The Scottish Government
Riaghaltas na h-Alba

Health and Social Care Integration

Strategic Commissioning Plans

An overview of strategic commissioning plans produced by Integration Authorities for 2016 - 2019

October 2016

Contents

Key messages

Strategic commissioning is more than the publication of a plan, it is an approach to making sure people have access to the right care at the right time, and in the right place. It involves a range of activities, centred around a continuous cycle of **analyse, plan, do and review,** and is iterative and dynamic to support collaborative system change across health and social care. Those Partnerships established in April 2015 have already reviewed and refreshed their plans, through this approach.

Functions of strategic commissioning plans include setting the vision and direction of travel, providing a means of communication, promoting effective and on-going engagement, building consensus, making linkages across a range of plans, services, different parts of the system, sectors and people, and determining strategic priorities.

- All Partnerships completed strategic commissioning plans by 1st April 2016 and these are high level and strategic. Further work is needed in a few plans and in supporting implementation plans to raise the scale of ambition and the pace at which it will be achieved, but most are aiming high.

- All plans include a list of functions that have been delegated by the Local Authority and by the NHS Board. A number of plans use tables and graphics to good effect in order to communicate this information.

- The reach and quality of engagement in the development of strategic commissioning plans is comprehensive and generally of good quality across Scotland. Strong engagement and working on a co-production basis needs to become the norm, not just in agreeing the vision and setting direction. This is emerging in a number of the Partnerships.

- Some plans describe how the Partnership is working with the Community Planning Partnership (CPP). This will ensure a common approach between key public sector agencies and optimise opportunities for joint work on shared priorities.

- Strategic Planning Groups have been established in each Partnership but this is not well covered in many of the strategic commissioning plans and should be given more prominence in subsequent iterations.

- Accessibility of plans and accompanying documents was generally good but there were sometimes difficulties in locating these. Scottish Government is currently working with a small number of Partnerships to identify good practice in engagement strategies, including publishing documents and improving accessibility.

- All Partnerships have undertaken a strategic needs assessment that considers needs, population dynamics and projections, service activity, supply and demand and gaps in provision to inform their strategic commissioning plan. Some are being further developed.

- Some plans include Market Facilitation Plans, and it is essential that these are completed in all Partnerships. Third and independent sector partners and procurement staff should actively participate in the development of these plans.

- Strategic commissioning plans do not deal with procurement arrangements. Effective procurement of care and support services is a crucial aspect of strategic commissioning and Partnerships must plan for how this will developed and improved, using best available evidence and guidance for implementing new approaches.

- There is little evidence that data from the third and independent sectors is included in strategic needs assessments. This is an area for development and work is underway through Source and in some Partnerships to address this.

- A brief analysis of deprivation in the Partnership's population is a particular feature of some plans. Deprivation constitutes a serious issue for many parts of Scotland and its impact should be considered in plans. Tackling health inequality is a strategic priority in almost all plans. This needs further development in some plans in order to move beyond identifying the issues to what action will be taken, often acting in collaboration with others such as community planning partners.

- A number of plans include equality impact assessments and outline the work the Partnership is doing to develop and publish equality outcomes. All Partnerships must publish robust Equality Outcomes and undertake an Equality Impact Assessment to ensure they are meeting their statutory obligations.

- All plans identify strategic priorities and there are a number that are broadly consistent across Partnerships. Where Partnerships have children's services and community justice social work services delegated, specific strategic priorities relating to these services are included

- Plans contain varying levels of financial information. To assist with the production of Annual Financial Statements in future years, the Scottish Government has published an advice note on the scope of these and what they should contain (http://www.gov.scot/Publications/2016/09/1985). We will also work with COSLA to produce a suggested pro-forma that will be issued in late Autumn of 2016.

- The financial impact of re-modelling services is not considered in many plans nor is the method made clear for how decisions will be made about the allocation of resources. This has been challenging for Partnerships to do ahead of finalising budgets and is an area for development across plans. To assist Partnerships with work required on prioritisation, the Scottish Government has published an advice note on the key characteristics that should be incorporated in this process (http://www.gov.scot/Publications/2016/09/9980).

- An area requiring specific attention is the financial planning for the sum set aside for hospital services. The Scottish Government is working with Partnerships, Health Boards and Local Authorities to draft guidance on good practice for budget setting, so that the processes will be better aligned for 2017/18.

- The number of localities in each Partnership ranges from two to nine. The size of localities ranges from a large urban population of 219,422 to a small island population of just 1,264. In all, 128 localities have been established in Partnerships to take forward work on a local basis. Further work is required across Partnerships to fully develop their locality arrangements and maximise the potential of the structured involvement of communities, and local professionals in planning and decision making.

- Some plans contain a high level summary of workforce issues. It is imperative that emergent integrated workforce plans carefully consider and seek to address the panoply of issues for staff in health and social care services, including in the third and independent sectors.

- Many plans emphasise the key role of primary care services in health and social care integration. Some explore the need to develop stronger and more innovative links with primary care, where most patient contact takes place. All plans identify GPs and primary care as a key component of local service delivery and locality planning.

- A number of plans clearly outline the relationship between the Partnership and acute care and identify the Partnerships' statutory role in strategic planning for emergency care services delivered in acute hospitals. In some plans, responsibility for planning for the emergency care pathway is low key and not well covered. Future iterations must pay more attention to this.

- While there may be opportunities for efficiency in some instances through establishing hosting arrangements, it is important that hosting is not used in multi –partnership Health Board areas to maintain existing NHS arrangements where there is scope through the Partnerships for greater local ownership and improvement.

- Housing is recognised in most plans as a key component of effectively shifting the balance of care from institutional care to community based services and supports. Some plans include information on the local Housing Plan and its fit with health and social care delivery. Just over half of plans contain a housing contribution statement.

- All partnerships have developed a performance framework that includes national and local outcomes and measures. Where appropriate, performance frameworks include children's outcomes and criminal justice outcomes as well as the National Health and Wellbeing Outcomes. Although not a requirement, first iterations of performance reports have been published by Partnerships established last year.

Introduction and background

1. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) put in place the framework for integrating health and social care. The Act places a duty on Integration Authorities (referred to throughout this document as Partnerships) – 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.

2. Scottish Government published statutory guidance on Strategic Commissioning Plans in December 2014. The strategic plan is the output of what is more commonly referred to as the strategic commissioning process. The statutory guidance provides the following definition of strategic commissioning: *it 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.* The guidance also explains that where we refer to the strategic commissioning plan, we are referring to the strategic plan described in the Act. These are not separate or different plans, they are one and the same.

> ***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 integration partnerships will deliver better care for people, and better use of the significant resources we invest in health and social care provision*.**
>
> Strategic Commissioning Plan, Statutory Guidance, December 2014

3. By developing strategic commissioning plans for, as a minimum, all adult care groups, and taking a population approach to planning, Partnerships are focusing on designing, commissioning and delivering services in new and sustainable ways, in collaboration with their partners.

4. All Partnerships completed their strategic commissioning plans by 1st April 2016, as required. Generally, these set out the vision, aims, ambitions and outcomes that each Partnership will seek to deliver, over the life of the plan. Some Partnerships have, or are in the process of, developing further iterations, clearly demonstrating that the plans are dynamic and being actively used. In addition, all Partnerships have developed or are developing detailed, costed implementation or operational plans for the delivery of strategic priorities identified through the strategic commissioning process.

5. This report provides an overview of the content and approach of these first iterations, and identifies common themes and key areas for further development. It is intended to assist local systems to accelerate the transformational potential of their plans, and deliver sustainable new models of care and support that are focused on improving outcomes.

Overall Content and Approach

6. Most Partnerships have produced plans that are easy to read and provide a clear, high-level direction for health and social care services and supports in the coming years. All articulate a clear vision, and many include principles, mission statements and values to support this.

7. The plans are high level and strategic. They do not cover anything in great detail but often provide links or appendices to supplementary material. These do offer more detail, but do not routinely include information about how plans will be delivered, with timescales and costs. A number of plans have a whole range of accompanying documents, which have both informed the plan or been developed as a result of it.

8. Some plans give commitments with timescales for when other plans will be produced and some provide obvious hooks and levers for the development of more detailed plans leading to transformational change. For example, for specific care groups, service redesign or new service delivery, each of which requires to be consistent with the direction established in the strategic commissioning plan, and deliver the intended change on a sustainable basis.

9. All plans draw on relevant extant plans and strategies, and some explain how the strategic commissioning plan relates to these in the immediate and longer-term. Some plans use good graphics to illustrate how various plans and strategies relate to the strategic commissioning plan. However, the strategic commissioning plan is not a summation of other strategies but provides the means for coherence across a range of inter-related plans.

10. All plans include an explanation of why change is necessary, emphasising increasing demand and rising public expectations combined with limited finance. Some make a particularly cogent case by drawing on key data that are specific to their Partnership and which highlight the enormity of what needs to change, and why, in that Partnership area.

11. The scale of ambition expressed varies amongst plans, but most are aiming high. Some plans contain clear statements about their aspirations and ambitions, whilst others describe their ambitions in a more oblique way through the plans they have for delivering new models of care that are sustainable and focused on improving outcomes.

12. Further work is needed in a few plans and in supporting implementation plans to raise the scale of ambition and the pace at which it will be achieved. An increased focus on how transformational and sustainable change will be achieved at pace and scale, using the resources available to the Partnership must be a key aspect of planning and implementation.

13. Innovation and relentless pursuit of established strategic priorities to deliver improved outcomes is vital, as is seizing opportunities, while responding flexibly to the rapidly changing landscape within which Partnerships operate. A small

number of plans highlight the opportunities integration presents and how they plan to use these.

14. The need to do things differently and to support innovation, particularly through more extensive and imaginative use of technology, is a feature of a number of plans. Telehealth is generally not well covered in plans.

15. Working in close partnership with staff, people who use services, carers and the third and independent sectors, as well as local communities, is also recognised throughout plans as a key aspect of working differently and supporting innovation.

Scope of plans

16. The scope of plans is determined by the functions delegated to Partnerships. All plans include a list of functions that have been delegated by the Local Authority and by the NHS Board. A number of plans use tables and graphics to good effect in order to communicate this information.

17. Some plans explicitly cover public protection and all Partnerships, as a minimum, have delegated responsibility for adult protection. Interagency procedures are already in place for child, adult and public protection, however integration offers an opportunity to refresh these and to strengthen public protection.

18. Some plans, where children's services are not within scope refer to the need to build strong and meaningful collaboration with integrated children's services. A list of delegated functions to each partnership beyond the statutory minimum is appended at Annex 1.

19. Plans have been prepared in a variety of formats and styles with length varying between 18 pages to over 250 pages. The lengthier plans tend to include a range of planning material, such as detailed needs assessments and equality impact assessments, as appendices, while shorter plans are usually supported by a suite of associated documents that are separately published.

20. Explanations about what Integration Joint Boards (IJBs) are, who is on them, the number of voting members and other members, including advisors, have helpfully been included in the majority of plans.

21. Some of the clearest and most accessible plans have included light touch information about the Act and other key policy objectives, often by using graphics and charts to good effect. This includes vignettes of what will change for people in new integrated health and social care arrangements and what the overall approach is to delivering change.

Reach and quality of engagement

22. A range of stakeholders including staff, people using services, carers, the third and independent sectors must be fully engaged in the preparation, publication and review of the strategic commissioning plan. This is to establish a meaningful

co-productive approach, to enable Partnerships to deliver the national outcomes for health and wellbeing, and achieve the core aims of integration.

23. The reach and quality of engagement in the development of strategic commissioning plans is comprehensive and generally of good quality across Scotland. All Partnerships have rolled out extensive programmes of meetings with staff, people using services, carers, providers, third and independent sectors, local communities and the wider public to gauge opinion on what's important to them, to inform strategic priorities. A large number of Partnerships also ran formal consultations on their plans and many made significant alterations as a result.

24. Although not all planning will require this level of engagement on such a broad scale, it must be recognised as being a key part of an on-going strategic commissioning process. Strong engagement needs to become the norm, not just in agreeing the vision and setting direction. This co-productive way of working and engaging is emerging in a number of the Partnerships. Locality planning (discussed below) is an additional helpful vehicle for this.

25. Strategic Planning Groups (SPGs) have a formal statutory role in preparing and monitoring strategic commissioning plans. SPGs have been established in each Partnership and form an important cornerstone for effective stakeholder engagement and involvement, with a link directly to the IJB. The role of the SPG is not well covered in many strategic commissioning plans and should be given more prominence in subsequent iterations.

26. The model for SPGs varies slightly across Scotland but the majority are meeting regularly, and have developed a programme of work focused on monitoring the implementation of the plans and reviewing and refreshing existing plans. Locality planning leads are now playing into a number of SPGs, providing real opportunities for local community engagement on matters affecting people living and working in localities.

27. Within SPGs and across an extensive range of other stakeholder groups, key relationships and engagement with people using services, carers, professionals and clinicians, along with the third and independent and housing sectors, and with the wider public are being developed and deepened. Many Partnerships have developed engagement strategies and are focusing on developing effective communications with their local stakeholders, and beyond.

28. Some plans describe how the Partnership is working with the Community Planning Partnership (CPP) to extend and co-ordinate reach into local communities and neighbourhoods. This link to CPPs ensures that health and social care is not isolated from wider and highly relevant agendas that include transport, leisure and recreation, education, economic development, housing, policing, and fire and rescue services.

29. An array of web platforms have been developed for Partnerships, with the majority being hosted by the Local Authority and/or Health Board. A few Partnerships have developed their own web sites. Many have social media

accounts and are regularly publishing updates and information bulletins, increasing the visibility of their Partnership.

30. One issue we noted, however, was occasional difficulty in locating plans (and more often linked documents) on websites. In response, the Scottish Government is currently working with a small number of Partnerships to identify good practice in engagement strategies, including publishing documents and improving accessibility.

31. With a requirement under the Act to publish strategic commissioning plans and other documents, it is imperative that they are made more readily accessible. This has implications not only for the accessibility of the plans and other information the public may wish to access about Partnerships, but for the general visibility of Partnerships, what they do and what they are setting out to achieve, and requires attention.

Strategic needs assessment

32. All Partnerships have undertaken a strategic needs assessment that considers needs, population dynamics and projections, service activity, supply and demand and gaps in provision to inform their strategic commissioning plan, and shape services and support to deliver better outcomes. A few Partnerships intend to undertake a more in depth analysis to better inform future iterations of their plans.

33. Most plans use information from strategic needs assessment to highlight the challenges faced by the Partnership. This is most effectively described in plans where the challenges are put in simple and fairly stark terms that demonstrate the scale of what needs to be done and provide clear justification for major change across the existing health and social care system.

34. As well as good use of population health and well-being data, many plans provide a range of high level needs assessment information on particular care groups and draw on a range of available data. There are some areas (notably community health services and social care services) where information is historically light, as this is not routinely collected nor joined up across data sets.

35. In order to improve the data available to Partnerships, the Scottish Government commissioned NHS National Services Scotland (Information Services Division - ISD) to develop a health and social care dataset, and to develop analytical capacity and skills in Partnerships. This work was known as the Health and Social Care Data Integration and Intelligence Project, now known as Source, and is a development of our longstanding work on the Integrated Resources Framework.

36. The IT platform to support Source has been available since April 2015 and provides a secure data collection, storage, linkage and reporting facility – a “datamart” - for each Partnership. The initial phase of this work has so far focussed on linking a range of existing health datasets with Local Authority social care data. Once Local Authorities have submitted their data, every Partnership will be able to access pseudonymised, individual level longitudinal data for about

70% of the resources used by their populations. Over time, our objective is to capture 100% of partnership resources at this level.

37. In addition, the Local Intelligence Support Team (LIST) has allocated its analytical staff directly to work within each of the 31 partnerships. This resource provides additional capacity and capability in Partnerships for data analysis, to underpin the strategic commissioning process. Feedback on LIST support and the Partnership embedded method of delivering it is very positive across the country.

38. The data now available has been put to effective use by many of the Partnerships in their plans. Improved data availability has encouraged a system-wide focus on how data can help inform future planning by improved understanding of what the current state of play is, and to identify what needs to change to better meet outcomes and build a more sustainable health and social care system.

39. Many plans indicate that the Partnership is adopting an assets-based approach. This is critical in order to fully recognise, develop and make best use of wider assets and resources available in local communities and to facilitate partnership working with local communities.

40. There is little evidence that data from the third and independent sectors is included in strategic needs assessments. This is an area for development as Partnerships develop their data sets, strategic analysis and locality profiling. Work is underway through Source and by some Partnerships in this regard. Locality planning and market facilitation work will necessitate a better understanding of the contribution made by the third and independent sectors, sharing and using data across sectors is at an early stage of development in most Partnerships.

41. Some plans include some basic market intelligence and data on service configuration. Some have Market Facilitation Plans as appendices, or available as separate documents. A few plans commit the Partnership to developing a Market Facilitation Plan. It is essential that third and independent sector partners actively participate in the development of such plans (and in any refresh of pre-existing plans), including in the provision of locally collected data about needs, outcomes, service configuration and costs.

42. It is also important that procurement staff are involved in the development of market facilitation plans, drawing on their expertise and knowledge as well as involving them directly in changing relationships with providers. Strategic commissioning plans do not deal with procurement arrangements, implying that this will require to be dealt with elsewhere. Effective procurement of care and support services is a crucial aspect of strategic commissioning and Partnerships must plan for how this will developed and improved, using best available evidence and guidance for implementing new approaches.

43. Data on high resource individuals is used in a few plans to highlight the significant level of resource being directed to the care and treatment of a relatively small number of people. This data is being used to plan improved and

clearer routes for people through the local health and social care system, and potentially for the redirection of resources.

44. A brief analysis of deprivation in the Partnership's population is a particular feature of some plans. Deprivation constitutes a serious issue for many parts of Scotland. Poverty and deprivation can have a devastating effect on health and well-being, none more starkly represented than in death rates in affluent areas compared to those in areas of deprivation, where people can die 15 years earlier due their economic and social circumstances. Deprivation and its impact needs to be part of the work on tackling inequalities, and should be more prominent in plans.

45. A few plans briefly explore equalities issues, describe the diversity of their populations, and highlight some of the difficulties equalities groups may experience in accessing and using health and social care services. A number of plans include equality impact assessments and outline the work the Partnership is doing to develop and publish equality outcomes, which the Partnership considers will enable it to better perform the equality duty set out in the Equality Act 2010, and accompanying regulations.

46. Having published their equality outcomes, Partnerships are required to publish reports on progress on mainstreaming the equality duty. These duties should be considered during the development of the strategic commissioning plan. All Partnerships must also carry out an Equality Impact Assessment when preparing their strategic commissioning plan to ensure they are meeting their statutory obligations.

Strategic priorities

47. All plans identify strategic priorities and many identify commissioning intentions for delivering on these priorities. Where commissioning intentions and action plans are not contained in the plan, local additional work is underway or completed.

48. Many plans map strategic priorities onto national outcomes for health and wellbeing, and indeed a few Partnerships have simply adopted the national outcomes as their strategic priorities and outlined what they intend to do to deliver on these.

49. A number of broadly consistent strategic priorities have been identified by Partnerships, partly as these relate closely to the nine national outcomes. Strengthening and working in partnership with local communities, reducing avoidable admissions to hospital, support for carers, prevention and early intervention, promoting healthy lifestyles, promoting self-management and independence, developing primary care and community responses, delivering integrated care models and single points of entry to services are frequently identified as strategic priorities.

50. Optimising efficiency and effectiveness, and achieving best value are also commonly identified as strategic priorities, as is valuing and developing the

workforce. Delivering personalised care and support alongside giving people more choice and control features as a priority in a number of plans.

51. Tackling health inequality together with the wider equality agenda and adopting a human rights approach is explored and identified as a strategic priority in almost all plans. This needs further development in some plans in order to move beyond identifying the issues to what action will be taken, often acting in collaboration with others, such as community planning partners.

52. Improving mental health and well-being is identified a strategic priority in a small number of plans, and is recognised as an issue in a number of others.

53. Establishing health and social care systems that keep people safe from harm, usually linked to protecting vulnerable people or wider public protection activity, was a strategic priority in a number of plans. Dignity at end of life and improved palliative care was also prioritised in a few plans.

54. Where Partnerships have children's services and criminal justice social work services delegated, specific strategic priorities relating to these services are included, such as giving children and young people the best possible start in life and reducing reoffending. Many strategic priorities are applicable to all sections of the population.

Financial planning

55. Robust financial planning to support strategic commissioning plans is essential. Plans contained varying levels of financial information ranging from the overall estimated sum available across the Partnership to details of indicative allocations for each service delegated.

56. Partnerships are required to publish an Annual Financial Statement on resources that it plans to spend in implementing the strategic commissioning plan. This is a summary of the financial plan that underpins the strategic commissioning plan. To assist with the production of Annual Financial Statements in future years, the Scottish Government has published an advice note on the scope of these and what they should contain. We will also work with COSLA to produce a suggested pro-forma that will be issued in late Autumn of 2016.

57. We recognise that reporting financial information in the way expected has been a challenge for Partnerships (and Heath Boards and Local Authorities) and that approximations may need to be made during initial planning and reporting cycles, while information systems are developed and bedded in.

58. The allocation of resources to improve outcomes is a key task of Partnerships, particularly in view of the key challenges of increasing demand and constrained resources. How sustainability will be achieved was generally not well detailed in plans although many referred to the need to develop sustainable services and that new, affordable models of care are needed that better meet people's outcomes.

59. The financial impact of re-modelling services is not considered in many plans nor is the method made clear for how decisions will be made about the allocation of resources in terms of investment and disinvestment to achieve identified strategic priorities. Such decisions must be based on the basis of clear criteria, a robust process and application of relevant and focused information, and must take account of the Partnership's duty to achieve best value.

60. This has been challenging for Partnerships to do ahead of finalising budgets and is an area for development across plans. To assist Partnerships with work required on prioritisation, the Scottish Government has published an advice note on the key characteristics that should be incorporated in this process.

61. The process for agreeing the initial allocations from Health Boards and Local Authorities and the associated due diligence was set out in Integration Schemes and supported by statutory guidance. Nevertheless, the process has been difficult and protracted in many partnerships and this has had an impact on financial planning.

62. One area requiring specific attention is the financial planning for the sum set aside for hospital services. It is evident from strategic commissioning plans that many partnerships haven't been provided with sufficient information on their population's use of hospital services to incorporate hospital capacity in their plans. This has been reinforced by the responses to recent surveys of Partnerships, where only thirteen were able to provide a figure for the bed capacity used by their populations.

63. The Scottish Government is working with Health Board and Local Authority Directors of Finance and IJB Chief Finance officers to draft guidance on good practice for budget setting, so that the processes will be better aligned for 2017/18, with the intention to move to a position of providing as much certainty as possible over a three year period.

64. Statutory guidance stipulates that budget setting for year 2 onwards should be a process based on negotiation about the level of funding, performance and associated risks, rather than a roll forward of individual service budgets used for the initial allocations. Together with early engagement between partners in looking forward to 2017/18, we expect that these developments will allow the process for agreeing future budgets to be more straightforward and to provide a framework for improved financial planning.

Outcomes

65. A number of plans refer explicitly to the integration principles set out in the Act and all include detailed references to achieving the national health and well-being outcomes, and to locally determined outcomes. Helpful charts and graphics have been used in some plans to make links between national health and well-being outcomes, strategic priorities and commissioning intentions.

66. The whole purpose of integrating adult health and social care services is to improve health and wellbeing outcomes for people in Scotland. As referred to

above, delivering personalised care and support was identified as a strategic priority of many plans.

67. Self-directed Support (SDS) is identified in some plans as an approach that supports the delivery of joined up, flexible, person-centred care and support with the express intention of providing people with greater choice and more control over how they live their lives. This was occasionally linked to, for example, people being able to choose to die at home, as well as a wider range of options for meeting personal outcomes.

68. Preventative, early intervention and self-management approaches are identified as important to achieving better outcomes in many plans. As is supporting people and communities to take greater responsibility for their own outcomes, reducing the need for services. Well targeted anticipatory care planning is also highlighted as an area for development in a number of plans.

69. In some plans, outcomes are identified at a wholly strategic level with little attention paid to personal outcomes, and how these are linked to and drive service and strategic level outcomes.

Localities

70. As expected, locality arrangements vary significantly across the country and some are at early stages of development. Some locality arrangements are focused on both an organisational unit for operational delivery and for locality planning, while others are entirely focused on one or the other with the intention of developing localities further over time.

"... **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

71. The statutory guidance on localities states that localities provide one route, under integration to ensure strong community, clinical and professional leadership of strategic commissioning of services. Essentially, it is the route whereby local communities and local clinicians and professionals can play an active role in service planning for their local population, in order to improve outcomes. This approach fits well with community empowerment. It ensures that people who live and work in a locality have a forum to inform redesign and improvement in that locality.

72. All plans (except two, where this is detailed separately) include details of the localities proposed or in place in each of the Partnerships. The number of localities in each Partnership ranges from two to nine. The size of localities ranges from a large urban population of 217,422 to a small island population of just 1,264.

73. In all, 128 localities have been established in Partnerships to take forward work on a local basis. A table of localities mapped to Partnerships and Health Boards is appended at Annex 2.

74. Many plans highlight the need to shift to more preventive approaches and to build community capacity. Working closely with local communities and building on their assets is also widely recognised, especially in locality planning and delivery. In this regard, many Partnerships have used positive learning and evidence from tests of change undertaken at locality levels to inform broader system changes prioritised within their plans.

75. Many localities are based on existing Community Planning Partnership areas to retain or develop a strong connection to community planning. This will ensure a common approach between key public service agencies and optimise opportunities for joint work on shared priorities.

76. A small number are based on long-standing locality arrangements between health and social care, which have been refreshed and enhanced to meet the requirements of the Act. Most have taken clear account of emerging GP cluster arrangements.

77. Some Partnerships have begun to develop locality plans and a few strategic commissioning plans include initial or outline priorities for localities, in addition to the strategic priorities for the Partnership. Many are developing locality profiles, using partnership wide data and disaggregating this to the locality area. This will be an important aspect of equipping localities to plan for their populations. Similarly, disaggregation of budgets to locality levels will be crucial for place based planning and is not yet complete in most Partnerships.

78. A number of Partnerships have established locality managers' posts, which have the combined responsibility for managing service delivery and locality planning in their patch. Some Partnerships have established locality leads who will work closely with GP locality leads, and others to establish and lead locality planning.

79. Further work is required across Partnerships to fully develop their locality arrangements and maximise the potential of the structured involvement of communities, and local professionals in planning and decision making. Overtime, it is intended that proportionate resources, responsibility and accountability will shift to localities. A level of infrastructure is required to support these arrangements and make them operate effectively, this is at early stages in some Partnerships.

Workforce and multi-disciplinary teams

80. Many Partnerships have either created or are planning the development of multi-disciplinary teams, flowing from priorities identified in strategic commissioning plans. These are intended to bring different professionals across health and social care together to make sure people receive seamless care or support from the right professional. Some of these teams will include input from the third sector.

81. Hubs have been established or are planned in many Partnerships, often focused around GP or primary care practices. These are designed to better meet people's changing and diverse needs, including improved understanding and use of community based supports. The development of multi-disciplinary teams will be a crucial aspect of transforming primary care services in integrated settings, which envisages GPs becoming expert-generalists in complex care and focusing more on quality and leadership.

82. The Scottish Government recently published a National Clinical Strategy for Scotland. It wholly supports the aims and intended outcomes of integration. The strategy sets out the intention to build capacity in primary care, with a broader mix of professionals involved, who will be working collaboratively in clusters and working with social care and the third sector.

83. In secondary care, the strategy is to consider the potential for developing fewer inpatient sites, that will provide more highly specialised services, linked to local hospitals. The Chief Medical Officer's annual report for 2014-15 introduced the adoption of an approach called "realistic medicine" in order to reduce harm and over treatment, and to ensure that treatment is tailored to patient preferences.

"Doctors generally choose less treatment for themselves than they provide for their patients."

Chief Medical Officer's Annual Report 2014-15

84. Some plans contain a high level summary of workforce issues and some indicate wider work is being undertaken on developing an integrated workforce strategy. A few contain outline workforce strategies. It will be imperative that these integrated workforce plans carefully consider and seek to address the panoply of issues for staff in health and social care services, including in the third and independent sectors.

85. Partnerships fully recognise the health and social care workforce as a major asset. Achieving the right skill mix, and having the right staff in the right places is a priority to better meet people's needs and achieve sustainability. Some highlight concern about the age profile of the workforce, while a few note recruitment and retention issues affecting a range of staff from GPs to social care assistants. Growing the social care workforce is jointly on the agenda with some CPPs.

86. Many plans highlight that organisational development resources have been deployed to support and bring different parts of the health and social care workforce together, as well as to support new senior management teams and IJBs. The development of cross sector or intra-professional integrated education and training opportunities is at an early stage in most Partnerships. Leadership development programmes are in place in some Partnerships.

Primary care

87. Many plans emphasise the key role of primary care services in health and social care integration. Some explore the need to develop stronger and more innovative links with primary care, where most patient contact takes place.

88. Some plans identify how the Partnership will support the development of improved primary care services, including improving links with the acute sector, introducing step up and step down beds as alternatives to hospital admission, developing better community links and improving access to a wide range of community services and supports.

89. A few plans also refer to the potential of promoting and enhancing primary care involvement in tackling inequalities.

90. Linking primary care to social care and community services features in a number of plans and as described above many Partnerships are building service hubs around GP or primary care practices. Similarly, improved working and communication between primary and secondary care is also covered in a number of plans.

91. All plans identify GPs and primary care as a key component of local service delivery and locality planning.

Links to acute care and cross partnership working

92. A number of plans clearly outline the relationship between the Partnership and acute care and identify the Partnerships' statutory role in strategic planning for emergency care services delivered in acute hospitals. In some plans, responsibility for planning for the emergency care pathway is low key and not well covered.

93. A number of Partnerships have developed close working relationship with the acute sector, and with neighbouring Partnerships where they share a common boundary within a Health Board. This has assisted with winter planning, which increasingly is described by Partnerships as year round, whole system capacity planning.

94. Many plans outline the arrangements that have been put in place to support services that cannot be easily disaggregated to individual Partnerships, within a Health Board area. To this end, what are variously described as lead partnership or more regularly as hosting arrangements have been established across a number of neighbouring partnerships. This has led to some close working between Chief Officers and their senior teams to address issues of common concern, including linking with acute care senior staff, and the development of new and sustainable models of care.

95. While there may be opportunities for efficiency in some instances through establishing hosting arrangements, it is important that hosting is not used in multi –partnership Health Board areas to maintain existing NHS arrangements where

there is scope through the Partnerships for greater local ownership and improvement.

96. Partnerships are required to have regard to one another's strategic commissioning plans, across neighbouring partnerships. Some plans explicitly mention this and what they have considered in this regard, but most do not.

97. A few plans provide good coverage of the need to improve the interface between communities and hospital, to focus hospital care on those who need it most and can gain most from it. Some plans set out clearly that reductions in bed days lost to delayed discharge and reductions in Accident and Emergency presentations and emergency admissions are needed. What this might imply in terms of disinvestment and reinvestment is not often as well covered.

98. Preventing unnecessary hospital admissions and expediting timely discharge from hospital is a priority of many Partnerships, as outlined above in the strategic priorities section. A decisive move to prevention and early intervention, along with investment in intermediate care are key aspects of the wider approach required to tackling these issues. This was emphasised in many plans but frequently it was not costed.

Housing

99. The housing sector is represented on all SPGs and on some Integration Joint Boards and is or will be involved in locality planning, as this develops.

100. Housing is recognised in most plans as a key component of effectively shifting the balance of care from institutional care to community based services and supports. It also seen as providing and promoting preventive approaches.

101. Some plans contained information on the local Housing Plan and its fit with health and social care delivery. 17 of the 31 plans contain a housing contribution statement. The housing contribution is strongest where the statement is not confined to an appendix in the plan, but where housing and its contribution are also reflected throughout the plan.

102. A lack of affordable housing is noted as a concern in a number of plans as well as the implications this has for local populations and for staff working in health and social care. The need to develop housing options as an alternative to residential care is also mentioned in a few plans. There is an opportunity to deepen and broaden the contribution of housing in future iterations of strategic commissioning plans.

Performance reporting

103. Each Partnership is required to publish an annual performance report setting out progress against the statutory outcomes for health and wellbeing, using the integrated budget. Annual performance reports will report on a core set of indicators, as well as additional measures agreed locally.

104. All partnerships have developed a performance framework that includes national and local outcomes and measures. Where appropriate, performance frameworks include children's outcomes and criminal justice outcomes, as well as the National Health and Wellbeing Outcomes.

105. Many included the framework in their strategic commissioning plans. Performance reports will be provided on a regular and routine basis to Integration Authorities, as well as to senior management teams, as part of on-going performance management responsibilities, in addition to annual reporting.

106. Although not a requirement, Partnerships that were established prior to April 2016 have begun to publish their performance reports. These outline what has been achieved by the Partnerships and include a mix of national and local measures.

107. Performance reports will provide a means for shared learning across Partnerships, although we fully recognise that what works well in one area may not wholly work in others, due to a number of factors, including how services are configured. That said, there are a number of consistent themes and priorities for Partnerships and there are opportunities for collaboration and learning, which will help inform decisions about transforming services while being mindful of the local circumstances and context of individual Partnerships.

Annex 1

Partnership	Children's Health Services	Children's Social Care Services	Criminal Justice Social Work	All Acute Services
East Ayrshire	Delegated	Delegated	Delegated	Not delegated
North Ayrshire	Delegated	Delegated	Delegated	Not delegated
South Ayrshire	Delegated	Delegated	Delegated	Not delegated
Scottish Borders	Not delegated	Not delegated	Not delegated	Not delegated
Dumfries & Galloway	Delegated	Not delegated	Not delegated	Delegated
Fife	Delegated	Not delegated	Not delegated	Not delegated
Clackmannanshire &Stirling	Not delegated	Not delegated	Not delegated	Not delegated
Falkirk	Not delegated	Not delegated	Not delegated	Not delegated
Aberdeen City	Not delegated	Not delegated	Delegated	Not delegated
Aberdeenshire	Not delegated	Not delegated	Delegated	Not delegated
Moray	Not delegated	Not delegated	Not delegated	Not delegated
West Dunbartonshire	Delegated	Delegated	Delegated	Not delegated
East Dunbartonshire	Delegated	Delegated	Delegated	Not delegated
East Renfrewshire	Delegated	Delegated	Delegated	Not delegated
Glasgow City	Delegated	Delegated	Delegated	Not delegated
Inverclyde	Delegated	Delegated	Delegated	Not delegated
Renfrewshire	Delegated	Not delegated	Not delegated	Not delegated
Argyll & Bute	Delegated	Delegated	Delegated	Delegated
North Lanarkshire	Delegated	Delegated	Delegated	Not delegated
South Lanarkshire	Delegated	Not delegated	Not delegated	Not delegated
East Lothian	Delegated	Not delegated	Delegated	Not delegated
Edinburgh	Not delegated	Not delegated	Not delegated	Not delegated
Midlothian	Delegated	Not delegated	Not delegated	Not delegated
West Lothian	Not delegated	Not delegated	Not delegated	Not delegated
Orkney	Delegated	Delegated	Delegated	Not delegated
Shetland	Delegated	Not delegated	Delegated	Not delegated
Angus	Not delegated	Not delegated	Not delegated	Not delegated
Dundee City	Not delegated	Not delegated	Not delegated	Not delegated
Perth and Kinross	Not delegated	Not delegated	Not delegated	Not delegated
Eilean Siar	Delegated	Not Delegated	Delegated	Not delegated

Lead Agency	Adult Health and Social Care	Children's Health and Social Care
Highland Health and Social Care Partnership	NHS Highland	Highland Council

Annex 2

PARTNERSHIP – NHS BOARD/LOCAL AUTHORITY		**LOCALITIES**
NHS Ayrshire and Arran	East Ayrshire	Kilmarnock
		East Ayrshire - North
		East Ayrshire – South
	North Ayrshire	Arran
		Irvine
		Kilwinning
		Ganock Valley
		North Coast
	South Ayrshire	Troon & Villages
		Prestwick & Villages
		Ayr South and Coylton
		Ayr North and Former Coalfield Communities
		Maybole and North Carrick Villages
		Girvan and South Carrick Villages
NHS Borders	Scottish Borders	Berwickshire
		Cheviot
		Eildon
		Teviot & Liddesdale
		Tweeddale
NHS Dumfries and Galloway	Dumfries and Galloway	Annandale and Eskdal
		Nithsdale
		Stewarty
		Wigtownshire
NHS Fife	Fife	North East Fife
		Glenrothes
		Kirkcaldy
		Levenmouth
		Dunfermline
		South West Fife
		Cowdenbeath
NHS Forth Valley	Clackmannanshire and Stirling	Clackmannanshire
		Stirling City with the eastern villages
		Bridge of Allan and Dunblane; Rural Stirling
	Falkirk	Falkirk
		Grangemouth, Bo'ness and Braes
		Denny, Bonnybridge, Larbert and Stenhousemuir

PARTNERSHIP - NHS BOARD/LOCAL AUTHORITY		LOCALITIES
NHS Grampian	Aberdeenshire	Banff and Buchan
		Buchan
		Formarine
		Garioch
		Marr
		Kincardine and Mearns
	Aberdeen City	Aberdeen North
		Aberdeen Central
		Aberdeen West
		Aberdeen South
	Moray	Moray East - Buckie / Cullen, Keith, Speyside Moray West - Elgin / Lossiemouth, Forres
NHS Highland	Highland	Caithness
		Sutherland
		Easter Ross
		Mid Ross
		Skye, Lochalsh and Wester Ross
		Inverness West
		Inverness East
		Lochaber
		Badenoch & Strathspey, Nairn & Ardersier
	Argyll and Bute	Lorn and the Isles
		Mid Argyll
		Kintyre
		Islay and Jura
		Bute
		Helensburgh and Lomond
NHS Greater Glasgow and Clyde	East Dunbartonshire	West of East Dunbartonshire
		East Dunbartonshire
	East Renfrewshire	Levern Valley
		Eastwood 2
		Eastwood 1
	Glasgow City	North West Glasgow
		North East Glasgow
		South Glasgow
	Inverclyde	East Inverclyde Central
		Inverclyde
		West Inverclyde
	Renfrewshire	Paisley
		West Renfrewshire
	West Dunbartonshire	Clydebank
		Alexandria and Dumbarton

PARTNERSHIP – NHS BOARD/LOCAL AUTHORITY		LOCALITIES
NHS Lanarkshire	North Lanarkshire	Airdrie
		Bellshill
		Coatbridge
		Motherwell
		North (Cumbernauld, Kilsyth and Northern Corridor)
		Wishaw
	South Lanarkshire	Hamilton
		Clydesdale
		East Kilbride
		Rutherglen and Cumbuslang
NHS Lothian	East Lothian	East - Haddington & Lammermuir, North Berwick, Dunbar & East Linton
		West - Musselburgh, Fa'side & Preston, Seton & Gosford
	Edinburgh City	North West North East South West - Pentlands, South West South East / Central
	Midlothian	East Midlothian
		West Midlothian
	West Lothian	East Lothian
		West Lothian
NHS Orkney	Orkney	East Mainland
		West Mainland
		Isles
NHS Tayside	Angus	North West Angus
		North East Angus
		South East Angus
		South West Angus
	Dundee City	Lochee
		Strathmartine
		West End
		Coldside
		Maryfield
		East End
		North East
		The Ferry
	Perth and Kinross	North Perthshire
		South Perthshire & Kinross
		Perth City

PARTNERSHIP NHS BOARD/LOCAL AUTHORITY		LOCALITIES
NHS Shetland	Shetland	North Mainland
		South Mainland
		West Mainland
		Central Mainland
		North Isles
		Whalsay & Skerries
		Lerwick & Bressay
NHS Western Isles	Nan Eilean Siar	Barra & Vatersay
		The Uists and Benbecula
		Harris
		Rural Lewis
		Stornoway & Broadbay