involve carers, local carer organisations, and other Third Sector organisations, as appropriate in the planning and shaping of services and support. | Evidence of involvement. | March 2017 | 6 |
| 9.3 Support carers to continue in their caring role | % from annual survey | 87% | 6 |
| 9.4 Support carers to access training opportunities relevant to their caring role | Number of carers accessing training programmes. | 230 | 6 |
| 9.5 Increase the uptake of Carers' Assessments, | Number of self-assessments issued to carers. | 150 | 6 |
| 9.6 Support young adult carers in the transition from young carer to young adult carer | Pathway established. | March 2017 | 6 |

| 10. Cross-cutting All Care Groups | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 10.1 Maintain or improve the number of registered services assessed as 'Good' or above by the Care Inspectorate | % of registered services assessed as Good, Very Good or Excellent | All registered services | 4 |
| 10.2 Implement new guidance in relation to adult protection procedures. | Guidance produced and operational.<br><br>% of MHOs trained | March 2017<br><br>100% | 7 |
| 10.3 Continue to deliver services which support a shift in the balance of care towards community-based services. | % of service users with high needs (>£10k per annum) support at home.<br><br>Move the balance of spend from residential/nursing to Care at Home | Baseline and target to be established<br><br>Baseline and target to be established | 2 |
| 10.4 Improve transition planning for service users moving between services or care groups. | Integrated pathways for transition developed for all areas of service. | March 2017 | 3 |
| 10.5 Develop joint strategic commissioning plans for main care groups. | Plans produced. | December 2017 | 9 |
| 10.6 Embed self-directed support model in locality teams. | Locality managers assume day to day management responsibility for budget monitoring and care planning for service users eligible for SDS. | June 2016 | 8 |
| 10.7 Implement a scheduling system within Care at Home services. | System operational. | March 17 | 9 |

| 11. Effective Organisation | | | |
|---|---|---|---|
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 11.1 Develop a Workforce Plan linked to the strategic priorities of the HSCP and the parent organisations. | Implementation of Workforce Plan. | March 2017 | 8 |
| 11.2 Implement new team structures to support increased workloads in relation to adult support and protection. | Teams established and operational. | December 2016 | 7 |

| 12. Hosted Services | | | |
|---|---|---|---|
| **Primary Care Support** | | | |
| **Action** | **Indicator** | **16/17 Target** | **National Outcome** |
| 12.1 Support practices into new contracting arrangements for April 2016 onwards, testing new ways of working in Inverclyde and learning from 17c practices. | Ongoing with indicator under development. | Under development. | 8 |
| 12.2 Develop the role of practice nurses to support emerging priorities of shifting the balance of care and supporting people to live longer in their own home. | Ongoing with indicator under development. | Under development. | 8 |
| 12.3 Improve resilience planning, identifying and working with practices which need support. | Ongoing with indicator under development. | Under development. | 8 |
| **Podiatry** | | | |
| 12.4 Improved access to podiatry services for new patients. | % of new referrals appointed within 4 weeks. | 90% | 3 |
| 12.5 Priority diabetic patients with active foot disease seen urgently. | % of diabetic active foot disease seen by member of Multi Disciplinary Team within 48 hours. | 95% | 4 |

# 1. Case Studies

## What this plan means for Alice...

Alice is 78 and lives alone. Her son visits as often as he can and phones every day but he lives a few hundred miles away. She's starting to have some mobility problems and sometimes forgets things. Today she fell and broke her wrist, which means she can't manage by herself at home just now. The hospital doctor wants to admit her overnight and her son thinks the fall means she will have to move into a residential home.

With close partnership working, health and social care services are able to offer an alternative pathway which will allow Alice to recover from her injury and continue to live at home, safely, with the appropriate support to meet her needs:

- After hospital treatment and monitoring, hospital staff contact Rehabilitation and Enablement Services (RES) to get Alice home and settled for the night.
- Care at home reablement services are in place the following day. This service supports Alice with personal care and mobility, and reminds her to take her medication.
- Alice is referred to the falls management team and her GP is notified of these details. The GP refers Alice to the Memory Clinic.
- After 6 weeks of reablement, Alice's wrist has healed and she is more confident when using the stairs. Handrails have been fitted in her bathroom and she has a community alarm.

On an ongoing basis, Alice is transferred to the long-term care at home service, to support her with her medication. She is also referred to Food Train, which means that she will be able to get a weekly shop delivered to her home and she has the reassurance of knowing a volunteer will call in twice a week.

The improvement in her mobility and confidence encourages her to start going out again and her confidence is increasing. She also attends a local day centre 1 day a week. Her home has been adapted to be more suitable to her needs.

All the people who need to know about Alice's case can share information, so Alice doesn't have to keep answering the same questions. Additionally, health and social care staff have access to a directory of community groups which might interest Alice and get her out and about in her community again.

## What this plan means for Becky...

Becky is a young woman who has an enduring mental health condition and is currently an in-patient in Dykebar Hospital. Nursing staff at Dykebar have supported Becky to manage her mental health condition and occupational therapy staff have supported her in community involvement. The occupational therapy staff have also supported Becky in maintaining a structured and productive weekly schedule, and social work staff are considering an application for supported accommodation.

Becky has a say in what is in her care plan and what we can provide to meet her needs.

Partnership working between health and social care services will provide:

- Services that are focused on early intervention so that Becky can get support before things reach crisis point.
- Advice, support and services to help Becky live as independently and safely as possible
- Access to tools to help Becky manage her own condition.
- A multi disciplinary team with shared information about the case so that different types of support can join up.

Our services, and our partners, will work together to keep you safe from harm and you will have a say in what's in your care plan. Our services will talk to each other so that you don't have to repeat the same information to different people and so that your journey through our services or between services is as simple as possible.

In Becky's case a peer support worker is working with her on a WRAP (Wellness Recovery Action Plan) and the physiotherapist is encouraging her to increase her physical activity.

The NetWork Service is supporting her with her vocational goals: poetry writing, making art and has facilitated her to make a film about her mental health recovery.

The service can provide support to help Becky into employment and can offer ongoing practical and emotional support to enable her to achieve and maintain work goals and aspirations.

## What this plan means for Malcolm...

Malcolm is 55 years old and lives alone in a flat on the 3rd floor. He has a long term health condition, chronic obstructive pulmonary disease (COPD), which has made him housebound as he has difficulty climbing stairs. Malcolm's brother, Andy, supports him as much as he can but he works full time and is sometimes away on business trips. Andy sometimes struggles to find time to help Malcolm with his personal care and finds it difficult to concentrate at work as he is concerned about Malcolm.

Malcolm has had multiple admissions due to COPD and chest infections and was recently admitted to hospital for the 10th time this year. Hospital staff have decided to change his medication and have sent out an electronic discharge letter to the chemist who changes his medication and delivers it to his home. A letter has also been sent to his GP informing him of Malcolm's latest admission into hospital and the decisions made to change his medication.

His GP visits Malcolm in his home to see how is getting on with the new medication. However Malcolm's living conditions raised other concerns that could be impacting his health, the GP referred him to social work services as a vulnerable person. Malcolm's GP was also concerned that he was at risk of being socially isolated. A social worker was able to go out and visit Malcolm to assess his living conditions and arranged more suitable accommodation. After Malcolm settled in to his new home, he was referred to the reablement team where he was assessed for walking aids and respiratory care at home. Home care has now been put in place to help with meals and some self care and Malcolm is able to get involved in some community activities.

Close working between primary and secondary health care and social care has meant that Malcolm's health is better managed now and he is able to live safely in the community with appropriate support that meet his needs. Malcolm has also been given access to tools, such as Telehealth monitoring, to help him manage his own condition and to help him live as independently as possible.

Good communication between hospital staff, Malcolm's GP and chemist means that he will get the right medication and support from the right people.

Andy's caring responsibilities have also been recognised by Malcolm's GP and he has been referred to the Carers Centre to help him get support and advice so that he can continue in his informal caring role without causing too much strain on his own life.

## What this plan means for Jack...

Jack is two and a half years old and lives with both of his parents. Jack enjoys going out shopping with his grandmother and playing in the park. Jack's Health Visitor has had concerns about developmental delays since he was a few months old and has been working closely with the PANDA Unit. The Panda unit is a specialist community paediatric facility, which focuses on children with additional support needs. All referrals are screened by an on call duty clinician and a decision is made about the most appropriate service(s) for the patient.

Jack was called for his 30 month assessment which is offered to all children in Renfrewshire. A health visitor carried out a developmental assessment and concluded that Jack would benefit from nursery placement as it will provide him with the opportunity to develop his play skills, increase his confidence and independence skills and prepare him for school. The recommendations from the assessment have been sent to Jack's parents, the GP and relevant professionals in social work and speech and language therapist.

There is ongoing social work involvement with Jack and his parents and Jack's development will continue to be assessed. The PANDA unit has worked closely with social work to provide Jack's parents with a list of nurseries and they have provided advice and support to apply for a grant to enable them to buy appropriate toys for Jack.

Jack's general health appears to be good and he attends all required health appointments. However concerns that his social and emotional health needs are not being met due to his isolation and limited contact with children his own age will be monitored and appropriate services will be involved to best meet Jack's needs.

Children's health services work closely with education to provide the best support that meets the child's needs and will work closely with social work services to provide support for the parents.

Parents of children with additional support needs are supported with housing issues, DLA, grant applications. The PANDA unit can also make referrals to the Renfrewshire carers centre for additional support for the parents.

By working closely with children's services the Partnership is able to support parents and carers of children with additional support needs and plan for the transition from children's services to adult services.

## 2. Developing Integrated Arrangements in Renfrewshire

The Public Bodies (Joint Working) (Scotland) Act 2014 set out the arrangements and terms for the integration of health and social care. The Health and Social Care Partnership in Renfrewshire is responsible for delivering adult social care and health services and children's health services. The partnership is led by the Chief Officer, David Leese. The Integration Authority is the Integration Joint Board (IJB) and is chaired in Renfrewshire by Councillor Iain McMillan.

### Integration Joint Board (IJB)

The 2014 Act sets out how the IJB must operate, including the makeup of its membership.

The IJB has two different categories of members; voting and non-voting. In Renfrewshire, the IJB has agreed that there will also be additional non-voting members to those required by law.

Current IJB members (March 2016) are noted below.

| **Voting Membership** | |
|---|---|
| Four voting members appointed by the Council | Cllr Iain McMillan<br>Cllr Derek Bibby<br>Cllr Jacqueline Henry<br>Cllr Michael Holmes |
| Four voting members appointed by the Health Board | Donny Lyons<br>John Brown<br>Donald Syme<br>Morag Brown |
| **Non-voting Membership** | |
| Chief Officer | David Leese |
| Chief Finance Officer | Sarah Lavers |
| Chief Social Work Officer | Peter Macleod |
| Registered Nurse | Karen Jarvis |
| Registered Medical Practitioner (GP) | Stephen McLaughlin |
| Registered Medical Practitioner (non GP) | Alex Thom |
| Council staff member involved in service provision | Liz Snodgrass |
| Health Board staff member involved in service provision | David Wylie |
| Third sector representative | Alan McNiven |
| Service user residing in Renfrewshire | Stephen Cruikshank |
| Unpaid carer residing in Renfrewshire | Helen McAleer |
| **Additional Non-voting Membership** | |
| Trade union representative - Council staff | John Boylan |
| Trade union representative - Health Board staff | Graham Capstick |

Integrating health and social care services supports the national 2020 vision:

"by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

- We have integrated health and social care

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

The 2014 Act sets out nine high level outcomes that every Health and Social Care Partnership, working with local people and communities, should deliver:

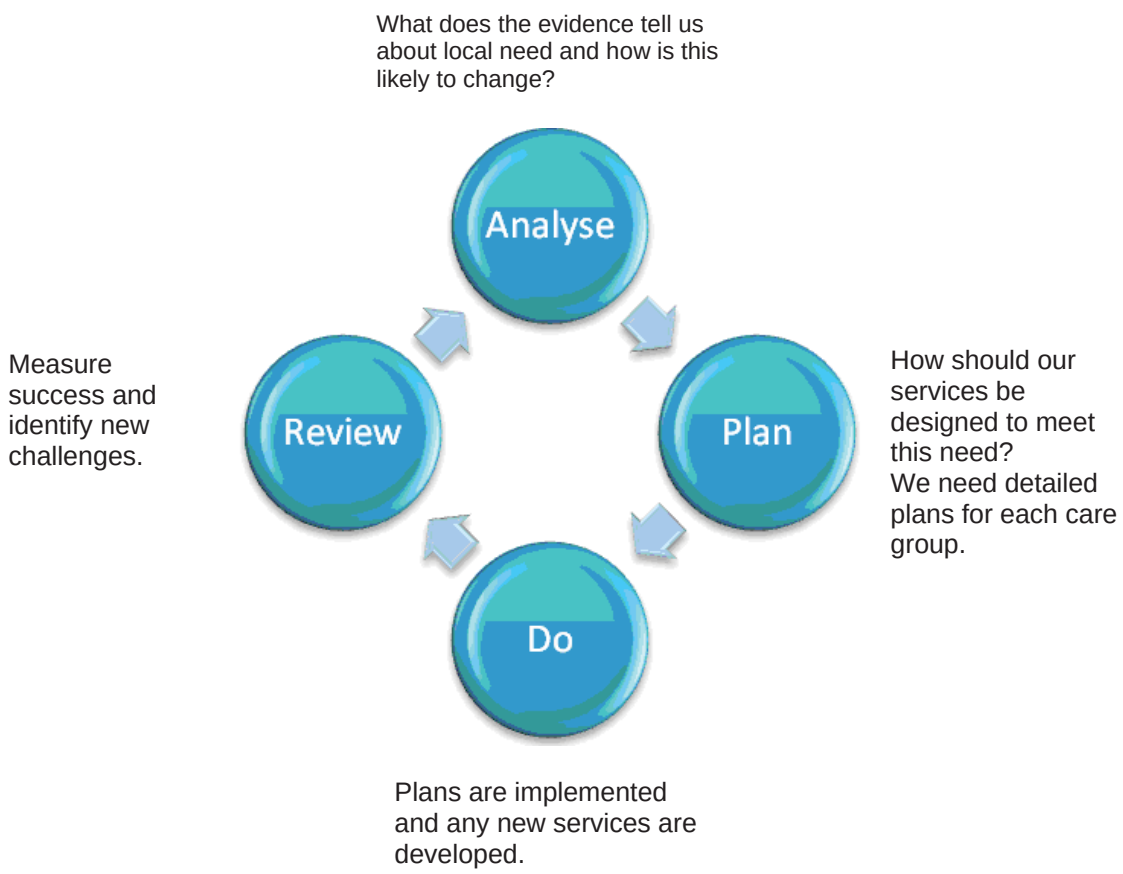
| | |
|---|---|
| **Outcome 1:** | People are able to look after and improve their own health and wellbeing and live in good health for longer |
| **Outcome 2:** | People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community |
| **Outcome 3:** | People who use health and social care services have positive experiences of those services, and have their dignity respected |
| **Outcome 4:** | Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services |
| **Outcome 5:** | Health and social care services contribute to reducing health inequalities |
| **Outcome 6:** | People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing |
| **Outcome 7:** | People using health and social care services are safe from harm |
| **Outcome 8:** | People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide |
| **Outcome 9:** | Resources are used effectively and efficiently in the provision of health and social care services |

Renfrewshire Health and Social Care Partnership's performance will at least be measured against these nine outcomes. Our performance framework will describe the indicators to be used to assess our performance against each outcome.

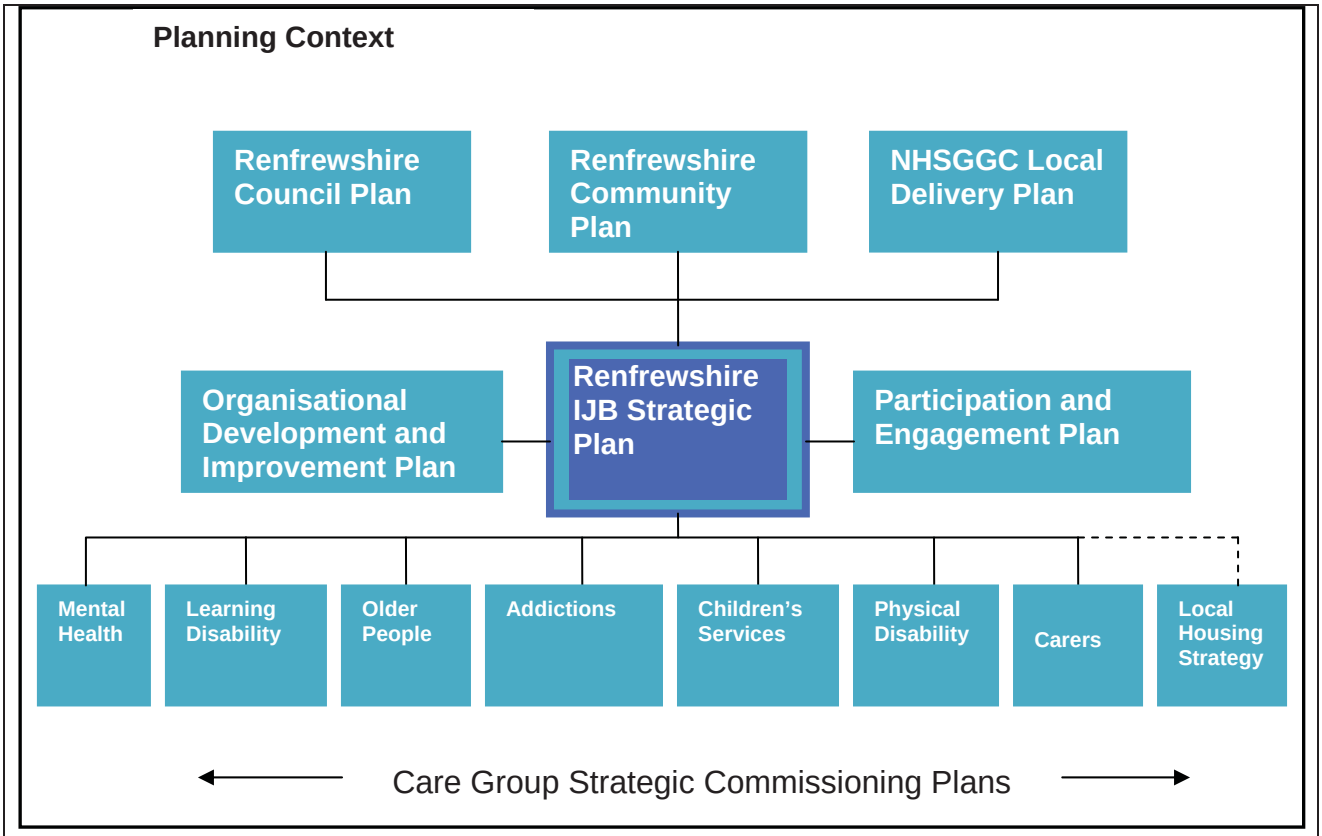
| | |
|---|---|
| | The diagram below lists the legal and policy drivers which direct and influence the Health and Social Care Partnership. |
| | **Legal and Policy Drivers**<br><br>There are key pieces of legislation governing health and social care. These include the ***Social Work (Scotland) Act 1968***, the ***National Health Service (Scotland) Act 1978*** and the ***Children (Scotland) Act 1995.*** These, along with other pieces of legislation and policy, set out the duties of councils and health boards in relation to people's health and wellbeing.<br><br>Legislation to assist individuals who have lost capacity to allow them to plan ahead and to support them to receive treatment and protection is a key driver of our work. This legislation includes:<br>– **Adults with Incapacity (Scotland) Act 2000**<br>– **Mental Health (Care and Treatment) (Scotland) Act 2003**<br>– **The Adult Support and Protection (Scotland) Act 2007**<br><br>Implementation of the ***Social Care (Self-directed Support) Act 2013*** will affect the delivery of services for people with assessed social care needs as it embeds over time. Where there is an assessed need, individuals can now have an allocated personal budget, which they can choose to take as a direct payment (cash) or to buy services and supports. The option to use local authority services is still available. It is expected that change will be gradual but it is clear that the preference of individual service users will impact on the demands for service providers.<br><br>***The Carers (Scotland) Bill*** was introduced to Parliament in March 2015. It covers a range of areas relating to supporting carers, such as Adult Carer Support Plans, Young Carers Statements and Carer Involvement. The Bill proposes a number of new duties and requirements, including a duty to support carers, the requirement to prepare a local Carers' Strategy and to involve carers in this.<br><br>***The Community Empowerment (Scotland) Act 2015*** received royal assent in July 2015. It aims to empower communities through ownership of land and buildings and by strengthening the community's voice in local decisions. It also supports a quickening of Public Sector Reform by focusing on achieving outcomes and improving the community planning process. This Plan is strongly linked to the Renfrewshire Community Plan so we will be mindful of any changes in this area going forward. |

This Strategic Plan and the associated care group plans which are being developed use a strategic commissioning approach. Strategic commissioning has four main stages – analyse, plan, do and review. This is a cycle and which means that the work we do and the lessons we learn at each stage feed into the next. It also means that we review the Strategic Plan and associated care group plans regularly to make sure that progress is being made and identify whether there have been any changes that might mean changes are required in the next cycle.

**Strategic Commissioning**




Our Strategic Plan is part of the wider planning frameworks of Renfrewshire Council, the NHS Board and local Community Planning partners. The table overleaf shows other plans which link to the Strategic Plan.




The 2014 Act requires that the NHS Board and the Council include a number of functions and services in the Partnership. As a minimum, health and social work services for people aged over 18 must be included. In Renfrewshire, children's health services are also included in the Partnership, recognising the important links with Specialist Board-wide Children's Services and the family based approach which General Practice uses. Children's Social Work Services are managed within the newly formed Children's Services Directorate in Renfrewshire Council. Interface arrangements between the HSCP and this Directorate have been established to ensure that the two organisations work together to improve outcomes for children. Below is a list of functions which will be delegated to the Partnership (some are already integrated):

| Renfrewshire Council services that are to be included | Greater Glasgow & Clyde Health Board services that are to be included |
|---|---|
| • Social work services for adults and older people<br>• Mental health services<br>• Services for adults with physical disabilities and learning disabilities<br>• Care at home services and care homes<br>• Drug and alcohol services<br>• Adult protection<br>• Domestic abuse | • District nursing services<br>• Substance misuse services<br>• Services provided by allied health professionals in an outpatient department, clinic or out with a hospital<br>• The public dental service<br>• Primary medical services (including GPs and other general practice services)<br>• General dental services<br>• Ophthalmic services |

- Carers' support services
- Community care assessment teams
- Support services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services and respite provision
- Local area co-ordination
- Occupational therapy services
- Re-ablement services, equipment and telecare
- Sensory impairment services
- Gardening assistance
- Pharmaceutical services
- Out of hours primary medical services
- Community older people's services
- Community palliative care services
- Community learning disability services
- Community mental health services
- Community continence services
- Services provided by health professionals that aim to promote public health
- School Nursing and Health Visitor Services
- Child and Adolescent Community Mental Health Services
- Specialist Children's Services
- Mental Health inpatient services
- Planning and health improvement services

The 2014 Act identifies a set of hospital-based services that the IJB can shape and influence. The Partnership will not manage these services directly but will be able to shape how unplanned care is designed to support independent living and must seek to do this by working with other Partnerships across NHS Greater Glasgow and Clyde. Arrangements for how this budget will be set and how Partnerships will work together are still being formed.

**Hospital-based services that are included**

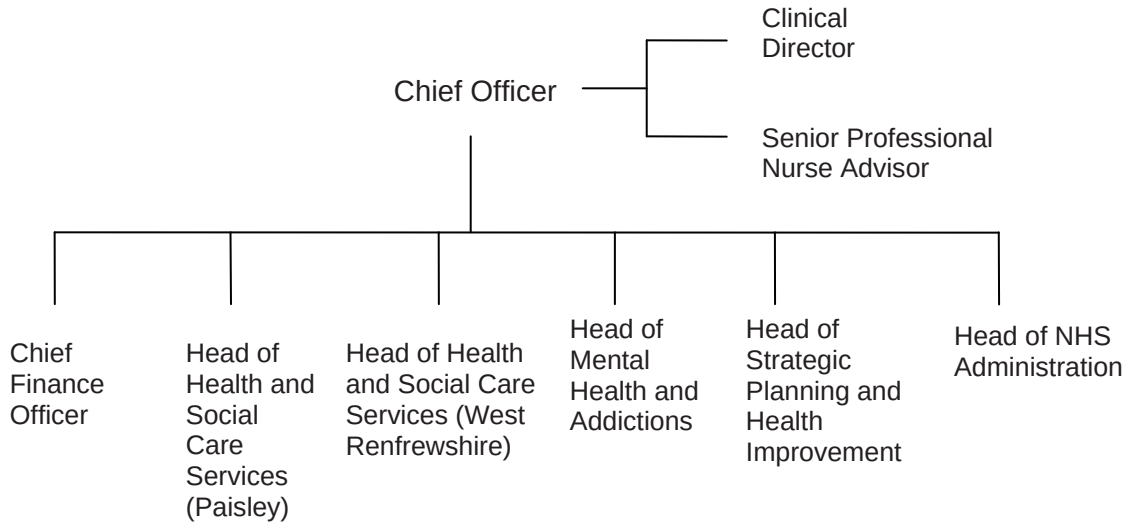
- Accident and Emergency services provided in a hospital
- Inpatient hospital services relating to the following-
  (a) general medicine
  (b) geriatric medicine
  (c) rehabilitation medicine
  (d) respiratory medicine
  (e) psychiatry of learning disability.
- Palliative care services provided in a hospital
- Services provided in a hospital in relation to an addiction or dependence on any substance

There are six Partnerships within the NHS Greater Glasgow and Clyde Board area. In some cases, a single Partnership will manage or 'host' a certain service on behalf of the whole area, with the other Partnerships having access to these to meet local outcomes. These arrangements have been in place for some time and continue to be appropriate in the new integrated environment. Where services are hosted by other Partnerships, the HSCP will be active in interface arrangements and will regularly review services.

| The Renfrewshire Partnership will continue to host: |
|---|
| • Podiatry Services<br>• Primary Care Contractual support (medical and optical)<br>• Strategic Planning for out of hours GP services |

| Other GG&C Partnerships will host: | |
|---|---|
| Glasgow | • Continence services outwith hospital<br>• Enhanced healthcare to Nursing Homes<br>• Sexual Health Services (Sandyford)<br>• Specialist drug and alcohol services & system- wide planning and co-ordination<br>• Specialist mental health services & mental health system- wide planning and co-ordination<br>• Custody and prison healthcare |
| West Dunbartonshire | • Musculoskeletal Physiotherapy<br>• Specialist children's services |
| East Dunbartonshire | • Oral Health- public dental services and primary dental care contractual support |
| East Renfrewshire | • Specialist learning disability services & learning disability system-wide planning and co-ordination |

The Chief Officer and Senior Leadership Group will lead the organisation. The management structure is shown in the diagram below:



| | |
|---|---|
| | The IJB is required to establish a local Strategic Planning Group (SPG), which is intended to be the main group representing local stakeholder interests in relation to the Strategic Plan. The role of the SPG is to act as the voice of local stakeholders and oversee the development, implementation and review of the Partnership's strategic plans. The SPG is responsible for reviewing and informing draft work produced by the Partnership in relation to strategic plans and for ensuring that the interests of their stakeholder groups are considered. |
| | The SPG will play a key role in ensuring that the work produced by the Partnership is firmly based on robust evidence and good public involvement and will strengthen the voice of stakeholders in local communities. The current membership of the SPG is shown in the diagram overleaf. |

## Membership of Strategic Planning Group

| Membership | Nominees |
|---|---|
| Chief Officer | David Leese |
| Nomination(s) by Renfrewshire Council | Anne McMillan, Corporate Planning<br>Ian Beattie, Head of Adult Services<br>Lesley Muirhead, Development and Housing |
| Nomination(s) by NHS Greater Glasgow and Clyde | Fiona MacKay, Head of Planning & Health Improvement<br>Mandy Ferguson, Operational Head of Service<br>Katrina Phillips, Operational Head of Service<br>Jacqui McGeough, Head of Acute Planning (Clyde) |
| Health Professionals (doctors, dentists, optometrists, pharmacists, nurses, AHPs) | Chris Johnstone, Associate CD<br>John Carmont, District Nurse<br>Rob Gray/Sinead McAree, Mental Health Consultant<br>Susan Love, Pharmacist<br>Caroline Horn, Physiotherapist<br>Lynda Mutter, Health Visitor |
| Social Care Professionals (social worker or provider) | Jenni Hemphill, Mental Health Officer<br>Anne Riddell, Older People's Services<br>Aileen Wilson, Occupational Therapist<br>Jan Barclay, Care at Home |
| Third Sector bodies carrying out activities related to Health and Social Care | Stephen McLellan, Recovery Across Mental Health |
| Carer of user of social care<br><br>Carer of user of health care | Diane Goodman, Carers' Centre<br>Maureen Caldwell<br>John McAleer, Learning Disabilities Carers' Forum |
| User of social care | Debbie Jones, Public Member |
| User of health care | Betty Adam, Public Member |
| Non commercial provider of healthcare | Karen Palmer, Accord Hospice |
| Commercial provider of social care | Linsey Gallacher, Richmond Fellowship |
| Commercial provider of healthcare | Robert Telfer, Scottish Care |
| Non-commercial provider of social care | Susan McDonald, Active Communities |
| Non-commercial provider of social housing | Elaine Darling, Margaret Blackwood Association |
| Chief Finance Officer | Sarah Lavers |
| Renfrewshire HSCP Comms | Catherine O'Halloran |
| Health TU Rep | Claire Craig |
| SW TU Rep | Eileen McCafferty |

In the first year of operation, the Strategic Planning Group has been drawn from recognised representative bodies and existing networks. In future years, a more inclusive process to establish membership will be considered – particularly to gain representation from service users and carers.

# Glossary

## ADP - Alcohol and Drugs Partnership

Renfrewshire Alcohol & Drugs Partnership has responsibility for addressing drug and alcohol issues in Renfrewshire. This means that various agencies come together and work in partnership on issues related to alcohol and drugs.

## AHP – Allied Health Professionals

Allied Health Professionals (AHPs) support people of all ages in their recovery, helping them to regain movement or mobility, overcome visual problems, improve nutritional status, develop communication abilities and restore confidence in everyday living skills. They work as key members of multi-disciplinary, multi-agency teams, bringing their rehabilitation focus and specialist expertise to the wider skills pool.

## Aids and Adaptations

Aids and adaptations can help older and disabled people to live independently in their own homes. They can reduce the risk of falls and other accidents in the home and also reduce the need for home care or long term admission to a care home. A wide variety of aids and equipment is available to help with daily living tasks ranging from simple adapted cutlery, to Telecare alarms, specialist seating and beds. Common examples of adaptations include replacing a bath with a level access shower, or making it easier to get in and out of the home by widening doors or constructing a ramp.

## Anticipatory Care

Anticipatory Care can take many forms however it is expected to help reduce avoidable and unscheduled acute admissions for people with pre-existing conditions. The purpose of advanced/anticipatory care planning is to support the individual to have greater choice, and control of care preferences through communication across the support team, across agencies and across care settings.

## ASN - Additional Support Needs

The Education (Additional Support for Learning) (Scotland) Act 2004, places duties on local authorities and other agencies to provide additional support where needed to enable any child or young person to benefit from education.

## Body Corporate Model

The Body Corporate Model is a model of integration where a Health Board and Local Authority both delegate the responsibility for planning and resourcing service provision for health and social care services to an Integration Joint Board, established as a separate entity. This is the model used in Renfrewshire.

## Carer

A carer is someone who provides unpaid care and support to a family member, partner, relative or friend, of any age, who could not manage without this help. This could be due to age, illness, disability, long term condition, a physical or mental health problem or addiction.

## Chief Officer

Where the body corporate model is adopted, a Chief Officer will be appointed to provide a single point of management for the integrated budget and integrated service delivery. They are accountable to the Integration Joint Board and to the Chief Executives of their Health Board and Local Authority for the delivery of integrated services.

## Choice and control

Choice and control is about shaping services to meet people's needs, rather than allocating people to fit around services.

## Community Capacity Building

Community capacity building aims to develop the capacity of local communities and increase community resilience. By supporting local people and organisations to develop their skills and focus on community activities, this approach aims to empower local residents and groups to address key issues within their community and reduce health and social care demand.

## Community Planning Partnership (CPP)

The Community Planning Partnership allows a variety of public agencies to work together with the community to plan and deliver better public services which make a real difference to people's lives and to the community. The key Renfrewshire Community Planning partners are Renfrewshire Council, Police Scotland, Scottish Fire and Rescue, NHS Greater Glasgow and Clyde, Engage Renfrewshire, Renfrewshire Chamber of Commerce, University of the West of Scotland, and West College Scotland.

## COPD – Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have difficulties breathing, primarily due to the narrowing of their airways. This is called airflow obstruction.

## Co-Production

Co-production is about combining our mutual strengths and capacities so that we can work with one another on an equal basis to achieve positive change.

## Data Zones

Datazones are groups of 2001 Census output areas and have, on average, populations of between 500 and 1,000 household residents. They nest within Local Authority boundaries and where possible, they have been constructed to respect physical boundaries and natural communities. As far as possible, they have a regular shape and contain households with similar social characteristics.

## Demographics

The characteristics of a human population, especially with regard to such factors as numbers, growth, and distribution, often used in defining consumer markets.

## Delayed Discharges

Delayed Discharges occur when a patient ready for discharge cannot leave hospital because the necessary care, support or accommodation is not available.

## Delegation

Delegation is the process used to integrate functions, by giving responsibility for health and social care functions to a single body.

## DLA – Disability Living Allowance

Disability Living Allowance (DLA) is a tax-free benefit for disabled people who need help with mobility or care cost.

## GIRFEC – Getting It Right For Every Child

Getting It Right For Every Child (GIRFEC) is the nation approach to improving the wellbeing of children and young people in Scotland. The approach puts the best interests of the child at the heart of decision-making; takes a holistic approach to the wellbeing of the child; works with children, young people and families on ways to improve wellbeing; advocates preventative work and early intervention to support children young people and their families; believe professionals must work together in the best interests of the child.

## Health Inequalities

Health Inequalities is the gap which exists between the health of different population groups such as the affluent compared to poorer communities or people with different ethnic backgrounds.

## Health and Social Care Partnership

The Renfrewshire Health and Social Care Partnership is now responsible for delivering adult services in our community. The integration of health and social care means that for the first time these services are managed and developed together.

## HEAT Targets

The HEAT performance management system sets out the targets and measures against which NHS Boards are publicly monitored and evaluated. HEAT is an acronym for Health Improvement, Efficiency and Governance, Access and Treatment. These are the four areas being targeted.

## Independent Living

Independent Living means having the same freedom, choice, dignity and control as other citizens at home, at work and in the community. It does not necessarily mean living by yourself or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life.

## Independent Sector

The Independent Sector encompasses individuals, employers, and organisations who contribute to needs assessment, design, planning, commissioning and delivery of a broad spectrum of social care services, which are wholly or partially independent of the public sector. The independent social care sector in Scotland includes care homes, care at home, housing support and day care services. The sector encompasses those traditionally referred to as the 'private' sector and the 'voluntary' sectors of care provision. It includes organisations of varying types and sizes, amongst them single providers, small and medium sized groups, national providers and not-for-profit voluntary organisations, associations and charities.

## Integration

Integration is the combination of processes, methods and tools that facilitate integrated care.

## Integrated Care

Integrated Care focuses on improving services in relation to access, quality, user satisfaction and efficiency. The aim is to enable better coordinated, joined-up and more continuous care, resulting in improved patient experience whilst achieving greater efficiency and value from health and social care delivery systems.

## Integrated Resource Framework

The Integrated Resource Framework (IRF) for Health and Social Care is a framework within which Health Boards and Local Authorities can better understand the patterns of care they provide, particularly to their shared populations of people and service users.

## Integration Authority

An Integration Authority is the body that is responsible for planning integrated care. It will decide which integrated services will be provided, how they will be funded and what they should look like. It can (and in many cases must) direct the Health Board and Local Authority to deliver those services.
The body that acts as the Integration Authority for a particular area will be determined by reference to the model of integration used in that area.

## Integration Functions

The services that Integration Authorities will be responsible for planning are described in the Act as integration functions. The legislation sets out which NHS and social care services must, may and cannot be delegated as part of the integration arrangements.

## Integration Joint Board

Where the body corporate model is adopted (as is the case in Renfrewshire) the NHS Board and Local Authority will create an Integration Joint Board made up of representatives from the Council, Health Boards, the Third and Independent Sectors and those who use health and social care services. The Integration Joint Board, through its Chief Officer, will have the responsibility for the planning, resourcing and the operational oversight of integrated services within the strategic plan.

## Integration Scheme

An Integration Scheme is the agreement made between the Health Board and the Local Authority. It sets out the make-up of the Integration Authority and how it will work. The Health Board and the Local Authorities submitted their draft Integration Scheme to Scottish Ministers for approval on 1 April 2015. Integration Schemes must be reviewed by the NHS Board and Local Authority at least every five years.

## Intermediate Care

Intermediate Care services support people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community and residential settings. The term has been defined as a "range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living". (NSF for Older People, DOH, June 2002).

## KPIs - Key Performance Indicators

The local government measure their performance and make this information available to the public so that they can assess how they are doing in providing those services which matter most to the public. They report a mix of local and national performance indicators which cover all of the core service areas. A suite of national indicators are collected from all Scottish councils and are reported by the Improvement Service. Reports on local indicators that are specific to Renfrewshire Council and their partners are also produced.

## Lead Agency Model

The Lead Agency Model is a model of integration where the Health Board or the Local Authority takes the lead responsibility for planning, resourcing and delivering integrated adult health and social care services.

## Locality Planning

Locality Planning is intended to keep the focus of integration on improving care in local communities. It will draw on the knowledge and experience of users of services, carers, staff and the third and independent sectors and provide the route for leadership by local clinicians and professionals from across health and social care – and, particularly, GPs – in planning service provision. Every Local Authority must define at least two localities within its boundaries for the purpose of locality planning.

## LTC - Long Term Conditions

Long Term Conditions (LTC) are conditions that last a year or longer, impact on many aspects of a person’s life, and may require ongoing care and support. The definition does not relate to any one condition, care group or age category, so it covers adults and older people as well as children and mental as well as physical health issues. Common long term conditions include epilepsy, diabetes, some mental health problems, heart disease, chronic pain, arthritis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease (COPD).

## LAAC – Looked After and Accommodated Children

Under the provisions of the Children (Scotland) Act 1995, Looked After Children are defined as those in the care of their Local Authority. The vast majority of looked after children have become 'looked after' for care and protection reasons. They may be looked after at home, or away from home (accommodated).

## Market Facilitation

Market Facilitation is a key aspect of the strategic commissioning cycle: Integration Authorities will undertake a range of activities to promote the successful development of services to meet the needs of the local population effectively. These activities should include the development of an accurate picture of local need and markets, published as a Market Facilitation Plan.

## MDT - Multi Disciplinary Team

A Multidisciplinary Team is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

## Multi-Morbidity

Multi-morbidity is used to describe when a person has two or more chronic medical conditions at the one time.

## National Care Standards

The National Care Standards have been published by Scottish Ministers to help people understand what to expect from a wide range of care services. They are in place to ensure that people get the right quality of care when they need it most.

## National Health and Wellbeing Outcomes

The nine national health and wellbeing outcomes provide a national framework for measuring the effect of integrated health and social care services on the health and wellbeing of individuals.

## Nursing Care Home

Nursing care homes provide residents the personal care benefits of a residential care home with the addition of a qualified nurse that is on duty 24 hours a day to carry out nursing tasks.

## Palliative Care

Palliative care aims to provide suitable care and support for people with a terminal illness. The main goal of palliative care is to achieve the best possible quality of life for the patient and their families.

## PAR – Practice Activity Reports

A comprehensive document produced annually that shows how an individual GP practice compares to neighbouring practices and national averages. Examples of areas where data are provided include lab usage, emergency admission rates, referral rates, Accident & Emergency attendances and screening uptake rates.

## Parent Organisations

The parent organisations are the main bodies in charge of the Partnership. In the case of Renfrewshire Health and Social Care Partnership, the parent organisations are NHS Greater Glasgow and Clyde and Renfrewshire Council.

## Personalisation

Personalisation means starting with the individual as a person with strengths and preferences who may have a network of support and resources, which may include family and friends. Personalisation reinforces the idea that the individual is best placed to know what they need and how those needs can be best met. It means that people can be responsible for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so.

## Person-centred

Person-centred is an approach to working with people which respects and values the uniqueness of the individual and puts the individual's needs and aspirations firmly at the centre of the process.

## Planning and Delivery Principles

The principles that underpin the making of arrangements for integration, and the strategic planning of integrated services, will inform how services are planned and delivered. They explain what people using services and their carers can expect from integrated services and the behaviours and priorities expected of organisations and people planning and delivering care and support.

## Quality Ambitions

The three Quality Ambitions of person-centred, safe and effective provide the focus for all our activity to support our aim of delivering the best quality healthcare to the people of Scotland and through this making NHS Scotland a world leader in healthcare quality. They explicitly reflect the things people have told us they want and need.

## Quality Strategy

The Healthcare Quality Strategy for Scotland is the approach and shared focus for all work to realise the 2020 Vision. It aims to deliver the highest quality healthcare to the people of Scotland to ensure that the NHS, Local Authorities and the Third Sector work together, and with patients, carers and the public, towards a shared goal of world-leading healthcare.

## Reablement

Reablement is about giving people the opportunity and the confidence to relearn/regain some of the skills they may have lost as a result of poor health, disability/impairment or entry into hospital or residential care. As well as regaining skill, reablement supports service users to gain new skills to help them maintain their independence.

## RES – Rehabilitation and Enablement Services

A rehabilitation service that is able to address physical, mental health and social needs to enable people to be able to cared for at home. RES includes both health and social care professionals, split into a number of sub-teams who work together to ensure that the correct clinician is involved with the patient at the time of need. They will formulate a patient-centred care plan which is shared within the service and across relevant agencies to allow multiple professionals if necessary to be involved in the care plan.

## Self-Directed Support

Self-directed Support (SDS) is the new form of social care where the service user can arrange some or all of their own support. This is instead of receiving services directly from local authority social work or equivalent. SDS allows people more flexibility, choice and control over their own care so that they can live more independent lives with the right support.

## Self-Management

Self-management encourages people with health and social care needs to stay well, learn about their condition and their care and support needs, and remain in control of their own health.

## Sheltered Housing

Sheltered housing is specifically designed to comfortably meet the needs of people who are aged 60 years or over. These properties are easy to maintain and offer tenants the safety of living in a secure environment, while also enabling people to retain their independent lifestyle. Sheltered properties have a communal lounge where social activities take place.

## SmartCare Project

SmartCare is a new programme that aims to improve the health, care and wellbeing of older people at risk of a fall across Ayrshire & Arran, Lanarkshire and Renfrewshire/East Renfrewshire.
SmartCare is working in partnership with service users, carers, third sector organisations and service providers to design and develop a range of digital tools to support falls management and prevention. This will help to improve the communication and co-ordination of a person's care.

## SSA – Single Shared Assessment

A Single Shared Assessment allows health and social care practitioners to share information in order to plan an individuals' care plan so that it is co-ordinated and avoids unnecessary duplication.

## Staff Partnership

Staff Partnership (NHS) describes the process of engaging staff and their representatives at all levels in the early stages of the decision-making process. This enables improved and informed decision making, through achieving and maintaining a positive and stable employee relations culture and gaining commitment, ownership and consensus to decisions through joint problem solving. The emphasis is therefore placed on working collaboratively at all levels and becoming an exemplary employer, both to the benefit of staff but also to the benefit of patient care.

## Statutory Services

Statutory services are public services that are required to be delivered by law. These services are supported by government legislation.

## Strategic Commissioning

Strategic Commissioning is a way to describe all the activities involved in:
• assessing and forecasting needs
• links investment to agreed desired outcomes
• planning the nature, range and quality of future services; and
• working in partnership to put these in place Strategic Needs Assessment

Strategic Needs Assessments (SNA) analyse the health and care needs of populations to inform and guide commissioning of health, wellbeing and social care services within Local Authority areas. The main goal of a SNA is to accurately assess the health and care needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities. The SNA will underpin Strategic Plans.

## Strategic Planning Group

The Strategic Planning Group (SPG) is the main group representing stakeholder interests in relation to the Strategic Plans produced by the Integration Joint Board. The group consists of representatives from the public sector, private sector, third sector and the public. The role of the Group will be to oversee the development, implementation and reviews of the strategic plans.

## Supported Accommodation

Supported accomodation provides individuals with support and housing options that are suited to their needs and helps them to maintain a tenancy in the community. Supported accomodation options are available for people with physical disabilities, learnig disabilities and older people with support provided based on the client’s needs to help them maintain their lifestyle and independence.

## Supported Living

Supported Living is an alternative to residential care or living with family members that enables adults with disabilities to live in their own home, with the help they need to be independent. It allows people to choose where they want to live, who they want to live with and how they want to be supported.

## TEC – Technology Enabled Care Programme

A major Scottish Government Programme designed to significantly increase choice and control in health, wellbeing and care services, and extend the number of people directly benefiting from TEC and support in Scotland.

## Telehealth Monitoring

Telehealth or Home Health Monitoring is a way of delivering medical care at home for people with long term conditions such as Heart Failure and COPD (Chronic Obstructive Pulmonary Disease). It consists of using an electronic tablet or your own mobile phone to answer simple questions about how a patient feels. Nurses can read details and if readings are outwith normal limits, it will send an alert to the nurse who will contact the patient to discuss how better to manage conditions.

## Third Sector

'Third Sector organisations' is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives. It also includes local intermediary organisations (Third Sector 61 Interfaces), and third sector strategic intermediaries, for example Voluntary Action Scotland (who represent Scotland's 32 Third Sector Interfaces) and the Health and Social Care Alliance Scotland.

Engage Renfrewshire is our local Third Sector Interface.

## Transformational Leadership

As opposed to the management of the delivery of services, Transformational Leadership relates to the ability to inspire, motivate and engage. These qualities are seen as being particularly important for times when organisations are being challenged by significant external changes. As opposed to the management of the delivery of services, Transformational Leadership relates to the ability to inspire, motivate and engage. These qualities are seen as being particularly important for times when organisations are being challenged by significant external changes.