The Highland Council/ NHS Highland

23rd June 2011

Agenda Item	
Report No	

Planning for Integration- Development of a Lead Agency Model in Highland for Care Services

Joint Report by Chief Executive, The Highland Council & Chief Executive, NHS Highland

1 Summary: The Highland Council and NHS Highland Board have agreed to develop a Lead Agency Model for the delivery of aspects of services to children and families and adults. This report sets out further detail behind these models and a proposed Governance framework which includes some guidance as to how commissioning would be developed.

1.1 **Members and NHS Directors are asked to:**

- Agree the development of an Integrated Children's Service with the Highland Council as the Lead Agency
- Agree the development of an Integrated Adult Service with NHS Highland as the Lead Agency
- Agree the proposed model of Governance
- Agree the approach to Commissioning
- Confirm that the outcome agreements and commissioning documentation will be the subject of further reports to the Board and Council
- Continue to support the programme of implementation

2. Background:

2.1 Previous reports to The Highland Council and Highland Health Board have outlined the proposal to integrate services to children and families as well as adults with the key aim of improving outcomes.

2.2 At the last joint meeting in May, agreement was reached to progress the Lead Agency Model as the preferred model, the case for change having been made. These papers can be accessed at
http://www.highland.gov.uk/yourcouncil/committees/thehighlandcouncil/2011-05-12a-hcnhs-ag.htm

2.3 Health Board and Elected members will recall the decisions at that meeting in May, namely to –

- Agree that the case for change is evidenced.
- Confirm that the Lead Agency Model is the preferred model.
- Agree that work continues on defining the scope of the services to be integrated and this will be presented to the joint Highland Council /Health Board meeting in June.
- Agree that a model of Governance will be presented to the joint Highland Council/Health Board meeting in June.
- Agree that at present, recognising there is further work to be done, that there are no identified impediments to developing this model in terms of legal, financial or HR issues and that work on the details will be progressed.
- Confirm that the outcome agreements and commissioning documentation will be the subject of further reports to the Board and Council.
- Continue to support the Programme of implementation.
- Acknowledge that there may be changes ahead that we are currently unaware of but may influence progress and implementation.

2.4 Work was to continue on defining the scope of the services to be integrated as well as a model of governance and this report outlines that work as requested.

3. Lead Agency Models:

3.1 The proposed model involves **single Lead Agency** arrangements, leaving both organisations jointly accountable for determining outcomes and the resources to be committed. The Lead Agency would assume responsibility for all aspects of business delivery, strategy, internal governance and operational delivery or commissioning of services and would be fully accountable for the delivery of agreed outcomes. This will include training requirements to ensure quality services are maintained.

3.2 The Lead Agency arrangements as detailed in previous reports are supported by a comprehensive form of pooled budgets in which the total resources for the care of a defined population are integrated in one organisation to either commission and/or provide the care for that population. (See section 4 Commissioning)

3.3 The Lead Agency arrangement achieves the same degree of integration of resources as pooling of resources but it has the attraction of using existing transactional relationships between Partners. This makes the financial governance and performance management of the integrated resource more straightforward than is the case with examples of limited pooling or where a separate organisation is charged with overseeing the pooled resource.

3.4 The Lead Agency service models for Children and Adults have been scoped with involvement from the Programme Board and the Staff Partnership Forum as well as information gathered at the staff workshops and meetings.

4. Commissioning:

4.1 Within the Highland context, the model of integration is the Lead Agency. The skills and behaviours required to progress this model are described as "commissioning".

4.2 Commissioning is not, therefore, simply a process of large scale procurement, or the way in which we buy that which we do not provide ourselves. Commissioning considers all of the resource available to us and all of the options for service delivery. As organisations and communities we need to develop the ability to analyse need, plan and review capacity plans and to understand costs, including the opportunity costs of doing one thing rather than another.

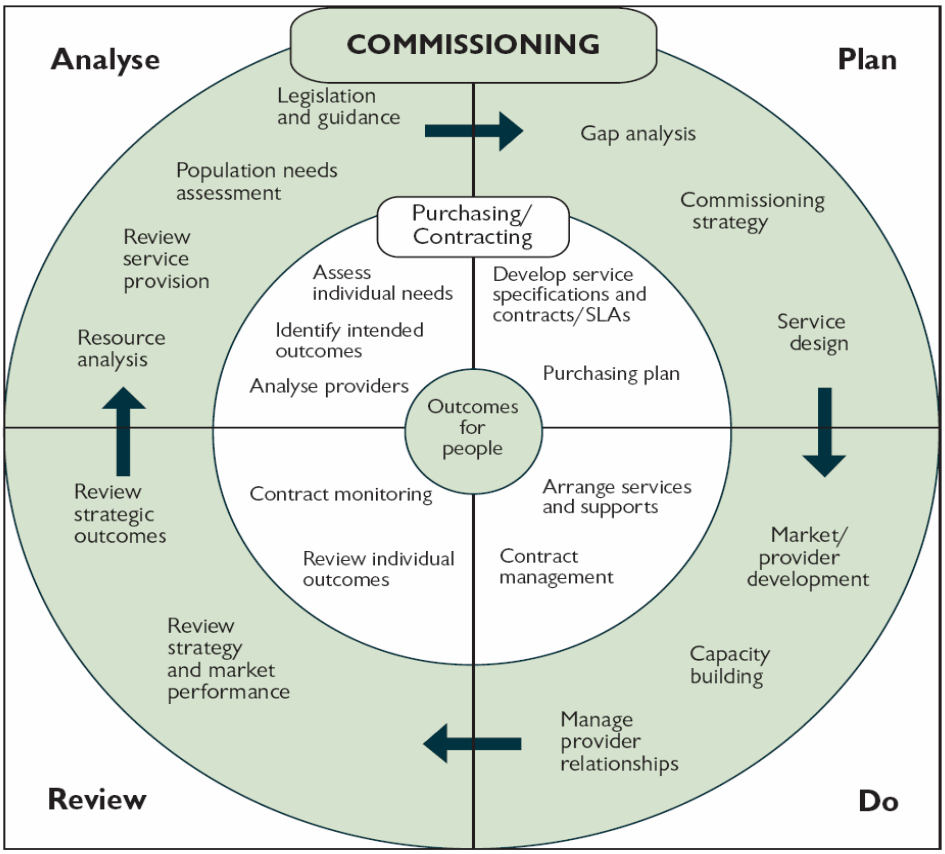
4.3 Commissioning is defined by the NHS improvement service as "the process of securing and managing appropriate healthcare services for relevant populations at value for money for taxpayers". More explicitly, SWIA defines it as "the term used for all the activities involved in assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place".

4.4 It is clear from these descriptions that Commissioning for improved outcomes is a complex multi-faceted process involving a wide range of skill-sets; moreover, this is made more complex where the outcomes for the population of interest - e.g. Adult Services, Children's Services, are dependent on care services accessed from a wide range of interdependent providers commissioned separately.

4.5 In these cases, evidence suggests that partnerships between commissioners designed to integrate the commissioning process can result in more effective and efficient commissioning. One of the key benefits of this integration is that it brings all of the service costs within a single commissioning process and promotes greater efficiency in allocating and utilising the resource. Figure 1 illustrates the cyclical nature of the commissioning process.

4.6 Regardless of structural configurations of services, delivering the public health function will require close working between several agencies as well as the voluntary sector. The commissioning process needs to ensure that the fully integrated service that the Lead Agency Model supports and enables takes account of these boundaries and explicitly sets out roles and responsibilities for all those involved in delivering the integrated service, not just those directly employed by the provider Lead Agency.

The Commissioning cycle



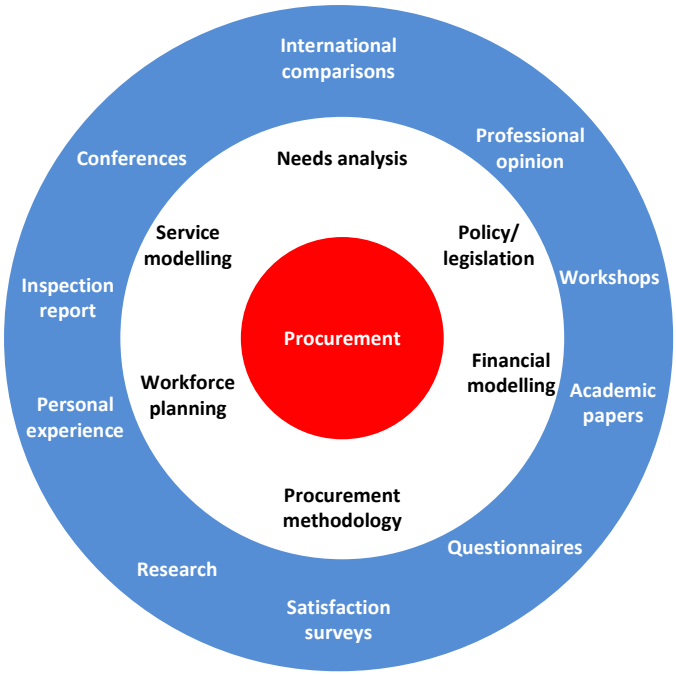
4.6 This model, based on that developed by the Institute of Public Care describes four categories of activity in the Commissioning cycle: *analyse, plan, do* and *review.*

4.7 Work continues with the Scottish Government to refine guidance on commissioning but it is recommended that in developing the commissioning documentation to support the development of our integrated services that this process is adopted.

4.8 The Highland Partnership would expect the following to be engaged in the process:

- Service users, carers, advocacy groups
- Service providers from all sectors; in-house, private, independent sectors
- Staff responsible for agreeing placements
- Service planners, policy officers – including public health
- Regulators
- Finance and contracting staff

4.9 A number of forums and approaches will be required to ensure effectiveness and the following schematic illustrates this:



The outer circle shows that information; advice and opinion will be collected from a wide variety of sources.
The second circle shows the functions of the formal commissioning group.
The inner circle indicates that as a final stage of commissioning a formal procurement process will be required.

5. Children's Services:

5.1 Planning for Integration is predicated on Highland Education, Health, Social Work developing an integrated approach to the commissioning of services and pooling budgets to deliver strategically commissioned services. This will require a more extensive approach to the planning of services than undertaken to date in Highland and is a once in a lifetime opportunity to reconfigure services and address some of the acknowledged challenges of delivering children's services across Highland.

5.2 In addition, it will allow a greater focus on the delivery of front line services, the opportunity to support professionals to deliver a service to children and young people within the scope of their expertise and will allow for a reduction in management costs to better support the delivery of front line care.

5.3 Furthermore, third sector partners may also be involved in the commissioning process adding further potential for improved service alignment and improved journeys of care for children and young people.

5.4 The Lead Agency Model for Children's Services has been informed by consideration of the literature on integrating Children's Services and, in addition, the external drivers that inform the scope of health elements in the Lead Agency Model in Highland.

5.5 These principles are considered alongside views of users, carers and staff as previously reported.

5.6 **Learning from the literature** The scope for Children's Services has been informed by emerging literature on the integration of health and social care and the related benefits that can be achieved by this approach and in particular the distinction between horizontal and vertical integration.

5.7 Horizontal integration occurs when services come together to deliver care at a similar level. There is an emerging knowledge base that suggests that there are a range of benefits for both service users and staff that can come from a greater level of integration and the use of joint commissioning and pooled budgets. Table 1 details the range of professionals delivering services at a similar level and where these are in scope for the Lead Agency Model.

5.8 Vertical integration occurs when services come together to deliver care at different levels. This is recognised to be more complex and therefore requires more consideration of the journeys of care. For example, vertical integration occurs at the interface of a Health Visitor and a Social Worker discussing a child in need of protection or a child within universal services developing an acute or chronic health condition that may or may not be time limited.

5.9 **Proposed Scope** Table 1 details the scope of service constituting an Integrated Children's Service delivered by The Highland Council on behalf of the Partnership and accountable to the Health Board and The Highland Council.

Table 1

Public Health Nurses/Health Visitors (Early Years)*
Surestart, early education, wraparound childcare

Public Heath Nurses/School Nurses*
Children's Service Workers
Health Promoting Schools

Integrated Service Coordinators
Integrated Service Officers

Early Years Workers
Pre school visiting services

Primary Mental Health Workers
Educational Psychology
Specialist Additional Support for Learning Education Services
Youth Action Teams

Physiotherapists**

Speech and Language Therapists**
Occupational Therapists NHS***
Occupational Therapists Highland Council***
Dieticians**

Community Learning Disability Nursing for Children***
Community Children's Nurses

NHS and Council services to Looked After Children including Through Care and After Care
NHS and Council Child Protection Advisors and Development and Training Team
Children and Families Social Work Services

Residential Care

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*Consideration of interfaces over immunisation and population public health services required
** Redesign of cradle to grave services within NHS Highland required
*** Redesign of cradle to grave services across NHS Highland and Highland Council required

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5.10 This is not considered to be a definitive list at this stage. Discussions to date indicate that approximately 230 staff in NHS Highland are currently directly associated with these functions and could be expected to carry out these functions in Highland Council from 1 April 2012 if the Lead Agency Model is approved.

5.11 Even an initial scan of this list presents a range of opportunities to design more integrated universal and additional services and journeys of care that are age and stage appropriate within a Lead Agency Model. However some staff have raised concerns that Health Visitors are included within the integrated service for children, but that community midwifery is not. It is intended that the merits of inclusion of community midwifery takes place once the new arrangements are established.

5.12 The principle external driver influencing the scope of health services included in the Lead Agency Model is the need to ensure a viable and sustainable acute/in patient child health service at Raigmore Hospital.

5.13 Changes to medical training, (Facing the Future: Review of Paediatric Services, Royal College of Paediatrics and Child Health 2011) has had a significant impact for recruiting to consultant training in Scotland and has meant that, for the last two years, Highland has struggled to recruit to the paediatric middle grade rota. In addition, the numbers of consultants in training and on schedule to complete their paediatric training are falling across the UK to the point where a discussion has started as to whether there is a need to reconfigure acute/in patient paediatric units across Scotland.

5.14 Raigmore Hospital plays a pivotal role in the provision of medical and community child health services for the population of Highland. The nearest inpatient units other than Raigmore are Elgin/Aberdeen and Stirling. In addition, Raigmore serves as a hub for the rural general hospitals and Broadford Community Hospital. All these units may encounter children with high dependency needs on a monthly basis and all are involved

with the retrieval of very sick children to the paediatric intensive care units in Edinburgh and Glasgow. In addition, medical colleagues provide an invaluable service for out of hours GP services.

5.15 In order to respond to these challenges the development of a Combined Child Health Service is proposed. It will include acute and community paediatrics, specialist nurses and Tier 3 Child and Adolescent Mental Health Services.

5.16 The focus of the combined Child Health Service will be on workforce and the development of journeys of care across acute, emergency/out of hours and surgical care, with appropriate links to regional tertiary centres. This is to ensure a sustainable acute/inpatient Child Health Service on the Raigmore site with networked arrangements with remote sites across Highland and access to tertiary centres outwith Highland for acute care as required. This approach will address many of the recommendations in Changing for the Better – A Review of Child Health Services NHS Highland, undertaken in 2009.

5.17 While NHS Highland will continue to employ and manage these staff groups Community Child Health Services and Tier 3 Child and Adolescent Mental Health Services (CAMHs) will be jointly commissioned by the Highland Partnership to support the delivery of an integrated Children's Service. The development of the combined child health service must therefore be predicated on pathways and interface with the integrated service.

5.18 Consideration has been given to whether dental services and oral health promotion services for children and young people should also be in the scope of the Lead Agency Model. On review, disaggregating the children's elements from the Community Dental Service and related funding is not a viable proposition. However the service is keen to continue to be an integral part of the delivery of services for children and young people. It is proposed that a similar approach be taken to the commissioning of paediatric services with the delivery of oral health promotion in particular being within the commissioning scope of the Lead Agency Model.

5.19 In addition to the scope outlined above, there will be ongoing support from the Directorate of Public Health and Health Improvement who will continue to provide specialist advice and consultation with regard to health protection, (immunisations/blood borne viruses) health improvement (specialist topic advice on sexual health/substance misuse/tobacco/healthy weight/exercise and training) and service improvement (commissioning/service standards/performance indicators/quality measures). These elements of service will also need to fall into the commissioning scope of the Lead Agency Model.

5.20 **Legal matters** - Functions whose performance involves surgery, radiotherapy, termination of pregnancies, endoscopy, the use of class 4 laser treatments and other treatments of an invasive nature or the provision of emergency ambulances cannot be transferred from the NHS and therefore are obviously out of scope. An exercise also requires to be carried out to ensure all those functions listed in table 1 are included in the list at schedule 2 of the regulations. This is a cross checking exercise and will provide added assurance.

5.21 In terms of a timeframe it is, imperative that a legal agreement be put in place before such time as the arrangements are to take effect. This will, therefore, require to be in place by April 2012.

5.22 A significant number of Public Health Nursing staff remain concerned about their ability to fulfil their role in delivering the vital universal health service and have written, stating these concerns, to Health Board and Elected Members. As stated previously this model ensures that accountability remains with the NHS, and the Council will have to demonstrate that they are meeting the outcomes in the universal health service. This will be clearly detailed in the commissioning documentation. The monitoring and performance framework will contain indicators that measure the universal health service and leaders will be held to account.

5.23 It is also important to re-affirm the Highland practice model developed through the GIRFEC pathfinder, which emphasises the role and value of universal health and education services. The Lead Agency Model is built around the universal services, reflects the child's development and role of services at different ages and stages, and is intended to both enhance the Health Visitor role and functions, and also better support the transition process as children enter early and primary education.

5.24 Indeed, the Lead Agency Model is intended to ensure greater integration across all services for children, and to better support the various transition points in a child's life, including post-school. Accordingly, it is intended that a further stage of development of the model may involve the full integration of all education services.

6. Adult Services:

6.1 Effective partnership working between the NHS and local authorities is widely recognised as a prerequisite for achieving good health and social care outcomes. For the last decade in Scotland, the focus has been on achieving better outcomes through partnership working, service redesign and the development of integrated clinical and care pathways (see the Community Care and Health (Scotland) Act 2002; the Partnership for Care (2003) White Paper; Better Together; establishment of CHPs via the NHS Reform (Scotland) Act 2004).

6.2 In the early years of joint working between community health and social care services, and particularly under the auspices of Joint Future, there was a strong focus on improving processes, on the assumption that good partnership working arrangements would lead to good outcomes. Integrated structures, HR arrangements, financial frameworks and assessment procedures were all seen as critical to enabling good integrated working across statutory organisations.

6.3 However, it was also recognised that changes to systems, processes and structures alone cannot deliver improvements – the quality of leadership, vision, communication and behaviours in partnerships are all critical factors.

6.4 The recent work to develop and test an Integrated Resource Framework (IRF) for health and social care services brings these developments to the current day. The IRF responds to the observation made by many of those working in health and social care that they could deliver better outcomes for people if resources could be moved around

the health and social care system more effectively to support shifts in the balance of care. This analysis has underpinned the evolution of a shared vision and Planning for Integration.

6.5 A further argument for integration lies in the inter-dependence of service providers' respective and shared objectives. An obvious example of this is the shared responsibility of health and social care for tackling delayed discharge; health improvement, with responsibilities across health, social care, environmental health and housing provides a further example.

6.6 It is also important to note that integration of patient-level commissioning of services is an increasingly important issue, particularly for local authorities, and should also to be taken into consideration. Patient-level commissioning is often seen as implying fragmentation of commissioning; however Kodner *(Kodner, D et al. Integrated care: meaning, logic, applications, and implications – a discussion paper. International Journal of Integrated Care – 2, 2002)* reports, from studies undertaken in Austria, Germany, the Netherlands and the US, that it can encourage more flexible service use and greater consumer satisfaction and quality – without harming inherent efficiency and effectiveness.

6.7 Understanding patient-level activity and cost is critical to the developing Self Directed Support agenda. Without this information for health and social care, allocation of funding to individuals, and consequential planning for investment and disinvestment, can be little more than guesswork.

6.8 The role of the third sector in terms of service provision also needs to be thoroughly explored, especially in the context of new types of provider organisations such as co-operatives, community businesses and co-production models. This is something which has been actively progressed through the development of the Change Fund application – Reshaping Care for Older People.

6.9 The following services are proposed as necessary for integration if outcomes in Adult Community Care are to be improved and efficiencies maximised:

Social Work Community Care Service
Adult Occupational Therapy Services - NHS and Council
Home Care Services
Community Alarm Service (Telecare)
Community Nursing Service
Community Allied Health Professionals Services
Community Learning Disability Service
Day Care Services
Step up/down Services
Respite Care
Community Mental Health Service
Substance Misuse Services – THC and NHSH
Institutional provision - care homes, community hospitals, district general services
Community development and support for volunteering
Education support for adults with learning disability

6.10 Discussions to date, indicate that approximately 1400 staff in the Highland Council are currently directly associated with these functions and could be expected to carry out these functions in NHS Highland from 1 April 2012 if the Lead Agency Model is approved. This is not necessarily a definitive list and further work is ongoing.

6.11 Some services such as independent practitioners are also essential to effective integration of services but due to contractor status will require to be considered in a different way. As in the case of the combined child health service, it will be essential to ensure that patient/client flows across the integrated service and the independent contractors improve to the benefit of users and carers. There is also a wide range of private sector providers - residential, respite, day care etc - who will play a valuable role in the future. Many have already risen to the challenge of the need to change if we are to successfully shift the balance of care and care for more people for longer in their own homes.

6.12 Work will continue to consider those staff that provide or support services, spanning children and adult groups and similar discussions are being held about the management and governance arrangements for Criminal Justice Services.

6.13 Some functions however remain bound in legislation and cannot be transferred in the same way to the Health Board. These relate to the appointment of Mental Health Officers Local Authorities' supervisory functions pursuant to the Adults With Incapacity (Scotland) Act 2000), the Adult Support and Protection (Scotland) Act 2007 and potentially other legislation. However there is provision in the legislation for the NHS Board to purchase some of these functions only i.e. Mental Health Officers.

6.14 Work continues with legal colleagues locally and in the Scottish Government to ensure appropriate arrangements are made and the Highland Adult Support and Protection Committee have also been asked to consider this issue.
It is essential that these discussions inform the current redrafting of MH legislation. It is anticipated that regulations may need to be introduced to ensure the transfer of Social Work staff to the NHS as all these staff may be required to assume the role of Council Officer under the Adult Support and Protection (Scotland) Act 2007.

6.15 An exercise also requires to be carried out to ensure all functions listed in the schematic above are named in section 3 of the Regulations and that the Partnership is committed to more effective use of resources.

7. Support services

7.1 It is widely recognised that in order to meet the needs of our population we require a wide range of skills and expertise. However some of that expertise is less visible in relation to front line delivery but nonetheless essential to the effective running of these services. In scoping out at local level therefore consideration must be given to -

1. Business support –
    - Administrative and clerical support - frontline services need an element of support to function effectively. It is delivered currently in a number of ways e.g. pooled resource supporting a number of teams or members of staff, individual personal support. In principle, existing levels of support

should not be compromised in development of the integrated models and such levels must be included in the detailed local plans.

- Contracting – this is a significant skill discharged by a number of individuals and very necessary as part of the commissioning process and working across sectors. This service must be scoped to ensure future procurement remains effective and efficient.

2. Corporate Services – this term encompasses a number of essential services that underpin everyday delivery to the Highland population. It includes Human Resources, Information Management and Technology, Finance, Facilities, Public Health. This is not intended to be a definitive list but rather an illustration of the services that are likely to be impacted upon as we develop the integrated models.

3. Management – the development of these models will enable a review of current management structures. The duplication in this area has been highlighted in previous reports and this is an opportunity to ensure appropriate levels of management support whilst reducing bureaucracy and streamlining accountability and decision making. It is envisaged that local management will develop around Associated School Groups for Children's Services and the evolving district model for Adults' Services. As a matter of principle management revisions will identify what is working well to ensure quality is not compromised, the need for Professional Leadership and the need to interface with other services and organisations.

8. Human Resource Issues

8.1 As indicated in the previous joint report, the Lead Agency Model raises a number of significant HR issues, and these are clearly of interest and concern to staff of both organisations.

8.2 The previous report indicated that the Staff Partnership Forum and its HR subgroup was developing an employment model that fulfilled the following criteria –
• Is consistent with the overall objectives of Planning for Integration
• Provides clarity with regard to pay and conditions
• Ensures best value

8.3 The Programme Board has approved a way forward based on these principles, and has confirmed that pay and conditions of employment and pensions will require to be protected for staff who transfer. This is a complex area however, as those staff will also wish to be assured of any entitlements of their new employer. A 'Frequently Answered Questions' about these matters was issued to staff in June, and staff side representatives will involve staff in the work of the HR sub group.

9. Governance:

9.1 **Principles** As a matter of principle the governance and management structures should adhere to the Good Governance Standard for Public Services which defines good governance as:

1. Focussing on the organisation's purpose and on outcomes for citizens and service users.
2. Performing effectively in clearly defined functions and roles.
3. Promoting values for the whole organisation and demonstrating the values of good governance through behaviour.
4. Taking informed transparent decisions and managing risks.
5. Developing the capacity and capability of the governing body to be effective.
6. Engaging stakeholders and making accountability real.

9.2 **Governance and Management structures** The basic principle of the Lead Agency Model is for the Council and NHS to jointly agree "commissions" for both children's and adult services. These should essentially be an agreement detailing the outcomes each partner will deliver for respective care groups while accountability stays with the statutory agency.

9.3 The partner organisations will trust each partner to deliver and demonstrate successful delivery of the commission for which they are lead agent. How they deliver will be largely for the Lead Agency.

9.4 Notwithstanding the above it will be essential that the Lead Agency provide accurate and timely assurance on the progress of delivering the commission throughout the year.

9.5 In addition the organisations recognise a unique responsibility held by elected councillors. As well as ensuring the efficient and effective management of services for which they are accountable they are also general advocates on behalf of their constituents in relation to a wide range of issues impacting on their communities.

9.6 The NHS will respect this role by establishing, in partnership with the Council, a series of locality/district partnership forums. These will meet to discuss the performance of the partnership and will involve Councillors, relevant managers, community representatives and representatives for professional groups (social work, nursing and GPs etc.).

9.7 The organisations agree that each partner will be required to undertake a review of their managerial and committee structures to accommodate the significant changes the Lead Agency Model will demand.

9.8 It is recognised that following the review of Community Health Partnerships (CHPs) by Audit Scotland and the commitment of Government to integration, we need to ensure that our developing governance systems are able to both influence and comply with anticipated Government guidance during 2012.

9.9 It has been recognised and agreed that the Partnership requires to develop a commission which will span 3-5 years, is based on the outcomes to be achieved in Adult and Children's Services and which will detail the performance management framework.

This performance management will be in each organisation with elected members and Health Board members holding the Lead Agency to account against the agreed commission.

9.10 The Partnership agrees to develop management structures that can deliver the objectives set out in the joint statement of intent, minimise disruption for users and carers, ensures accountabilities and responsibilities are clear and delivers services that are safe and fit for purpose.

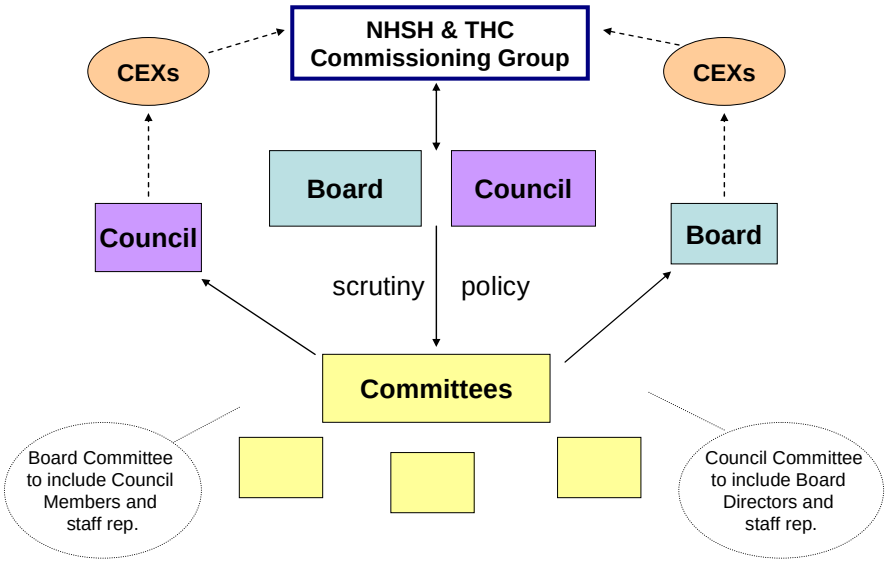
9.11 The Partnership therefore commits to defining and establishing new management structures for the two integrated services, to be operational from April 1st 2012. It is likely that interim management arrangements will need to be established to support the existing CHPs, until new governance structures are established, further to the expected Government advice.

9.12 This establishment of a single budget and management structure for the Lead Agencies from April 2012 will enable –

a. The establishment of pooled, transactional budgets, devolved as part of the new management arrangements
b. Single management of services for adults, and services for children
c. Development of the requirements for lead agency operation in enabling work such as HR, Finance, IM&T, Legal etc.
d. Development of local integrated teams
e. Opportunistic testing of the model of integrated local teams
f. Creation and support of local partnerships
g. Further discussions with Scottish Government on the basis that it is the Partnership's belief that the model being put in place will allow alignment to meet any emerging model of CHPs or their successors as anticipated during 2012

9.13 The schematic below outlines the proposed model, ensuring routes for scrutiny and performance management and appropriate representation of Health Board and Elected Members on the governance committees.

9.14 The Partnership stress that if they have any concern that the quality of care or that child or public safety could be compromised by these proposals, they could not support these new arrangements. The primary concern of the Highland Partnership is the safety, health and wellbeing of the public. The belief is that the approach being developed will lead to improved outcomes for Highland's population. Further, given the work undertaken both nationally and locally the Partnership considers there is no other viable model that can better achieve integration. The Partnership remains open to the consideration of evidence that may indicate otherwise, and would not implement the Lead Agency Model if there were not a case for such change.



9.14 **Professional leadership** This has been recognised as an essential element of good quality services and as such must be explicitly described and organised to ensure that staff working in another agency are not compromised and have access to the professional advice and support required to fulfil their role. Social care and health staff have been explicit that professional leadership is fundamental to the success of the model.

9.15 In order to progress this groups have been pulled together in the NHS and Council with a view to establishing the actions required and enabling engagement of staff as we develop arrangements. It is imperative that those responsible for Governance and quality, such as the Health Board Nurse and Medical Directors and the Chief Social Work Officer in the Council, are assured that processes are in place and assurance can be given. Some examples of what should be included would be standards of care, implementation of policies, medication management, auditing of quality of care, managing Critical Incident Reviews and maintaining professional registration.

9.16 **Staff Governance** The HR subgroup of the Planning for Integration Staff Partnership Forum has sought assurance from the Chief Executives that staff governance will have the same standing as financial and clinical governance across both NHS Highland and The Highland Council, with particular reference to staff transferring from the NHS to the Council. The Chief Executives have asked the Transitions Director and the Staff Partnership Forum to compare current approaches and identify any differences that need to be addressed in order to give that assurance.
The HR subgroup has agreed to take forward this piece of work and report back to the Staff Partnership Forum and the Programme Board.

10. Implementation

10.1 High level plans dependent on decisions to be reached by Health Board and Elected members, have been developed and set out a number of deliverables previously presented. These are **–**

1. PROJECT MANAGEMENT
2. LEAD AGENCY MODEL
3. SERVICE SPECIFICATION
4. COMMISSIONING DOCUMENTATION
5. CHANGE MANAGEMENT PROGRAMME
6. EVALUATION/BENEFITS REALISATION

10.2 It is anticipated that implementation will be focussed around teams who currently deliver the services ensuring engagement of staff, partnership representatives, third sector and users and carers in redesigning the integrated model.

10.3 Whilst joint staff side and component Trade Unions are supportive of integration, at this point in time, they are unable to endorse this model as the full and final detail is still being worked up. However they commit to continue to engage in the process going forward.

11. Summary

11.1 Further work has been progressed in Planning for Integration but much is still required to be completed to enable implementation of Integrated Services in a Lead Agency Model. Much of the focus is on working with the public and communities through ward forums and stakeholder events and staff – through meetings, newsletters, FAQs and websites to explore the model and the implications. Reporting remains through the Programme Board and Leadership and Performance Group.

11.2 Members **and NHS Directors are asked to:**

- Agree the development of an Integrated Children's Service with the Highland Council as the Lead Agency
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