CORRESPONDENCE FROM THE SCOTTISH GOVERNMENT TO THE PUBLIC AUDIT COMMITTEE, DATED 19 DECEMBER 2014

Please see a copy of the letter that was sent to NHS Board Chairs and CoSLA on 19 December 2014 regarding NHSScotland Local Delivery Plans and Strategic Commissioning Plans Guidance for the new integrated partnerships for health and social care.

SHONA ROBISON

CABINET SECRETARY FOR HEALTH, WELLBEING AND SPORT, THE SCOTTISH GOVERNMENT TO NHS BOARD CHAIRS AND COSLA, DATED 19 DECEMBER 2014.

The Scottish Government is integrating health and social care services to ensure that people get the right care in the right place at the right time and today the Scottish Government issued the Local Delivery Planning guidance for the NHS in Scotland and the Strategic Commissioning Plans Guidance for the new integrated partnerships for health and social care.

Planning for the NHS and integrated partnerships needs to be mutually supportive if we are to successfully address key challenges such as improving preventative and anticipatory care, reducing demand on acute hospitals, improving flow within hospitals, and tackling delayed discharge.

The Scottish Government has reaffirmed its commitment to our 2020 vision for health and social care. We will refresh our strategy for achieving the 2020 vision to ensure that it reflects the changing needs and expectations of the people of Scotland, and the new way services will be delivered under health and social care integration. I look forward to engaging with you on this in the New Year.

SHONA ROBISON

NHSScotland 2015-16
Local Delivery Plan Guidance

Contents Page

Contacts

Queries about the Local Delivery Plan Process should be directed to:

Robert Williams

0131 244 3568

Robert.williams@scotland.gsi.gov.uk

Queries relating to financial plans should be directed to:

Robert Peterson

0131 244 3569

Robert.peterson@scotland.gsi.gov.uk

Queries relating to workforce should be directed to

Kerry Chalmers

0131 244 3434

Heather.love@scotland.gsi.gov.uk

1. Local Delivery Plan 2015-16

1.1 Increasing healthy life expectancy purpose target

The Scottish Government has a key purpose target to increase healthy life expectancy. Increasing healthy life expectancy will mean that people live longer in good health, increasing their capacity for productive activity and reducing the burden of ill health and long term conditions on people, their families and communities, public services and the economy generally.

1.2 2020 Vision

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

- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self-management
- Where hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- 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

1.3 New approach to health and social care planning

During 2015/16 as we transition towards integrated health and social care, the Local Delivery Plan will continue to be the contract between Scottish Government and NHS Boards. Separate guidance is being produced for Integrated Joint Boards on their strategic commissioning plans and these two sets of guidance should be read together. More on this is set out below.

Last year's LDP saw an increased focus on delivering outcomes for the people of Scotland, and this year will build on that. The Scottish Government has reaffirmed its commitment to the 2020 vision and will refresh the strategy for achieving its 2020 vision for health and social care to ensure that it reflects the changing needs and expectations of the people of Scotland and the new way services will be delivered under health and social care integration. NHS Board Chairs and Chief Executives are fully engaged in designing the refresh of the strategy, and reviewing the national, regional and local planning arrangements. Wider public and service engagement will take place in the new year on the refreshed strategy and delivery arrangements.

The LDP will be updated next year to reflect the refreshed strategy. This year's LDP builds on last year and requires NHS Boards to develop plans focused on new actions planned in a small number of strategic priority areas -

prevention and health inequalities, antenatal and early years, person centredness, safety, primary care and integration.

The LDP has to be considered alongside the new strategic commissioning planning arrangements for Integrated Joint Boards. The LDP will be mutually supportive of the Integration Schemes that will establish local integrated health and social care arrangements, the strategic commissioning plans that the new integrated partnerships will develop, the statutory outcomes for health and wellbeing, and the indicators that underpin the outcomes. **The LDP should include an 'at a glance' mapping of key local plans for health and social care.** The new integration indicators are being developed in partnership and include person centred experience measures including views on how well people were supported to live as independently as possible and the extent to which health and care services seemed to be well co-ordinated. They also include system measures including delayed discharge and emergency bed day rates.

In order to ensure high quality, continuously improving health and social care in Scotland it is important that we strike the right balance between improvement, performance management and scrutiny. In light of maturing quality improvement activity in Scotland, and many HEAT targets being successfully delivered this year, the Scottish Government has reviewed both the Improvement Priorities for Scotland in 2015/16 and the suite of Hospital Efficiency and Access Targets (HEAT) targets and standards. The intention is to provide a focused set of priorities and standards to sustain improvement and performance and provide transparency in key areas.

In using this guidance, Health Boards and their partners in local government must take account of the effect of their plans on the outcomes for health and wellbeing set out in legislation as part of integration of health and social care, and on the indicators that underpin them. These outcomes apply to Health Boards, Local Authorities and Integration Authorities; once established during 2015/16, Integration Authorities will lead on their delivery, with the support of Health Boards and Local Authorities.

Progress against the improvement priorities, LDP standards and the integration indicators will together inform progress being made on health and social care.

Special Health Boards are expected to develop their LDPs so that they support territorial Health Boards and Integrated Joint Boards deliver the improved outcomes for the people of Scotland.

2. Improvement Priorities

2.1 Six Strategic Priorities

NHS Scotland is recognised as a global leader in the application of improvement science to improve outcomes for people. As outlined above, Local Delivery Plans should focus on improvement activity around six key strategic priorities:

NHS Scotland Improvement Priorities 2015/16

- **Health Inequalities and Prevention**
- **Antenatal and Early Years**
- **Person-centred care**
- **Safe care**
- **Primary Care**
- **Integration**

2.2 Health Inequalities and Prevention

The Scottish Government is committed to enabling those more at risk of health inequalities to make better choices and positive steps toward better health and wellbeing. Four areas have been identified for specific NHS action:

- NHS procurement policies should support employment and income for people and communities with fewer economic levers;
- actions relating to employment policies that support people to gain employment or ensure fair terms and conditions for all staff;
- actions to support staff to support the most vulnerable people and communities have been identified as specific areas for NHS action; and
- health improvement actions to promote healthy living and should include, preventing obesity, promoting a healthy diet, tobacco related health inequalities, uptake of smoking amongst young people, protecting children from second-hand smoke, supporting smokers to quit, targeting alcohol brief interventions on harder to reach communities including those in deprived areas, access to alcohol and drug misuse, and promoting physical activity. This activity should be focussed through workforce and the Health Promoting, Health Service as well as the wider community.

The LDP should set out local priorities for addressing health inequalities and improving prevention work based on the needs of the local population. Plans should focus on those communities where deprivation is greatest. The plan should outline how these will be achieved setting out improvement aims, levels of activity, and demonstrating how the activity is embedded in to routine practice. The plan will also include

information about how the NHS Board and its partners prioritise action and monitor progress.

2.3 Antenatal and Early Years

It has long been recognised that there are significant benefits to children's wellbeing - not least their health - as well as to the vibrancy of communities and the sustainability of services from a systematic approach to early intervention and primary prevention. The focus on primary prevention and early intervention has also increased the importance of antenatal and early years support. Early antenatal access will help ensure a foundation for the future health of the baby and mother, and health boards should continue improving antenatal access to strengthen that foundation. Early years care will be substantially affected by the new duties to be placed on health boards through the Children and Young People (Scotland) Act 2014. Specifically, under the Act, health boards will be responsible for providing a Named Person service for every child up to 5 and a single statutory Child's Plan for every under-5 who requires one. **The LDP should set out the local actions to be taken to ensure that the relevant parts of the workforce will have the capacity, training and relevant protocols to carry out these duties under the Act by 1 August 2016.**

2.4 Person centred care

In person-centred care, health and social care professionals work collaboratively with people who use services. Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care. It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion and respect. The NHS in Scotland is committed to developing a culture of openness and transparency in NHS Scotland that actively welcomes feedback as a tool for continuous improvement**. The LDP should set out how services will support a positive care experience delivered in accordance with the "five must do's with me". It should also outline the key local action being taken to transform the culture to support staff and the public to be open and confident in giving and receiving feedback; widely publicise the information people need to give feedback and make complaints, and the support available for them to do so; and with a focus on learning from feedback, implementing the changes, and telling people what improvements were made as a result of their feedback. The plan will include information on how progress will be measured locally.**

2.5 Safe care

NHS Boards have made significant progress in providing safe care within their hospitals. Along with a range of Hospital Associated Infection (HAI) improvement activity, the Scottish Patient Safety (SPS) Programme continues to drive improvement in clinical care and has been extended beyond the acute programme into primary care, maternity, neonates and paediatrics and mental

health services. **The LDP should set out the priority actions the NHS Board is taking across these programmes of work, the plans for spread and sustainability and the impact they are having on patient care and should include an example from each SPS programme of how safety of care has improved in the last 12 months. This should include plans to ensure that governance and leadership across managerial and clinical staff is in place for each programme and that robust data collection methods are in place to demonstrate improvement. Boards will work towards implementing the recommendations set out in the Vale of Leven Inquiry Report.**

2.6 Primary Care

Successful primary care is integral to the 2020 vision and integrated health and social care. The overwhelming majority of healthcare interactions are at primary care level, both in-hours and out-of-hours. In the context of an aging population with more people living with two or more long term conditions the number of interactions will increase as they are supported to manage their own conditions and live at home. Last year NHS Boards developed strategic assessments of primary care. These identified four key themes: leadership & workforce, planning & interfaces, technology & data, contracts & resources. **The LDP should set out the prioritised local actions that are being pursued to increase capacity in primary care and the resources identified to achieve this. The plan should also identify where national action would help local delivery.**

2.7 Integration

The Scottish Government has set out nine national health and wellbeing outcomes in secondary legislation supporting the Public Bodies (Joint Working) (Scotland) Act 2014. In the planning and delivery of health and social care services, the new integrated partnerships for health and social care are aiming to ensure successful delivery of these outcomes. A suite of integration indicators, to underpin the national health and wellbeing outcomes has also been developed to demonstrate progress. Integrated partnerships will be required to report on the national health and wellbeing outcomes and the underpinning indicators annually. Quality and safety for people who use our services must remain at the forefront during 2015-16 while the system transitions towards integration.

It is through the strategic commissioning process that the national health and well-being outcomes will be delivered and the required shift in the balance of care achieved. Integrated partnerships will be responsible for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway, alongside primary and community health care and social care. The role of clinicians and care professionals, along with the full involvement of the third and independent sectors, service users and carers, will be embedded as a mandatory feature of the commissioning and planning process through the clinical and care governance framework now agreed, and through locality

arrangements. Integrated partnerships will be required to establish a strategic planning group to prepare the strategic plan - this group will include representation of these key stakeholders.

The LDP should set out the key local actions that are being pursued to ensure effective involvement of clinical and care professionals in the strategic planning group. The LDP should also set out the redesign priorities emerging for the integrated care pathways delivered in the community.

3. LDP Standards

Through the Local Delivery Planning approach, the NHS in Scotland has transformed unscheduled, elective and cancer waiting times; and we now see healthcare associated infections among the lowest on record delivered within the planned financial resources. The delivery of unscheduled and elective waiting times focussed on redesign of elective pathways and strengthening capacity both of which are fundamental to the delivery of quality services. Local improvement science capacity has been transformed over the last 10 years - since the introduction of HEAT - including the use of local stretch aims to drive improvement.

The LDP Standards are intended to provide assurance on sustaining delivery which will only be achieved by evolving services in line with the 2020 vision. As part of the LDP process, NHS Boards produce their own local capacity plans showing how they will deliver elective and unscheduled waiting time guarantees and standards. We expect the vast majority of elective patients to be treated locally or within NHSScotland facilities such as the Golden Jubilee or Stracathro. NHS Boards also develop Local Unscheduled Care Action Plans which in their third year will include a focus on site specific management; and unscheduled and elective capacity planning.

The Scottish Government has an established set of performance management principles to promote a culture in which targets and standards are delivered within the spirit they were intended, recognising that clinical decision making is more important than absolute delivery of targets and standards.

The A&E 4 hour standard follows clinical advice to sustain at least 95% of A&E patients being treated within four hours, as a step towards achieving 98%, which is among the toughest A&E standard anywhere in the world.

NHS Boards are expected to improve the 12 week outpatient waiting times performance during 2015/16 to achieve a 95% standard with a stretch aim to 100%, which applies to all source first outpatient referrals – not just those from GPs. Each and every NHS Board is expected to achieve the 12 week outpatient standard and the LDP should include a delivery trajectory. Long waits for outpatient appointments are unacceptable and NHS Boards must also eradicate waits over 16 weeks which is the longstop. This standard is intended to support clinicians ensure that urgent referrals continue to be prioritised and help NHS Boards to reduce costs associated with managing short-term disruptions to capacity and demand. The improvement work to transform outpatient services will support NHS Boards.

NHS Boards should deliver the 12 weeks outpatient standard in line with the 18 weeks RTT which remains in place with its 10% tolerance. As part of the RTT pathway, it is important that the 8 key diagnostic tests remain as short as possible - long waits are unacceptable. NHS Boards' local capacity plans must include diagnostics. NHS Boards will need to ensure that they are

compliant with the 12 weeks legal TTG. This package of elective waiting times standards is among the most comprehensive anywhere in the world. The Scottish Government will continue to closely monitor elective waiting times across Scotland.

The Scottish Government expect that NHS Boards will improve SAB infection rates during 2015/16 - close monitoring of SAB will continue. Research is underway to develop a new SAB standard for inclusion in LDP next year.

The Scottish Government will continue to review the LDP Standards to ensure that their definitions are consistent with changes in service delivery through the 2020 vision.

NHS LDP Standards

People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase)
31 days from decision to treat (95%)
62 days from urgent referral with suspicion of cancer (95%)
Early diagnosis and treatment improves outcomes.

People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support
Enable people to understand and adjust to a diagnosis, connect better and plan for future care

12 weeks Treatment Time Guarantee (TTG 100%)
18 weeks Referral to Treatment (RTT 90%)
12 weeks for first outpatient appointment (95% with stretch 100%)
Shorter waits can lead to earlier diagnosis and better outcomes for many patients as well as reducing unnecessary worry and uncertainty for patients and their relatives.

At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation
Antenatal access supports improvements in breast feeding rates and other important health behaviours.

Eligible patients commence IVF treatment within 12 months (90%)
Shorter waiting times across Scotland will lead to improved outcomes for patients.

18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)
Early action is more likely to result in full recovery and improve wider social development outcomes.

18 weeks referral to treatment for Psychological Therapies (90%)
Timely access to healthcare is a key measure of quality and that applies equally to mental health services.

Clostridium difficile infections per 1000 occupied bed days (0.32)
SAB infections per 1000 acute occupied bed days (0.24)
NHS Boards area expected to improve SAB infection rates during 2015/16. Research is underway to develop a new SAB standard for inclusion in LDP for 2016/17.

Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)
Services for people are recovery focused, good quality and can be accessed when and where they are needed.

Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings
Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas
Enabling people at risk of health inequalities to make better choices and positive steps toward better health.

48 hour access or advance booking to an appropriate member of the GP team (90%)
Often a patient's first contact with the NHS is through their GP practice. It is vital, therefore, that every member of the public has fast and convenient access to their local primary medical services to ensure better outcomes and experiences for patients.

Sickness absence (4%)
A refreshed Promoting Attendance Partnership Information Network Policy will be published in 2015.

4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
High correlation between emergency departments with 4 hour wait performance between 95 and 98% and elimination of long waits in A&E which result in poorer outcomes for patients

Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement
Sound financial planning and management are fundamental to effective delivery of services.

4. Financial planning

It is recognised that there are specific cost pressures that will need to be managed within the context of Boards' achieving financial balance in 2015/16. The Draft Budget 2015/16 sets out NHS Board allocations. Final NHS Board allocations will be agreed through the Scottish Budget. Financial planning is an integral component of LDPs. **To ensure that Boards plan over the longer term, financial plans are generally required for a three year period. However, a five year plan is required where any of the following apply: major infrastructure development, brokerage arrangements are in place, underlying deficit of over 1% of baseline resource funding or major service redesign**. In terms of capital, a five year plan is required from all Boards. Boards are notified individually regarding the period of their financial plan. NHS Boards must include draft financial plans as part of their LDP submission, in line with the timetable presented. In particular, NHS Boards are asked to complete the financial templates and provide a supporting narrative. Particular emphasis should be placed on workforce planning and NHS Boards should provide assurances that their proposed workforce requirements are driven by and reflect service change and are affordable. The detailed financial information included in the templates will be used to assess each Board's financial projections, including key risks/assumptions, to ensure achievement of financial targets. Financial templates will also include plans for efficiency savings. All savings are retained locally by territorial Boards to reinvest in front-line services which directly benefit patients.

5. Workforce

Everyone Matters:2020 Workforce Vision Implementation Plan 2015-16 builds on the actions from 2014-15. Boards are required to provide information on 2 key workforce areas in the LDP this year.

NHS Boards should provide a short outline of their local implementation plans for 2015-16 to deliver the 5 priorities in the Everyone Matters: 2020 Workforce Vision Implementation Plan 2015-16. The 5 priorities are: Healthy Organisational Culture, Sustainable Workforce, Capable Workforce, Integrated Workforce and Effective Leadership and Management.

NHS Boards should indicate any workforce areas where there is a risk to delivering service. Specifically Boards are asked to make clear reference to:

- the use of Nursing and Midwifery Workload and Workforce Planning tools; recruitment issues, vacancy rates or concerns – professions or groups of professions affected, services affected – steps being taken or national approach required;
- areas in which services are being developed which may have specific implications for the NHS workforce, or for individual professions as appropriate, and steps taken to manage these locally e.g. Health

Visitors, School Nurses, Advance Nurse Practitioners, Health Care Support Workers;
- demographic information i.e. age of workforce impacting on service delivery, local pressures, staff numbers, other workforce factors influencing the sustainability or otherwise of services;
- how workforce factors are being dealt with as part of action being taken to address services which are under stress e.g. A&E, Oncology, Radiology.

NHS Boards will continue to be required to publish their wider workforce plan during 2015 and further guidance on the timings and process for submitting these, and workforce projections to the Scottish Government, will follow in due course. NHS Boards are reminded that the application of the Nursing and Midwifery Workload and Workforce Planning Tools are mandatory and should be used and documented in the development of Workforce Plans and workforce projections.

6. Community Planning Partnership Contribution

The Community Empowerment (Scotland) Bill, introduced to Parliament in June 2014, strengthens community planning by: giving Community Planning Partnerships (CPPs) a statutory footing; explicitly stating public bodies, including NHS Boards, will work together with communities to improve outcomes for a local area; and placing new duties on a CPP and public sector partners to resource and improve local priority outcomes. The Bill will be enacted during 2015, subject to Parliamentary approval. But NHS Boards and partners should anticipate its provisions, both through their own contribution to community planning, and by monitoring and if necessary testing the contributions of other partners as part of effective performance management within the CPP. In light of the integration of health and social care (see above), NHS Boards will of course also need to work in partnership with the new Integration Authorities to ensure correlation between plans and consistency across the planning landscape.

In this LDP we are asking NHS Boards to indicate how they will continue to strengthen their approach to community planning during 2015/16, through both their direct contributions and how they demonstrate leadership within the CPP. This should focus on how the CPPs act to improve local priority outcomes which relate to health and wellbeing, and how they shift activity and spend towards tackling inequalities, prevention and community empowerment. The Scottish Government will discuss progress against these commitments with NHS Boards.

7. LDP Submission

Final LDPs should be submitted on 20 March 2015.

The Scottish Government
Riaghaltas na h-Alba

Health and Social Care Integration

Public Bodies (Joint Working) (Scotland) Act 2014

Strategic Commissioning Plans Guidance

WHO SHOULD READ THIS GUIDANCE?

This guidance is for everyone involved in commissioning health and social care services.

The requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 ("the Act"), which puts in place the framework for integrating health and social care, mean that people working in the statutory bodies, i.e., Health Boards, Local Authorities and Integration Joint Boards (IJBs), will have a specific interest.

It is important to note, nonetheless, that the Act places a duty on Integration Authorities – either Integration Joint Boards, or Health Boards and Local Authorities in a lead agency arrangement – to involve a range of service providers, service users and their carers, representative bodies, and professionals in the commissioning process.

This guidance, and the advice notes that accompany it with practical advice on a range of subjects, will therefore be of interest and relevance to a wide range of organisations and individuals.

WHAT OTHER GUIDANCE IS RELEVANT?

This guidance should be read alongside the Scottish Government's guidance on a range of matters relating to integration[1], and the guidance on Local Delivery Planning for Health Boards.

HOW IS THIS GUIDANCE LAID OUT?

This guidance covers the following topics:

1. Introduction
2. Background
3. Wider context
4. What does strategic commissioning look like, and who is involved?
5. When should strategic commissioning start?
6. What should a good strategic commissioning plan look like?
7. Setting objectives, measuring outcomes and reporting on performance

Annex A: Detailed requirements
Annex B: Draft indicators

[1] http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance

1 INTRODUCTION

'Let me be clear about the objectives of this programme of reform. We want to ensure that adult health and social care services are firmly integrated around the needs of individuals, their carers and other family members; that the providers of those services are held to account jointly and effectively for improved delivery; that services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve rather than the needs of the organisations through which they are delivered; and that those arrangements are characterised by strong and consistent clinical and professional leadership…

There is now a consensus around the contention that separate and—all too often—disjointed systems of health and social care can no longer adequately meet the needs and expectations of the increasing number of people who are living longer into old age, often with multiple, complex, long-term conditions and who, as a result, need joined-up, integrated services.'

Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary for Health and Wellbeing, December 2011

1.1. The Scottish Government is integrating health and social care services to ensure that people get the right care, in the right place, at the right time. Historically, there has been a divide between "health" and "social care" services. Increasing numbers of people do not experience neatly segregated "health" and "social care" needs, so our systems to support them need to evolve to reflect complexity of needs and multimorbidity in the population.

1.2. The Act places a duty on Integration Authorities – either Integration Joint Boards or Health Boards and Local Authorities acting as lead agencies – to create a "strategic plan" for the integrated functions and budgets that they control.

1.3. The strategic plan is the output of what is more commonly referred to as the "strategic commissioning" process. Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place[2]. Within this guidance, where we refer to the strategic commissioning plan, we are referring to the strategic plan described in the Act.

1.4. The importance of effective strategic commissioning for the success of integrated health and social care provision cannot be over-stated. It is the mechanism via which the new integrated partnerships will deliver better care and support for people, and make better use of the significant resources we invest in health and social care provision.

1.5. Integration – and therefore strategic commissioning – needs to deliver better outcomes, particularly for people with multimorbidities and in terms of improving preventative and anticipatory care, with less inappropriate use of institutional care and better support in communities. Its impact will be measured against the statutory national outcomes for health and wellbeing and the indicators that underpin them.

[2] Joint Strategic Commissioning – A Definition: Strategic Commissioning Steering Group, June 2012

1.6. These are high aims. Achieving them will require partnership working – between statutory agencies and professionals and also, vitally, with the third and independent sectors, localities and communities – on a scale that we have not achieved before. This guidance sets out how strategic commissioning needs to operate in order for integration to deliver on its potential to improve people's lives.

> ' . . . effective services must be designed with and for people and communities – not delivered 'top down' for administrative convenience'
>
> **The Christie Commission Report**
> Commission on the future delivery of public services, June 2011

2 BACKGROUND

'Public service providers must be required to work much more closely in partnership, to integrate service provision and thus improve the outcomes they achieve. We must prioritise expenditure on public services which prevent negative outcomes from arising. And our whole system of public services – public, third and private sectors – must become more efficient by reducing duplication and sharing services wherever possible. Experience tells us that all institutions and structures resist change, especially radical change. However, the scale of the challenges ahead is such that a comprehensive public service reform process must now be initiated, involving all stakeholders."

The Christie Commission Report
Commission on the future delivery of public services, June 2011

'Strategic commissioning is the fulcrum around which the future planning and aspirations of the local partnerships to meet the outcomes of the local populace will be set. Thorough analysis of joint strategic needs can identify population need, meaning services can be reshaped to meet needs more closely now and in the future. That gives services, in partnership with service providers, the space to innovate and inspire and to more effectively target resources at prevention.'

Peter Macleod, Director of Social Work at Renfrewshire Council

2.1 The Act places a duty on Integration Authorities to develop a "strategic plan"[3] for integrated functions and budgets under their control.

2.2 Each Integration Authority must produce a strategic commissioning plan that sets out how they will plan and deliver services for their area over the medium term, using the integrated budgets under their control. Stakeholders must be fully engaged in the preparation, publication and review of the strategic commissioning plan, in order to establish a meaningful co-productive approach, to enable Integration Authorities to deliver the national outcomes for health and wellbeing, and achieve the core aims of integration:

- To improve the quality and consistency of services for patients, carers, service users and their families;
- To provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

2.3 By developing strategic commissioning plans for all adult care groups, Integration Authorities will design and commission services in new ways in collaboration with their partners. Strategic commissioning plans should incorporate

[3] NB that this is referred to in the Act and related subordinate legislation as a "strategic plan", as explained in paragraph 1.3 above.

the important role of informal, community capacity building and asset based approaches, to deliver more effective preventative and anticipatory interventions, in order to optimise wellbeing and the potential to reduce unnecessary demand at the 'front door' of the formal health and social care system.

2.4 Services cannot continue to be planned and delivered in the same way; the current situation is neither desirable in terms of optimising wellbeing, nor financially viable. With the full involvement of all stakeholders, and the creation of a single system for strategic commissioning of services, Integration Authorities can now think innovatively about how support services might be provided in the future.

2.5 The focus should be less about how it is done now and more about how it should be done in future. This might mean, through a robust option appraisal process, that the Integration Authority makes decisions about disinvesting in current provision of services in order to reinvest in other services and supports that are required to meet on-going and changing demand.

2.6 Regulations supporting the Act set out the services that must be included in integrated arrangements, and therefore the scope of strategic commissioning in local areas. Broadly, strategic commissioning will cover, at least, adult primary and community health care and social care, and those aspects of adult hospital care that are most commonly associated with the emergency care pathway[4].

'If we believe that Health and Social Care Partnerships will be unable to meet all resource claims placed upon them, then strategic commissioning is crucial for ensuring that needs are met efficiently and equitably.

'The development of robust processes will be required in order to defend the shift in resources implied by reshaping the balance of care. Partnerships are well placed to do this but it can only happen in any significant way with sound strategic commissioning.'

Professor Cam Donaldson, Yunus Chair in Social Business & Health, Glasgow Caledonian University

[4] http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/HSCFuncNote

3 WIDER CONTEXT

'Strategic commissioning is about challenging historical spending patterns in light of what we know about population need. While that will be different for each partnership because of varying populations of need locally, it is likely that all partnerships will have to deal with the two major trends of our time – our ageing population and an increase in co-morbidity.

'These changes to our population require a different type of health and social care system, one that is modelled on supporting people to live independently in the community. Therefore the real added value of strategic commissioning will be in our ability to shift resources from the old model to the new model. It is not a panacea, but it is a crucial element of reform.

'To optimise the effectiveness of strategic commissioning, we now need to redistribute power from the centre to partnerships and localities.'

Ron Culley, Chief Officer, Health & Wellbeing at CoSLA

3.1 The Commission on the Future of Public Services, 'the Christie Commission'[5], identified, as a priority, "maximising scarce resources by utilising all available resources from the public, private and third sector, individuals, groups and communities", while adding "implementing better long-term strategic planning, including greater transparency around major budget decisions like universal entitlements".

3.2 The Scottish Government response to the Christie Commission[6] set out four pillars of public service reform that should be kept in mind when developing plans for public services:

- A decisive shift towards prevention;
- Greater integration of public services at a local level driven by better partnerships, collaboration and effective local delivery;
- Greater investment in the people who deliver services through enhanced workforce development and effective leadership; and
- A sharp focus on improving performance through greater transparency, innovation and use of digital technology.

3.3 In 2012, Audit Scotland[7] reviewed how effectively the public sector commissions social care services, examining how well Local Authorities and their partners plan, and either procure or deliver, effective social care services. The report contained a number of key messages and recommendations. In summary, the key messages were:

- Councils and their NHS partners need to do much more to improve how social care services are planned, procured and delivered, through better engagement with users and providers and better analysis and use of information.

[5] The Commission on the Future of Public Services, 'the Christie Commission' June 2011
[6] Renewing Scotland's Public Services, November 2011
[7] Commissioning Social Care, Audit Scotland, February 2012

- People who need small amounts of support are not being offered the preventative services that might help or delay them needing more costly intensive support.
- More needs to be done to manage the risks to users when a provider goes out of business or closes, including contingency plans and financial monitoring of voluntary and private providers.
- Users and carers need to be more involved in decisions about social care services, with better evidence of what differences the services make to people's quality of life. Councils may need a significant amount of support to effectively implement self-directed support.

3.4 Strategic commissioning plans should be developed to take account of the Scottish Government's 2020 Vision for Health and Social Care, of which integration is, of course, one of 12 priorities[8].

Our '2020 Vision' for health and social care

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

We will have a care system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the 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.

[8] A Route Map to the 2020 Vision for Health and Social Care, May 2013

4 WHAT DOES STRATEGIC COMMISSIONING LOOK LIKE, AND WHO IS INVOLVED?

'Traditionally the starting point for forward planning for many of us is to consider what we've already got and then look at how to preserve, sustain or increase it. Strategic commissioning enables us – indeed *expects* us – to start somewhere else and ask a different set of questions:

- What exactly are we trying to achieve, and for whom?
- How successful have we been?
- What do we need to do differently for a better result, and how are we going to resource that?

'The fact that we're also expected to do this collaboratively with those organisations, groups and people directly affected by our planning activity, but who have previously had little or no direct influence in relation to it adds to the challenge, but potentially makes success more likely for all of us.

'From a third sector perspective, it's the first time that there has been an explicit expectation that we are partners in this endeavor, rather than simply suppliers, interest groups or consultees and crucially, that this offer of partnership extends to the people for whom we provide care and support.'

Annie Gunner Logan, Director, Coalition of Care and Support Providers in Scotland

4.1 Most models of commissioning emphasise its cyclical nature, with strategic commissioning providing the context for procurement and contracting. The cycle is sequential and of equal importance to one another.

4.2 A key principle of the commissioning process is that it should be equitable and transparent, and therefore open to influence from all stakeholders via an on-going dialogue with people who use services, their carers and providers. Outcomes for people are at the centre of the model shown in Figure 1:

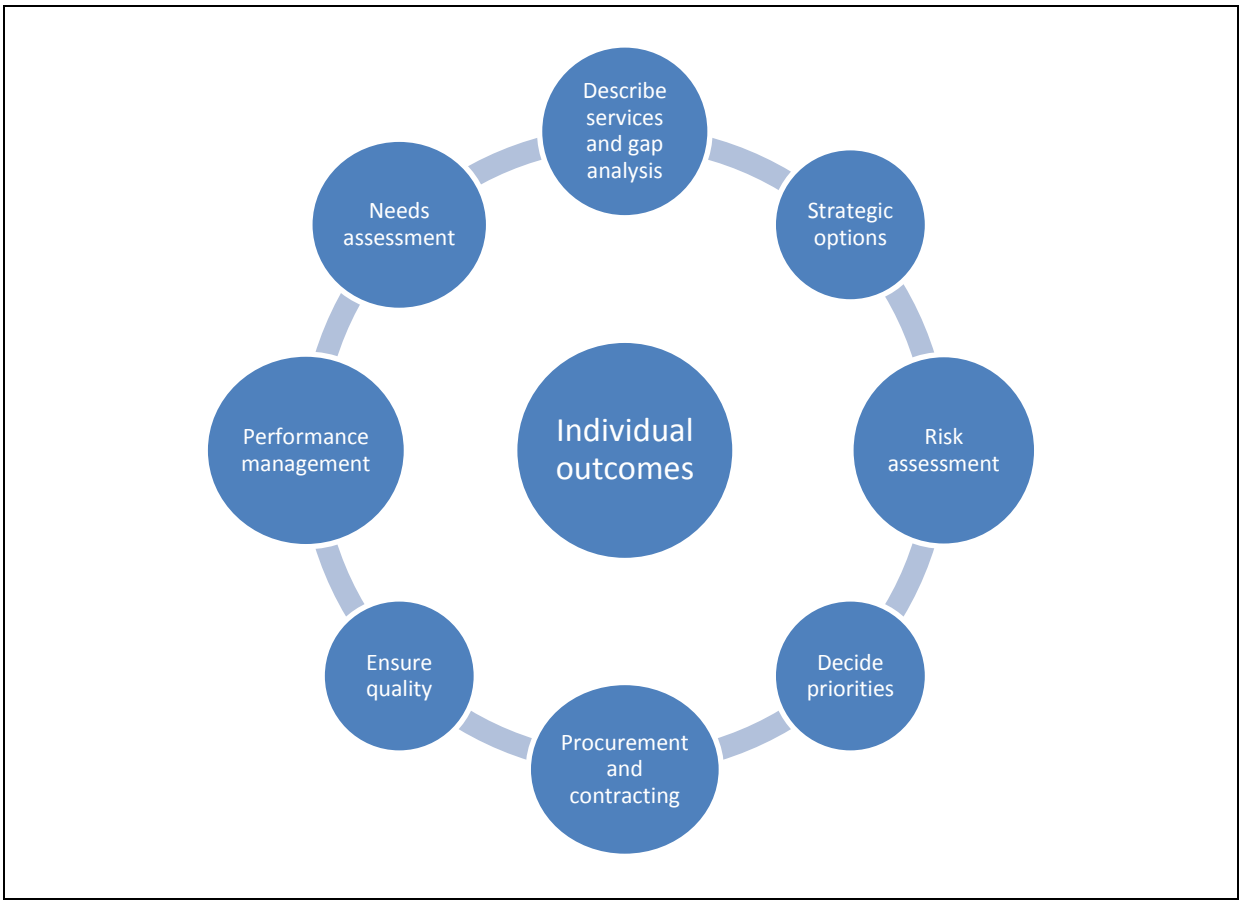

Figure 1

4.3 In order to ensure the effective engagement of stakeholders, the Act requires each Integration Authority to establish a Strategic Planning Group, which is described in detail below and in Annex A. The Strategic Planning Group will be concerned with a series of questions throughout the commissioning process, such as those illustrated below, based on work by Audit Scotland:

Figure 2

4.4 The process itself does not start or end with the publication of the strategic commissioning plan. Engagement with stakeholders and the involvement of the Strategic Planning Group are all part of a continual, iterative cycle.

4.5 The role of the Strategic Planning Group is in developing and finalising the strategic commissioning plan and in continuing to review progress, measured against the statutory outcomes for health and wellbeing, and associated indicators. The strategic commissioning plan should be revised as necessary (and at least every three years), with the involvement of the Strategic Planning Group.

4.6 Localities will be key to effective strategic commissioning. The Act requires each Integration Authority to divide its geographical area into at least two localities, whose views must be taken into account as part of the strategic commissioning process. Localities, and locality planning, provide a key mechanism for strong local clinical, professional and community leadership, ensuring that services are planned and led local in a way that is engaged with the community.

4.7 Planning for those aspects of hospital care included within the integrated arrangement will form an important part of the strategic commissioning plan. Refer to the Scottish Government's guidance on Financial Planning for Large Hospital Services and Hosted Services, which provides further advice[9].

[9] http://www.scotland.gov.uk/Resource/0046/00465642.pdf

‘Integration is about improving outcomes and tackling the disconnects that exist within health and between health and social care. Strategic commissioning provides a robust, coherent cross-system methodology for identifying the priorities for change in support of this. Its cyclical nature – analyse, plan, do, review – will bring the strategic plan to life.

‘A co-production approach will be essential to effective strategic commissioning and finding common ground among the stakeholders on changes which need to be made will be central to the success of integration. Strategic commissioning gives a process for finding this common ground, a methodology for ensuring it is established on a solid foundation and links the agreed changes to improved outcomes.

‘Over time, integration must be built on more mature relationships and transparency between all stakeholders. Strategic commissioning will be a critical part of the scaffolding which will support this movement and that is ultimately why it is so important.’

Allan Gunning, Director for Strategic Planning, Policy and Performance at NHS Ayrshire & Arran

5 WHEN SHOULD STRATEGIC COMMISSIONING START?

5.1 The new integrated arrangements come into being from April 2015, and Integration Authorities have until 1 April 2016 to meet their statutory requirement to produce a strategic commissioning plan and to begin their integration arrangements. However, local partnerships are encouraged to have their integrated arrangements fully operational in advance of April 2016.

5.2 Functions cannot be delegated to the Integration Authorities until the strategic commissioning plan has been finalised: without a strategic commissioning plan via which to discharge their duties, Integration Authorities cannot take up their duties.

6 WHAT SHOULD A GOOD STRATEGIC COMMISSIONING PLAN LOOK LIKE?

6.1 The strategic commissioning plans for older people that were developed in 2013 as part of Reshaping Care for Older People offer a good start. Nonetheless, strategic commissioning, as envisaged for this programme of reform, which is co-produced, fully inclusive, and spans health and social care, has never been done before. This is a new, and relatively untried, process. We will share good practice as it emerges. In the meantime, Integration Authorities and their partners will be expected to collaborate with revised national improvement and support arrangements to ensure the maximum potential of this approach is realised.

6.2 The National Steering Group for Strategic Commissioning[10] has suggested that a good plan should be based around the established strategic commissioning cycle and should:

- Identify the total resources available across health and social care for each care group and for carers and relate this information to the needs of local populations set out in the Joint Strategic Needs Assessment (JSNA);
- Agree desired outcomes and link investment to them;
- Assure sound clinical and care governance is embedded;
- Use a coherent approach to selecting and prioritising investment and disinvestment decisions; and
- Reflect closely the needs and plans articulated at locality level.

6.3 The Steering Group further suggests that strategic commissioning plans should be based around the established strategic commissioning cycle, which will be fully described in an advice note.

6.4 Integration Authorities should take account of the "3-step Improvement Framework for Scotland's Public services"[11], ensuring that there is an agreed vision, that work is undertaken to improve the culture and capacity of partnership working, and that plans are implemented with impact measured appropriately, to demonstrate improvement. This framework emphasises the need to tell 'a story', to enable people to recognise where they have been and where they are heading. Strategic commissioning plans should describe how people's lives, health and wellbeing will be improved.

6.5 It is envisaged that Integration Authorities will develop an easy-read, overarching summary of the strategic commissioning plan which will provide details of the vision. That in itself though will not meet the statutory requirements, and so the full, detailed plan must also be published.

6.6 All Local Authority/Health Board partnerships produced strategic commissioning plans for older people in 2013/14. The Act however, requires a strategic plan to cover all functions included in the integration arrangements, so will by necessity cover at least all adult care groups. It will be a matter for each Integration Authority to decide how best to achieve that. However, it is generally acknowledged that under an overarching framework, separate sections of the plan should focus on particular sections of the population, for example older people or

[10] http://www.scotland.gov.uk/Resource/0040/00408719.pdf
[11] The 3-Step Improvement Framework for Scotland's Public Services, June 2013

adults with a physical disability. Where criminal justice and children's services are delegated locally then the strategic plan must cover those services as well.

6.7 Annex A provides further detail on the statutory requirements of strategic commissioning, and how it should be carried out.

6.8 An advice note will be prepared to share emerging good practice and outline the support that is available to help on all aspects of the commissioning process.

7 SETTING OBJECTIVES, MEASURING OUTCOMES AND REPORTING ON PERFORMANCE

7.1 The indicators that underpin the statutory national health and wellbeing outcomes include important measures of whole system working, the success of which will be key to shifting the balance of care from institutions to the community, e.g., reducing unplanned hospital admission rates and addressing delayed discharges. Strategic commissioning plans will identify the resources that are being used to help address these challenges, and will set out how service provision will shift over time to support anticipatory and preventative care.

7.2 The Act places a duty on Integration Authorities to publish an annual performance report, which will allow progress to be measured and benchmarked against performance in other areas. Integration Authorities will be expected to set out clearly, in their strategic commissioning plans, how improvement will be delivered against the statutory outcomes and associated indicators. In addition, they should set out how rebalancing care will enable the delivery of key NHS targets in respect of A&E performance, the 18 Week Treatment Time Guarantee, and assuring financial balance. The annual performance report produced by each Integration Authority will need to set out actual performance in comparison to the objectives set out in the strategic commissioning plan.

ANNEX A: DETAILED REQUIREMENTS

The Act places a number of duties on Integration Authorities in relation to strategic commissioning. These are summarised below, along with further detail on how these requirements should be taken forward by Integration Authorities.

a) Requirement to prepare strategic plans (section 29)

The Integration Authority can include such material as it thinks fit in the strategic commissioning plan. There are nonetheless two matters that must be covered:

- A strategic commissioning plan must set out the arrangements for carrying out the integration functions in the Local Authority area over the period of the plan. The area must be divided into a minimum of two localities for this purpose, and the arrangements for each locality must be set out separately.
- A strategic commissioning plan must also set out the way in which the arrangements for carrying out the functions are intended to achieve or contribute towards achieving the national health and wellbeing outcomes.

The first strategic commissioning plan of an Integration Authority must be prepared before the integration start date, which is the date on which the Health Board and the Local Authority delegate functions to the Integration Authority. The strategic commissioning plan must be prepared before this date so that the Integration Authority can function immediately.

Scottish Ministers have prescribed in Regulations that functions must be delegated on 1 April 2016, if not before. The strategic commissioning plan must, at the latest, be prepared in time to allow delegation of functions on this date. The Health Board and Local Authority may choose to delegate the functions on a day that is earlier than the day prescribed by the Scottish Ministers. Where this occurs, the Integration Authority must make clear in its first strategic commissioning plan the date on which functions are to be delegated.

b) Considerations in preparing strategic plans (section 30)

The Integration Authority is required to take into account the integration planning and delivery principles set out in the Act, and the national health and wellbeing outcomes set out in Regulations, in preparing a strategic commissioning plan. This is to ensure the principles and national outcomes are at the heart of planning for the population and to embed a person centred approach, alongside anticipatory and preventative care planning.

Each Integration Authority, when preparing a strategic commissioning plan which sets out, or proposes to set out, arrangements for the use of services, facilities or resources used by another Integration Authority, must take account of any other strategic commissioning plan that has been, or is being, prepared which also sets out arrangements for the use of those services, facilities, or resources. Essentially, areas that share resources or services must take account of this in their respective strategic plans. Many local areas will plan hospital usage in a neighbouring area so close communication and co-operation will be needed.

The strategic commissioning plan should ensure correlation with other local policy directions as outlines in, for instance, Single Outcome Agreements, NHS Local Delivery Plans, Housing Strategies, NHS Clinical Strategies, community plans and other local corporate plans.

Under the terms of the Local Government in Scotland Act 2003 or, where applicable, the Public Finance and Accountability (Scotland) Act 2000, the implementation of the duty of Best Value[12] will apply to the Integration Authority. That duty is:

- To make arrangements to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost; and in making those arrangements and securing that balance.
- To have regard to economy, efficiency, effectiveness, the equal opportunities requirements, and to contribute to the achievement of sustainable development.

c) Integration delivery principles (section 31)

The integration delivery principles are:

- that the main purpose of services which are provided to meet integration functions is to improve the wellbeing of service-users,

- that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible:
    - is integrated from the point of view of service-users
    - takes account of the particular needs of different service-users
    - takes account of the particular needs of service-users in different parts of the area in which the service is being provided
    - takes account of the particular characteristics and circumstances of different service-users
    - respects the rights of service-users
    - takes account of the dignity of service-users
    - takes account of the participation by service-users in the community in which service-users live
    - protects and improves the safety of service-users
    - improves the quality of the service
    - is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
    - best anticipates needs and prevents them arising
    - makes the best use of the available facilities, people and other resources

These integration delivery principles must be taken into account in the preparation of the strategic commissioning plan and in the actual carrying out of functions included in integration arrangements. The effect is to ensure a focus on integrated delivery, including consideration of the needs of different service users and different areas, the dignity of service users, the participation by service users in the community in which they live, protecting and improving the safety of service users, improving the quality of services local planning and leadership, the anticipation and prevention of

[12] Best Value, May 2011

need, and the effective use of resources. Consideration should be given to how adherence to these principles will be given effect in order to demonstrate effective implementation. It will require clinical and care professionals to apply the principles in all that they do in delivering integrated health and social care services.

d) Establishment of Strategic Planning Group (section 32)

Integration Authorities are obliged to establish a Strategic Planning Group for the area covered by their Integration Scheme for the purposes of preparing the strategic commissioning plan for that area. Depending on the model of integration chosen, the group must involve members nominated by the Local Authority or the Health Board, or both. In effect, this provides for the partners who prepared the Integration Scheme, and are party to the integrated arrangements, to be involved in the development of the strategic commissioning plan.

In addition, the Integration Authority is required to involve a range of relevant stakeholders. These groups must include representatives of groups prescribed by the Scottish Ministers in regulations as having an interest. These are:

- Users of health care
- Carers of users of health care
- Commercial providers of health care
- Non-commercial providers of health care
- Health professionals[13]
- Social care professionals[14]
- Users of social care
- Carers of users of social care
- Commercial providers of social care
- Non-commercial providers of social care
- Non-commercial providers of social housing
- Third sector bodies carrying out activities related to health or social care

The Integration Authority can include other persons it considers appropriate, such as Local Authority housing colleagues. The Integration Authority is to determine the

---

[13] The Public Bodies (Joint working) (Health Professionals and Social Care Professionals) (Scotland) Regulations 2014 provides a description of Health and social care professionals.
Health Professionals are anyone who is included in the:

- Register of medical professionals kept by the registrar of the General Medical Council
- Dentists register kept by the General Dental Council
- Register of optometrists or the register of dispensing opticians kept by the General Optical Council
- Register of osteopaths kept by the General Osteopathic Council
- Register of chiropractors kept by the General Chiropractic Council
- Part 1 or Part 2 of the register maintained by the General Pharmaceutical Council
- Register of qualified nurses and midwifes kept by the Nursing and Midwifery Council
- Register of member of relevant professionals kept by the Health and Care Professions Council

[14] The Public Bodies (Joint working) (Health Professionals and Social Care Professionals) (Scotland) Regulations 2014 provides a description of Health and social care professionals.
Social Care Professionals are:

- A person who is included in the register of social workers and social service workers kept by the Scottish Social Services Council, or
- A person who is engaged in the provision of care or support to users of social care services which are provided under the integrated arrangements

number of members in its Strategic Planning Group and the process for the appointment, replacement and removal of members.
The Act allows the Integration Authority to:

- appoint members of the Strategic Planning Group from persons nominated;
- remove persons from membership of the group; and
- appoint members in place of members who resign or are removed from membership of the group.

It also provides for members nominated by the Local Authority and/or Health Board to be removed from the Strategic Planning Group by the body which nominated them, and replaced with a different nominee. Furthermore, a member of the Strategic Planning Group can resign at any time.

The views of localities must be taken into account with the Integration Authority required to identify the most appropriate person to represent each locality on the Strategic Planning Group. Local flexibility is allowed, so that an individual can represent more than one locality. The Strategic Planning Group's ability to make decisions should not be undermined by any vacancy in its membership.

The Integration Authority is to determine the procedure of the group, and may pay members of the group expenses and allowances. It will be up to each Integration Authority to decide how the group should operate.

While Integration Authorities will be expected to make best use of established local user, carer and advocacy groups, they should not be constrained by a traditional working group approach. Rather, they may wish to introduce innovation in respect of networks and in-roads to community engagement.

Strategic commissioning is crucially about establishing a mature relationship between different partners from across the public, third and independent sectors in a way which will help to achieve the best services for the population. Providers themselves will bring knowledge and experience of their services and the outcomes they are delivering. Every partner has a role to play in strategic commissioning, and that is why it is important that local arrangements promote mature relationships and constructive dialogue. Those involved in the strategic commissioning process need to develop their skills in working with a range of partners including the independent and third sector, along with service users and their carers to build and implement commissioning priorities. Clinicians and care professionals in localities also play a key role in ensuring that local needs are understood, and that they inform the overall priorities. They will be key to the delivery of improvements in services and support, and in ways of working on the scale of what is envisaged in strategic commissioning plans.

It is vital that the full extent of the third sector's knowledge, expertise, and information, both in relation to communities and the sector itself, is brought to bear upon strategic commissioning and locality planning in order to achieve the outcomes of health and social care integration. This will require all parties to work with trust and mutual respect.

The role of Third Sector Interfaces (TSIs), established in 2011, provide a strong, coherent and cohesive voice for local organisations in each of Scotland's 32 Local

Authority areas – seeking to influence the architecture of community planning structures in the interests of the community. Evidence from the Reshaping Care for Older People (RCOP) programme has shown that a relatively small amount of additional support for the third sector can result in more co-ordinated and innovative responses to the challenges facing the sector and communities. This helps to harness the assets to deliver locally and ensure the voices of local people are connected to the local and national agenda.

The housing sector already makes a very significant contribution to national outcomes on health and social well-being by:

- providing information and advice on housing options;
- facilitating, or directly providing 'fit for purpose' housing that gives people choice and a suitable home environment;
- providing low level, preventative services which can obviate the need for more expensive interventions at a later stage;
- building capacity in local communities; and
- undertaking effective strategic housing planning.

The integration of adult health and social care is recognised as bringing opportunities to strengthen the connections between housing and health and social care, to improve alignment of strategic commissioning, to support the shift to prevention, and to incorporate (and if necessary review) current arrangements for housing support and homelessness services.

The Scottish Government engaged with the Institute of Public Care (IPC) to produce a Learning Development Framework[15], to assist all those involved in the strategic commissioning process. IPC, along with the Joint Improvement Team (JIT) has also provided a learning and development programme across all partnerships, for those people involved in commissioning. Further development and support continues to be available from the JIT. Integration Authorities must ensure that members of the Strategic Planning Group are fully supported to be able to carry out their functions in a meaningful and effective way.

It will be important that the workforce is supported so that people who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide, and feel engaged with the work they do.

An advice note will be prepared that sets out the policy context within which the workforce is operating. It will set out who is included in the workforce and the national learning frameworks available to individuals and employers and the wider public.

e) Preparation of strategic plan (section 33)

The Strategic Planning Group is required under the Act to be involved in the development of the strategic commissioning plan, assuring the group's engagement in the process from the start.

[15] Joint Strategic Commissioning – A Learning Development Framework, IPC, November 2012

The Integration Authority is required to prepare proposals about matters the strategic commissioning plan should contain, and consult the Strategic Planning Group on the proposals and then to prepare a first draft of the strategic commissioning plan, reflecting the views of the group expressed during the consultation. The Integration Authority must then consult the Strategic Planning Group on the draft.

Taking into consideration the views in response to the consultation on the first draft, the Integration Authority is required to prepare a second draft of the strategic commissioning plan and send a copy of it for comment to all interested stakeholders. This must include the Local Authority and the Health Board, or both (depending on the model of integration chosen), as well as representatives of any groups prescribed by the Scottish Ministers.

It is essential that the Integration Authority shares the draft strategic commissioning plan widely with those who have an interest in the delivery or receipt of health and social care within the geographic boundaries of the proposed Integration Authority. The integration planning principles state that services should be *"planned and led locally in a way which is engaged with the community (including those who look after service-users and those who are involved in the provision of health and social care)*". A wide and diverse engagement will ensure that the strategic commissioning plan is not simply controlled by the small number of people on the Strategic Planning Group but rather the population that will be affected by its findings. For example, this would include the involvement and engagement of existing representative fora, such as joint planning groups, advocacy organisations, locality planning groups and those involved in local community planning. It will be important to ensure that engagement supports human rights and equalities, recognising that some groups may face greater barriers to having their voices heard, and proactively supporting their contribution.

It is important that the Integration Authority develops an agreed communication and engagement plan at an early stage. In line with Scottish Government policy, such consultation can take place in a variety of ways – written information, public meetings, focus groups, questionnaires and on-line and interactive discussion forums. Integration Authorities should make best efforts to allow groups of people with an interest to participate in a consultation process in order to express an opinion on the draft strategic commissioning plan.

This will ensure that any other parties with an interest will have an opportunity to fully understand the direction of travel and to comment on the draft plan. The Integration Authority is duty bound to take into account the views obtained through consultation on the second draft of the strategic commissioning plan when finalising the strategic commissioning plan.

To ensure proper proportionality in the potential communication exercise that consulting with the above might entail, the Integration Authority should consult with people that they can reasonably expect to recognise as representatives of these groups. Integration Authorities should consider various methods to engage their target audience.

f) Provision of information for purpose of preparing strategic plan (section 34)

Health Boards, Local Authorities and Integration Joint Boards have duties to share information with each other for the purpose of preparing the strategic commissioning plan. Information must be shared if it is information which may be reasonably required for the purpose of preparing a strategic commissioning plan.

The Scottish Government recognise the importance of developing and supporting strategic planning and locality planning capabilities in partnership, so that leaders of integration – and particularly Chief Officers and their senior teams – are equipped with the skills and information necessary to improve care and outcomes for people.

Integration Authorities will require robust information and intelligence if the potential benefits of strategic planning are to be realised. In order to support this, the Scottish Government has commissioned NHS National Services Scotland (NSS) to develop linked individual level longitudinal health and social care datasets for all Integration Authorities[16]. These datasets will be provided via a secure storage solution.

The Integration Authority should oversee the production of Joint Strategic Needs Assessments (JSNAs) to analyse the needs of local populations and to inform and guide the commissioning of health, wellbeing and social care services within their area. As indicated above, the main goal of a JSNA is to accurately assess the care needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities.

As stated previously, public support will be vital in taking any redesign forward. It is important that stakeholders have been fully involved in the process, from the start, and not presented with a conclusion. Integration Authorities will want to have an agreed and transparent option appraisal process in place, especially to underpin major investment and disinvestment decisions. The Scottish Government has been testing one such approach – Programme Budgeting & Marginal Analysis – and will provide detail in advice notes that will accompany this guidance.

An advice note will be prepared to provide further details on JSNA and the data store being developed by NSS. This will also provide a single reference point for information that is available to help prepare a strategic commissioning plan.

g) Publication of strategic plans (section 35)

Integration Authorities have a duty to publish strategic commissioning plans. This can be done in a variety of formats but it will be expected as a minimum that these would be made available on the internet. These must be published as soon as practicable after the plan has been finalised. The Integration Authority must also publish a statement at the same time it publishes its strategic commissioning plan, which describes the consultation it undertook.

In addition to the publication of the strategic commissioning plan, the financial statement (see below) and the description of the consultation, Integration Authorities

[16] Health and social care data integration and intelligence project

should also consider an implementation plan or set of implementation plans outlining how the strategic commissioning plan will be delivered. This could include a procurement plan providing specific detail to direct those responsible for contracting services. In line with the recommendations of the task force for the future of residential care,[17] a Market Facilitation Plan, which is a summary of the key requirements to meet current and future demand, should be incorporated within the strategic commissioning plan, clearly stating the level and type of services required. Although this recommendation came from the task force market facilitation should not be confined to residential care or older people. Based on a good understanding of need and demand, market facilitation is the process by which strategic commissioners ensure there is sufficient, appropriate range of provision, available at the right price to meet needs and deliver effective outcomes.

An advice note will be prepared on Market Facilitation Plans, self-directed support and issues around the links with procurement.

h) Significant decisions outside strategic commissioning plan: public involvement (section 36)

Where an Integration Authority, which is a Health Board, Local Authority or Integration Joint Board plans on making a decision that would have a significant effect on the provision of an integrated service, outwith the context of the strategic planning cycle, then the Integration Authority must involve and consult its Strategic Planning Group, along with users, or potential users, of the service.

i) Review of strategic commissioning plan (section 37)

An Integration Authority is required to review its strategic commissioning plan at least every three years, and may carry out additional reviews from time to time. In carrying out a review of the strategic commissioning plan, Integration Authorities must consider:

- the national health and wellbeing outcomes
- the indicators associated with the national outcomes
- the integration delivery principles
- the views of the Strategic Planning Group

There should be a clear recording and measurement framework so that there is an ongoing process to assess whether aims are being achieved. Arrangements should also be put in place so that any information relating to risks or significant changes in trends that emerge from the ongoing JSNA process can be considered and responded to timeously by the Integration Authority, at any time during the strategic planning cycle.

The Health Board and Local Authority are required to provide the Integration Authority with the information that is reasonably required to carry out the review of the strategic commissioning plan. A review may result in the integration authority making any necessary changes by replacing its strategic commissioning plan. Flexibility is provided for Integration Authorities to determine the details of the review process they use.

[17] Recommendations for the future of residential care for older people in Scotland, February 2014

A strategic commissioning plan which is prepared following a review must specify the date on which it takes effect.

j) Requirements on Integration Joint Boards to prepare replacement strategic plan (section 38)

The Act provides for the Local Authority and the Health Board, acting jointly, to direct the IJB to prepare a replacement strategic commissioning plan where they both agree the strategic commissioning plan prohibits them from carrying out any of their functions. A direction from both the Local Authority and the Health Board requiring the replacement of the strategic commissioning plan is binding on the Integration Authority.

k) Strategic plan: annual financial statement (section 39)

The Integration Authority must publish an annual financial statement upon publication of its first strategic commissioning plan, and every year after that. The financial statement must set out the total resources that the Integration Authority intends to allocate under the provisions of the strategic commissioning plan.

An advice note will be prepared on the financial aspects involved in strategic commissioning.

l) Scrutiny (sections 54 to 56)

Sections 54 to 56 of the Public Bodies (Joint Working) (Scotland) Act 2014 amend the Public Services Reform (Scotland) Act 2010 and The National Health Services (Scotland) Act 1978 to extend the remit of the Social Care and Social Work Improvement Scotland and Healthcare Improvement Scotland (HIS) to inspect the planning, organisation or co-ordination of the services that Health Boards and Local Authorities delegate, as set out within their Integration Schemes, to Integration Authorities.

These amendments set out the purpose of these inspections that can include:

- reviewing and evaluating the extent to which integrated services are complying with the integration planning and delivery principles and contributing to achieving the national health and wellbeing outcomes.
- reviewing and evaluating the extent to which the planning, organisation or co-ordination of integrated services are complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes.
- reviewing and evaluating the effectiveness of a strategic commissioning plan prepared under section 29 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes.
- encouraging improvement in the extent to which implementation of a strategic commissioning plan prepared under section 29 of the 2014 Act complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes.

- enabling consideration of the need for any recommendations to be prepared as to any such improvement to be included in the inspection report.

Healthcare Improvement Scotland and Social Care and Social Work Improvement Scotland are able to inspect health and social care services for the purpose of reviewing and evaluating how the planning and provision of services is contributing to the achievement of the outcomes. Alongside this they are able to encourage improvements and make recommendations in relation to the implementation of strategic commissioning plans in order to contribute to achieving the outcomes (sections 54 and 55 of the 2014 Act).

The outcomes apply to all Integration Authorities, and to all persons carrying out integration functions. By reference to the outcomes, the effect of integrated health and care services on the health and wellbeing of individuals can be measured. As the outcomes apply nationally, their application will provide for the reduction of unwarranted variation in the quality of health and care services between geographical areas.

Section 56 of the Act states that Healthcare Improvement Scotland and Social Care and Social Work Improvement Scotland may jointly conduct an investigation into a service provided by an Integration Scheme and also a Local Authority, Health Board or Integration Joint Board in relation to a strategic commissioning plan.

ANNEX B: DRAFT INDICATORS FOR INTEGRATION OF HEALTH AND SOCIAL CARE

This annex sets out the core suite of indicators currently being developed to support integration. These indicators have been developed where possible from national data sources so that the collection is consistent across areas. Further work will be taken forward with stakeholders before the final set of indicators is confirmed.

(a) Outcome indicators based on survey feedback:

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

(b) Outcome indicators based on administrative data:

11. Premature mortality
12. Rate of emergency admissions for adults (including proposal to also look at rate of emergency bed days for adults)
13. Readmissions to hospital within 28 days
14. Proportion of last 6 months of life spent at home or in community setting
15. Falls rate per 1,000 population in over 65s
16. Proportion of care and care at home services rated 3 or above in Care Inspectorate Inspections
17. Delayed discharge – 14 days, 72 hours, bed days lost
18. Percentage of adults with intensive needs receiving care at home