WEST DUNBARTONSHIRE HEALTH &SOCIAL CARE PARTNERSHIP BOARD AUDIT COMMITTEE

At a Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit Committee held in Committee Room 3, Council Offices, Garshake Road, Dumbarton, on Wednesday, 30 September 2015 at 2.00 p.m.

Present: Councillors Gail Casey, Jonathan McColl and Martin Rooney, West Dunbartonshire Council; Ms Ros Micklem (Chair), and Mr Allan Macleod, Non-Executive Members, NHS Greater Glasgow & Clyde Health Board.

Attending: Keith Redpath, Chief Officer; Jean Middleton, Chief Financial Officer; Chris McNeill, Head of Community Health & Care Services; Soumen Sengupta, Head of Strategy, Planning and Health Improvement; Jackie Irvine, Head of Children's Health, Care and Community Justice; Colin McDougall, Audit & Risk Manager and Nuala Borthwick, Committee Officer, West Dunbartonshire Council.

Also Attending: Elaine Boyd, Senior Audit Manager and Laurence Slavin, Senior Audit Manager, Audit Scotland; and Non-Voting Members -Wilma Hepburn, Professional Nurse Advisor for the Health & Social Care Partnership and Barbara Barnes, Co-Chair of the West Dunbartonshire HSCP Public Engagement Forum and Chair of the HSCP's Locality Engagement Network for the Alexandria & Dumbarton area.

Apology: An apology for absence was intimated on behalf of Dr Heather Cameron.

Ros Micklem in the Chair

WELCOME AND INTRODUCTIONS

The Chair welcomed everyone present to the inaugural meeting of the West Dunbartonshire Health & Social Care Partnership Board Audit Committee and thereafter introductions were made around the table.

DECLARATION OF INTEREST

Councillor Casey declared an interest in the report entitled, "Care Inspectorate Reports for Support Services operated by Independent Sector Providers in West Dunbartonshire', given that she is a Board Member of Dalmuir Park Housing Association. Thereafter, Councillor Casey intimated that she would take part in the discussions thereon.

DRAFT

AUDIT COMMITTEE TERMS OF REFERENCE

A report was submitted by the Chief Financial Officer on the proposed Terms of Reference for the Audit Committee.

Having heard the Chief Officer, the Chief Financial Officer and the Head of Strategy, Planning and Health Improvement in further explanation of the report and in answer to Members' questions, it was agreed:-

(1) to approve the proposed Terms of Reference for the Audit Committee subject to the addition of the undernoted wording at paragraph 5.2, and subject to agreement with the Chair :-

"That the Chief Officer and the Chief Financial Officer will bring detailed reports to the Audit Committee on performance and delivery of services for scrutiny by Members as and when requested to do so by the Committee";

(2) that a review of the Terms of Reference would be submitted to a meeting of the Audit Committee in 6 months to enable Members to consider any additional cost implications associated with the system of internal financial control to the Audit Committee; and

(3) that the financial costs associated with the external audit service provided by Audit Scotland to the Partnership Board be confirmed and provided to the Audit Committee at a future meeting.

INTERNAL AUDIT OPERATIONAL AGREEMENT

A report was submitted by the Chief Financial Officer presenting the proposed Operational Agreement for the West Dunbartonshire Health & Social Care Partnership Board's Internal Audit Service.

Having heard the Chief Financial Officer and Audit & Risk Manager in further explanation of the report and in answer to Members' questions, the Committee agreed to approve the proposed Internal Audit Operational Agreement.

DRAFT STRATEGIC RISK REGISTER

A report was submitted by the Head of Strategy, Planning and Health Improvement presenting the first Strategic Risk Register in draft for the new Partnership.

Following discussion and having heard the Chief Officer and relevant officers in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to endorse the draft Strategic Risk Register for recommendation to the West Dunbartonshire Health and Social Care Partnership at its meeting on 18 November 2015; and

DRAFT

(2) that Members were required to identify the risks in place and the consequence of these risks; and

(3) that, having reviewed the content of the Risk Register, that individual risk assessment reports be submitted to the meeting of the Partnership Board on 18 November 2015, for the undernoted risks:-

(a) Risk 2 – Failure to monitor and ensure the wellbeing of people in independent or West Dunbartonshire Council residential care facilities;

(b) Risk 6 – Failure of NHS Greater Glasgow & Clyde-wide MSK Physiotherapy Service to meet nationally determined waiting time target by end of March 2016; and

(4) it was noted that individual risk assessment reports would be submitted to future meetings of the Board, with particular reference having been made to Risk 3 – Failure to deliver efficiency savings and targets and operate within allocated budgets and Risk 4 – Failure to plan and adopt a balanced approach to manage additional unscheduled care pressures and business continuity challenges that are faced in winter.

CARE INSPECTORATE REPORT FOR OLDER PEOPLE'S RESIDENTIAL CARE SERVICES OPERATED BY WEST DUNBARTONSHIRE COUNCIL

A report was submitted by the Head of Community Health and Care providing information on the most recent inspection reports for two of the Council's Older People's Residential Care Home Services.

Following discussion and having heard the Chief Officer and the Head of Community Health and Care in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to note the work undertaken to ensure the grades awarded reflect the quality levels expected;

(2) that all action plans submitted to the Care Inspectorate in response to inspection report will be submitted to the Audit Committee for information following publication of Care Inspectorate reports are published; and

(3) otherwise to note the contents of the report.

CARE INSPECTORATE REPORTS FOR SUPPORT SERVICES OPERATED BY THE INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE

A report was submitted by the Head of Strategy, Planning and Health Improvement on the most recent inspection reports for two of the Council's Older People's Residential Care Home Services.

DRAFT

Having heard the Head of Community Health & Care and the Head of Strategy, Planning and Health Improvement in further explanation of the report and in answer to Members' questions, it was agreed:-

(1) to note the work undertaken to ensure the grades awarded reflect the quality levels expected;

(2) that all action plans submitted to the Care Inspectorate in response to inspection report will be submitted to the Audit Committee for information following publication of Care Inspectorate reports are published; and

(3) otherwise to note the contents of the report.

FORTHCOMING AUDIT SCOTLAND REPORTS

A report was submitted by the Head of Strategy, Planning and Health Improvement providing information on two national audits that have been initiated by Audit Scotland that are of direct relevance to the work of the Health & Social Care Partnership.

Having heard the Head of Strategy, Planning and Health Improvement and the in further explanation of the report and in answer to Members' questions, the Audit Committee agreed to:-

(1) note the Audit Scotland work being undertaken with respect to health and social care integration; and changing models of health and social care; and

(2) direct the Chief Officer to bring a report to the Audit Committee on each of the above once the final reports are published.

FUTURE MEETINGS

The Board agreed the undernoted dates, times and venues for future meetings:-

Wednesday, 13 January 2016 at 2.00 p.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU

Wednesday, 23 March 2016 at 10.00 a.m.in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU

Wednesday, 15 June 2016 at 2.00 p.m.in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU

The meeting closed at 3.40 p.m.

DRAFT

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13 January 2016

Subject: Financial Governance Update

1. Purpose

1.1 To seek the Health & Social Care Partnership Board's approval with :

- The Scheme of Delegation arising from the HSCP Board's Financial Regulations;
- The HSCP Boards joining of CNORIS scheme;
- Endorsing the integrated approach towards business continuity

2. Recommendations

2.1 The Audit committee is recommended to approve:

- The delegation of expenses incurred to be authorised by the Chief Officer and Chief Financial Officer;
- The HSCP Boards joining of CNORIS;
- The endorsing of the integrated approach towards business continuity.

3. Background

3.1 The recently published Audit Scotland report on Integration of Health and Social Care stresses that good governance is vital to ensure that public bodies perform effectively.

4. Main Issues

Financial Delegation of Payment for Expenses Incurred by HSCP Board

4.1 The Public Bodies (Joint Working) (Scotland) Order 2014 states that "an integration joint board may pay to its members all reasonable expenses relating to travel and subsistence costs incurred by them in connection with their membership of the integration joint board." The legislation also allows this to be extended to members attending sub-committees of the integration joint board; individuals confirmed as participating in defined strategic planning meetings; and members of groups consulted where a proposed decision may significantly affect the provision in a locality.

4.2 The financial delegation provides a financial framework for the HSCP Board to ensure proper administration of the HSCP Board's financial affairs and secures that the Chief Officer and Chief Financial Officer has the responsibility for the administration of those affairs.

4.3 The financial delegation noted above in section 4.1 and 4.2 of the Health & Social Care Partnership will not supersede the Scheme of Delegation of West Dunbartonshire Council or NHS Greater Glasgow & Clyde; it is an overarching document which will operate alongside Partners regulations.

Indemnification

4.4 The objective of CNORIS is to provide cost-effective risk pooling and claims management arrangements for those providing health and social care services across Scotland.

4.5 The level of indemnity cover provided by CNORIS to Member organisations relates to Employer's Liability, Public / Product Liability and Professional Indemnity type risks (inter alia). The level of cover provided is at least £5m Public Liability, £10m Employers Liability, and £1m Professional Indemnity; "Indemnity to Principal" will also been provided where required. CNORIS also provides cover in relation to Clinical Negligence. However, there are a number of exclusions, where CNORIS does not provide cover, such as for travel, property insurance, personal accidents and income generating activities. Further details in relation to the cover provided by CNORIS, including details of the exclusions, can be found on the CNORIS website.

4.6 The risks associated with Integration Joint Boards (IJBs) membership of CNORIS is considered low and therefore an annual contribution of £3,000, payable each financial year; has been set, with notification of the contribution being confirmed in December of the preceding year. The contribution level has been assessed at this level due to the limited risks anticipated in relation to the statutory status of IJBs and CNORIS cover being provided mainly in relation to indemnity for IJB Board members and officials.

Business Continuity

4.7 An integrated template and unified approach for business continuity and civil contingency planning across the HSCP services within West Dunbartonshire has been developed and by the Head of Strategy, Planning & Health Improvement, the Council Civil Contingency Officer and the NHSGGC Head of Civil Contingency; and agreed by the Chief Officer and Senior Management Team of the HSCP. Officers are now using this unified approach and integrated template to bring together and update existing business continuity plans for HSCP services.

Additional Governance Items

4.8 The following outstanding items are subject to final national guidance. The current status of these items is noted below.

- Statement of Internal Control – Governance Statement & Financial Assurance. This document will be provided as part of the annual accounts process.
- Reserves Strategy – we can now formulate a reserves strategy on the basis of the above provisional assessment that the IJB will be a local government body.

4.9 Those papers which will be submitted to the HSCP Board in due course.

5. People Implications

5.1 None

6. Financial Implications

6.1 Approval of the financial delegation detailed in section 4.1 and 4.2 will ensure the HSCP Board complies with the requirements of Section 95 of the Local Government (Scotland) Act 1973, which states that relevant authorities" shall make arrangements for the proper administration of their financial affairs and shall secure that the proper officer of the authority has responsibility for the administration of those affairs."

6.2 The Integration Scheme already confirms that recording of all financial information in respect of the HSCP Board – and its Audit Committee - (e.g. expenses) will be processed via the Council ledger, with specific funding being allocated by the HSCP Board to the Council for this.

7. Professional Implications

7.1 None

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 The NHS Boards SFIs and LA Standing orders are currently in place and HSCP Scheme of delegations are currently in place.

9.2 In order for HSCP Board to operate, powers need to be delegated to its Chief Officer and Section 95 Chief Finance Officer; and subject to scrutiny via the HSCP Audit Committee.

9.3 CNORIS provides cost-effective risk pooling and claims management arrangements for those providing health and social care services across Scotland.

10. Impact Assessments

10.1 None

11. Consultation

11.1 None

12. Strategic Assessment

15.1 Proper budgetary control and sound financial practice are cornerstones of good governance and support HSCP and officers to pursue the strategic priorities of the HSCP Boards Strategic Plan.

15.2 This report links to the strategic financial governance arrangements of both parent organisations

Jeanne Middleton – Chief Financial Officer

Date: 1 December 2015

Person to Contact: Jeanne Middleton

Appendices: None

Background Papers: Public Bodies (Joint Working) (Scotland) Order 2014
Governance - Processes & Procedures paper
NHS Greater Glasgow & Clyde Standing Financial Instructions
West Dunbartonshire Council Standing Orders
West Dunbartonshire Integration Scheme

WD HSCP Board Financial Regulations
The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme (Scotland) Amended Regulations 2015 (SSI 102/2015).

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13th January 2016

Subject: Reserves Policy

1. Purpose

1.1 This paper sets out the proposed Reserves Policy of the Health & Social Care Partnership Board, and describes the purposes for which reserves may be held.

2. Recommendations

2.1 It is recommended that the Audit Committee approves the attached Reserves Policy.

3. Background

3.1 As the Health & Social Care Partnership Board has the same legal status as a local authority, i.e. a section 106 body under the Local Government (Scotland) Act 1973 Act, and is classified as a local government body for accounts purposes by the Office of National Statistics (ONS), it is able to hold reserves which should be accounted for in the financial accounts and records of the Partnership Board.

3.2 Reserves require to be considered and managed to provide security against unexpected cost pressures and aid financial stability. To assist in this regard, CIPFA have issued guidance in the form of *Local Authority Accounting Panel (LAAP) Bulletin 55 – Guidance Note on Local Authority Reserves and Balances*. This guidance outlines the framework for reserves, the purpose of reserves and some key issues to be considered when determining the appropriate level of reserves.

3.3 This policy has been applied in line with West Dunbartonshire Council reserves policy. Note that while within a local authority context all receipts and payments are made via the General Fund, in respect of the Partnership Board all receipts and payments will be administered through the ledgers of the respective partners.

3.4 In light of the size and scale of the HSCP Board's responsibilities, over the medium term it is proposed that a prudent level of general reserves will represent approximately 2% of net expenditure. This value of reserves must be reviewed annually as part of the Partnership Board Budget and Strategic Plan; and in light of the financial environment at that time.

4. Main Issues

Utilisation of Reserves

4.1 The Chief Finance Officer of the Partnership Board is responsible for determining the appropriate accounting policies for its operation and this includes its policy in relation to the holding and use of reserves. This policy will set out the level of reserves required and their purpose.

4.2 The Partnership Board will allocate the resources it receives from the partner Health Board and Local Authority in line with the Strategic Plan. In doing this it will be able to use its power to hold reserves so that in some years it may plan for a contribution to build up reserve balances, in others to break even, or to use a contribution from reserves in line with the reserve policy. This will be integral to the medium term rolling financial plan.

4.3 The Partnership Board may also build up reserves year on year as a result of unanticipated underspends.

4.4 As members will recall from the report on *Financial Processes and Procedures* previously discussed by the Partnership Board at its July 2015 meeting, in the event of a forecast overspend on either arm of the operational Integrated Budget, the Partnership Board may increase the payment to the overspending partner by utilising the balance on the general fund, if available, of the Partnership Board in line with the reserves policy.

4.5 Whilst it is recognised that the scope for building up reserves is limited within the context of the current challenging resource environment, it is important for the long term financial stability of both the Partnership Board and of the parent bodies that sufficient usable funds are held in reserve to manage unanticipated pressures from year to year.

4.6 Similarly, it is also important that in year funding available for specific projects and government priorities is able to be earmarked and carried forward into the following financial year, either in whole or in part, to allow for the spend to be committed and managed in a way which represents best value for the Partnership Board in its achievement of the national outcomes.

4.7 Usable reserves should be accounted for in the books of the Partnership Board.

4.8 The proposed Reserves Policy of the Partnership Board is attached at Appendix 1.

5. People Implications

5.1 None

6. Financial Implications

6.1 The Reserves Policy is a key component of the Partnership Board's governance arrangements. They set out the expectations on and the responsibilities of the Partnership Board and senior officers in relation to the proper administration of the Partnership Board's finances.

7. Professional Implications

7.1 None

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 Approval of the Reserves Policy will ensure the Partnership Board is empowered in line with the Legislation, under Section 106 of the Local Government (Scotland) Act 1973 as amended, which empowers the Partnership Board to hold reserves which should be accounted for in the financial accounts and records of the Partnership Board.

10. Impact Assessments

10.1 None

11. Consultation

11.1 This report has been agreed with the Health Board's Director of Finance and Council's Section 95 Officer

12. Strategic Assessment

12.1 Proper budgetary control and sound financial practice are cornerstones of good governance and support the Partnership Board and officers to pursue the strategic priorities of the Strategic Plan.

12.2 This report links to the Reserves Policy of West Dunbartonshire Council.

Author: **Jeanne Middleton – Chief Financial Officer**
Date: **30 December 2015**

Person to Contact: Jeanne Middleton – Chief Financial Officer
Garshake Road, Dumbarton, G82 3PU
Telephone: 01389 737311
e-mail: jeanne.middleton@ggc.scot.nhs.uk

Appendices: Appendix 1 **-** Health & Social Care Partnership Board Reserves Policy

Background Papers:

Local Authority Accounting Panel (LAAP) Bulletin 55 – Guidance Note on Local Authority Reserves and Balances

WD HSCP Board Papers 1 July 2015: Processes and Procedures – Section 6 Managing Financial Performance

West Dunbartonshire Council Reserves Policy

Wards Affected: All

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board

Reserves Policy

CONTENTS

1. Background

1.1 To assist local authorities (and similar bodies) in developing a framework for reserves, CIPFA have issued guidance in the form of the *Local Authority Accounting Panel (LAAP) Bulletin 55 – Guidance Note on Local Authority Reserves and Balances*. This guidance outlines the framework for reserves, the purpose of reserves and some key issues to be considered when determining the appropriate level of reserves. As the **West Dunbartonshire Health & Social Care Partnership Board** has the same legal status as a local authority, i.e. a section 106 body under the Local Government (Scotland) Act 1973 Act, and is classified as a local government body for accounts purposes by the Office of National Statistics (ONS), it is able to hold reserves which should be accounted for in the financial accounts and records of the Partnership Board.

1.2 The purpose of a reserve policy is to:

- outline the legislative and regulatory framework underpinning the creation, use or assessment of the adequacy of reserves;
- identify the principles to be employed by the Partnership Board in assessing the adequacy of the Partnerships Board's reserves;
- indicate how frequently the adequacy of the Partnership Board's balances and reserves will be reviewed; and
- set out arrangements relating to the creation, amendment and use of reserves and balances.

1.3 In common with local authorities, the Partnership Board can have reserves within a usable category.

2. Statutory/Regulatory Framework for Reserves

Usable Reserves

2.1 Local Government bodies - which includes the Partnership Board for these purposes - may only hold usable reserves for which there is a statutory or regulatory power to do so. In Scotland, the legislative framework includes:

Usable Reserve	*Powers*
General Fund	Local Government Scotland Act 1973

2.2 For each reserve there should be a clear protocol setting out:

- the reason / purpose of the reserve;
- how and when the reserve can be used;
- procedures for the reserves management and control; and
- the review timescale to ensure continuing relevance and adequacy.

3. Operation of Reserves

3.1 Reserves are generally held to do three things:

- create a working balance to help cushion the impact of uneven cash flows and avoid unnecessary temporary borrowing – this forms part of general reserves;
- create a contingency to cushion the impact of unexpected events or emergencies – this also forms part of general reserves; and
- create a means of building up funds, often referred to as earmarked reserves, to meet known or predicted liabilities.

3.2 The balance of the reserves normally comprises of three elements:

- funds that are earmarked or set aside for specific purposes. In Scotland, under Local Government rules, the Partnership Board cannot have a separate Earmarked Reserve within the Balance Sheet, but can highlight elements of the General Reserve balance required for specific purposes. The identification of such funds can be highlighted from a number of sources:

    - future use of funds for a specific purpose, as agreed by the Partnership Board; or
    - commitments made under delegated authority by Chief Officer, which cannot be accrued at specific times (e.g. year end) due to not being in receipt of the service or goods;

- funds which are not earmarked for specific purposes, but are set aside to deal with unexpected events or emergencies; and
- funds held in excess of the target level of reserves and the identified earmarked sums. Reserves of this nature can be spent or earmarked at the discretion of the Partnership Board.

4. Role of the Chief Finance Officer

4.1 The Chief Finance Officer is responsible for advising on the targeted optimum levels of reserves the Partnership Board would aim to hold (the prudential target). The Partnership Board, based on this advice, should then approve the appropriate reserve strategy as part of the budget process.

5. Adequacy of Reserves

5.1 There is no guidance on the minimum level of reserves that should be held. In determining the prudential target, the Chief Finance Officer must take account of the strategic, operational and financial risks facing the Partnership Board over the medium term and the Partnership Board's overall approach to risk management.

5.2 In determining the prudential target, the Chief Finance Officer should consider the Partnership's Board's Strategic Plan, the medium term financial outlook and the overall financial environment. Guidance also recommends that the Chief Finance Officer reviews any earmarked reserves as part of the annual budget process and development of the Strategic Plan.

5.3 In light of the size and scale of the Partnership Board's responsibilities, over the medium term it is proposed that a prudent level of general reserves will represent

approximately 2% of net expenditure. This value of reserves must be reviewed annually as part of the Partnership Board Budget and Strategic Plan; and in light of the financial environment at that time. The level of other earmarked funds will be established as part of the annual financial accounting process.

6. Reporting Framework

6.1 The Chief Finance Officer has a fiduciary duty to ensure proper stewardship of public funds.

6.2 The level and utilisation of reserves will be formally approved by the Partnership Board based on the advice of the Chief Finance Officer. To enable the Partnership Board to reach a decision, the Chief Finance Officer should clearly state the factors that influenced this advice.

6.3 As part of the budget report the Chief Finance Officer should state:

- the current value of general reserves, the movement proposed during the year and the estimated year-end balance and the extent that balances are being used to fund recurrent expenditure;
- the adequacy of general reserves in light of the Partnership's Board's Strategic Plan, the medium term financial outlook and the overall financial environment;
- an assessment of earmarked reserves and advice on appropriate levels and movements during the year and over the medium term; and
- if the reserves held are under the prudential target, that the Partnership Board should be considering actions to meet the target through their budget process.

7. Accounting and Disclosure

7.1 Expenditure should not be charged direct to any reserve. Any movement within Revenue Reserves is accounted for as an appropriation and is transparent. Entries within a reserve are specifically restricted to 'contributions to and from the revenue account' with expenditure charged to the service revenue account.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13th January 2016

Subject: NHS Greater Glasgow & Clyde Health Board – Health & Social Care Integration: September 2015 Opening Budget Reports

1. Purpose

1.1 To present the report from NHS Greater Glasgow & Clyde Health Boards 2015/16 Opening Budget Report. The report includes West Dunbartonshire Health & Social Care Partnership health budget.

2. Recommendations

2.1 The Audit Committee is asked to note

- The budget setting approach followed by NHSGGC.
- The due diligence work undertaken as the basis for the 2015/16 Health Care budget.
- Opening budgets for each Integration Joint Board detailed within the report is consistent with the budgeting approach undertaken in prior years.
- NHSGGC financial plan and budgeting approach have been considered and approved at Health Board level.
- Further work remains to agree remaining elements of proposed delegated budgets and to identify all required savings/plans to address cost pressures.
- All budgets, as tested, will be subject to further alteration, with input from the Chief Financial Officer (or current equivalent) for each partnership area before being submitted to the Health & Social Care Partnership Board for final approval within the context of its Strategic Plan.

3. Background

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament on 25 February 2014 and received Royal assent in April 2014. It establishes the framework for the integration of health and social care in Scotland.

3.2 The Integration Joint Board (IJB) is a legal entity in its own right, created by Parliamentary Order, following Ministerial approval of an Integration Scheme. The NHS Greater Glasgow & Clyde Board and West Dunbartonshire Council have delegated functions to the West Dunbartonshire Health & Social Care Partnership Board which has responsibility for planning, resourcing and operational delivery of all integrated services.

3.3 The Partnership Board is required to allocate the resources it receives from the Health Board and Local Authority in line with the Strategic Plan. The Partnership Board is able to use its power to hold reserves so that in some

years it may plan for an underspend to build up reserve balances and in others to break even or to use a contribution from reserves in line with the reserves policy. A Reserves Policy has been prepared and is separately presented to the Audit Committee for consideration.

3.4 Due diligence work, as recommended in the guidance provided around the formation of IJBs, has been undertaken by NHS Greater Glasgow & Clyde to consider the sufficiency of the Health Care budget provided for the Partnerships as outlined in Appendix 1.

4. Main Issues

4.1 An element of work remains before all of the Integration Joint Board budget allocations will be finalised across the NHSGGC-area, as it is still necessary to calculate the notional set aside budget for unscheduled care services within the scope of integration.

4.2 All budgets, as tested, will therefore be subject to further alteration, with input from the Chief Financial Officer (or current equivalent) for each partnership area before being submitted to the Health & Social Care Partnership Board for final approval within the context of its Strategic Plan.

5. People Implications

5.1 Any workforce implications arising from this budget will be dealt with in conjunction with the NHS and Council HR services as appropriate and within the context of the WD HSCP Workforce & Organisational Development Strategy.

6. Financial Implications

6.1 The Health Board's due diligence work has not identified any control deficiencies or other findings to report.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no locality implications associated with this report.

9. Risk Analysis

9.1 Audit Scotland have emphasised that health and social care integration requires effective governance arrangements for the new joint bodies; and that a crucial element of governance is audit committee arrangements.

10. Impact Assessments

10.1 None

11. Consultation

11.1 This report has been prepared by NHS GGC internal auditors and agreed by the NHS GGC Health Board's Director of Finance as appropriately based.

12. Strategic Assessment

12.1 Proper budgetary control and sound financial practice are cornerstones of good governance and support the Partnership Board and officers to pursue the strategic priorities of the HSCP Strategic Plan.

Jeanne Middleton – Chief Financial Officer

Date: 13 January 2016

Person to Contact: Jeanne Middleton – Chief Financial Officer,
Garshake Road, Dumbarton, G82 3PU.
Telephone: 01389 737311
e-mail: jeanne.middleton@ggc.scot.nhs.uk

Appendices: NHSGGC Opening Budget Report Final 8 September 2015

Background Papers: None

Wards Affected: None

NHS Greater Glasgow and Clyde

Health and Social Care Integration: Opening Health Budgets

Final Report

September 2015

pwc

Contents

This report has been prepared by PwC at the request of the Head of Finance for NHS Greater Glasgow and Clyde.
This report has been prepared solely for your use and should not be quoted in whole or in part without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose.

1. Background and Scope

Introduction

In April 2014, the Scottish Government passed the Public Bodies (Joint Working) (Scotland) Act 2014 ('the Act') as part of its programme to improve the quality of experience for users of health and social care services through the integration of planning and delivery of certain services. The Act places a requirement on NHS Boards and Local Authorities to integrate health and social care budgets, holds both jointly accountable for nationally agreed outcomes and introduces a requirement to strengthen the role of clinicians, care professionals and the third and independent sector in the delivery of care.

The legislation allows for either an Integration Joint Board (IJB) to be established in a corporate body arrangement or for the Local Authority or Health Board to take the lead in a Lead Agency arrangement. On 18 February 2014 the Board of NHS Greater Glasgow and Clyde (NHSGGC) approved the body corporate model of delivery and IJBs are in the process of being established with the following local authorities:

- East Dunbartonshire Council;
- Glasgow City Council;
- Renfrewshire Council;
- East Renfrewshire Council;
- Inverclyde Council; and
- West Dunbartonshire Council.

Since the Act was passed in April 2014, a number of regulations and orders have been issued by the Scottish Government, including:

- The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 - sets out the governance arrangements for the IJB;
- The Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014 - prescribes matters that must be included in a joint integration scheme required by the Act;
- The Public Bodes (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 - sets out the functions that must be transfer; and
- Public Bodes (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Regulations 2014 - sets out the functions that must be transfer.

The Integrated Resources Advisory Group (IRAG) was also set up by the Scottish Government to consider the financial implications of integration and develop guidance for Local Authorities and Health Boards. IRAG has released the document 'Professional Guidance, Advice and Recommendations for Shadow Integration Arrangements' which covers matter such as financial reporting, financial planning and financial management and also provides illustrative accounts.

In addition, the Scottish Government published a guidance note 'Guidance for Integration Financial Assurance' which recommended that financial assurance be carried out over the proposed initial budgets to be delegated to the IJB.

In the context of this highly complex and high profile changing environment, and the Scottish Government Guidance note, NHSGGC engaged PwC to carry out a specific scope of work. The agreed scope, per our terms of reference, was as follows:

- Assess the framework for setting each budget including detailed assumptions, savings (recurring and non-recurring) efficiencies, activity and scenario planning.
- Agree baseline budget information to underlying records (where possible).
- Confirm that the both parties have had sight of relevant budget information from the other party and the underlying process for deciding them.
- Confirm that pooled budgets have been appropriately approved.
- Review the process and approach to ensure the effective use of national integration funding provided to the partnership

Our findings from this work are contained in the remainder of this report.

Overall, we have not identified any control deficiencies or other findings to report. We note that the budget setting approach followed by NHSGGC to establish opening budgets for each IJB detailed above is consistent with the budgeting approach undertaken in prior years. The allocations to IJBs were, at the time of testing, still indicative, and subject to further scrutiny and analysis within NHSGGC. However, the financial plan and budgeting approach have been considered and approved at Board level. Contributions from Local Authority partners were approved in February 2015, in line with Local Authority budgeting schedules.

Further work remains to agree remaining elements of proposed delegated budgets and to identify all required savings/plans to address cost pressures.

2. Findings

Integrated Budgets

Document and assess the framework for setting each budget including detailed assumptions, savings (recurring and non-recurring) efficiencies, activity and scenario planning and agree baseline budget information to underlying records (where possible)

The budget allocations to the six IJBs are detailed below, the majority of which (£1,001.2m) will be delegated from NHSGGC. It should be noted however that the Local Authority budget setting process is not in scope for this review.

IJB	From NHSGGC (£'m)	From Council Partners (£'m)	Total (£'m)
East Dunbartonshire	64.6	41.9	106.5
Glasgow City	613.8	395.9	1,009.7
Renfrewshire	134.7	91.7	226.4
East Renfrewshire	47.7	47.1	94.8
Inverclyde	68.6	48.8	117.4
West Dunbartonshire	71.8	60.6	132.4
Total	1,001.2	597	1,598.2

Testing carried out in relation to the opening health board budgets is documented in Appendix 1. Our observations on the budgets to be transferred to the IJB are set out below.

Observations

- At the time of our review, the Cash Releasing Efficiency Savings (CRES) reflected in the NHS proposed delegated budget have not yet been fully identified . The Financial Plan (presented to the Board on 23 June 2015) reported a CRES target of £40.9m of which £33.9m has been identified, leaving a shortfall of £7m. However, management has clarified that none of this gap relates to community or primary care services and will not impact on allocations to IJBs. This shortfall is to be addressed non-recurringly in 2015/16. Identifying the savings remains a focus for NHS GGC, and will continue to be monitored as budgets are finalised.
- The proposed delegated budgets used as the basis of our testing do not include 2015/16 pay and price inflation, being a roll-forward of the 14/15 budgets. A paper was presented to the Board on 23 June 2015, outlining the necessary uplifts as a result of pays and price changes. These allocations have now been processed and added to the indicative 2015/16 budgets shown above.

- NHSGGC's proposed delegated budget is based on recurring future funding. The partnerships will need to agree a process for accounting for any future in year allocations received which relate to services transferred to the IJBs although many of these are ring fenced and are specifically allocated to council areas at source.
- West Dunbartonshire IJB went live on 1 July 2015, with the remaining IJBs due to go live between 1 September 2015 and 1 April 2016. A number of items remain for discussion in relation to the budgets proposed for transfer to IJBs with later go live dates. The budgets as tested by Internal Audit were indicative, and will be subject to a formal process of analysis, scrutiny and negotiation with local council partners before being finalised. Our discussions with management indicate that the remaining budget proposals should go before IJB Boards for approval before these IJBs go live.

Confirm that the both parties have had sight of relevant budget information from the other party and the underlying process for deciding them

The budgets at a partnership and service level have been shared between NHSGGC and its Local Authority partners. A number of reports have been prepared in the budget setting process, which have been shared with shadow IJBs. Although the process for determining the NHSGGC budgets was detailed in reports to the NHS Board, the detailed workings underlying the process have not been shared. However, the scope of this review is such that the workings have been subject to scrutiny by PwC.

Confirm that each health budget has been appropriately scrutinised and approved

The integrated budgets for 2015/16 have not yet been formally submitted for scrutiny to each of the (Shadow) Integrated Joint Boards. The budgets have however been presented for scrutiny to the Boards of those IJBs which have either already went 'live' (West Dunbartonshire) and those expected to 'go live' in September 2015, and subsequently approved. It is expected the remaining budget plans will go before the relevant Boards for scrutiny prior to the "go live" date of each IJB either during 2015/16 or by default on 1 April 2016.

Observations

- An element of work remains before all of the IJB budget allocations will be finalised, as it is still necessary to calculate the notional set aside budget for unscheduled care services within the scope of integration. All budgets, as tested, will therefore be subject to further alteration, with input from the current CFOs of each Shadow Integration Board before being submitted to the Integrated Joint Board for final approval.

Review the process and approach to ensure the effective use of national integration funding provided to the partnership

In July 2014, the Scottish Government announced a £100m Integrated Care Fund for health and social care partnerships to help integrate services and ensure more money is directed to community and voluntary sector preventative services. NHS Greater Glasgow and Clyde was allocated £23.66m over three years from this fund. The 2015/16 allocation of £7.098 million was contained in the Board's base allocation for 2015/16 and has been passed to each partnership based on the Scottish Government Health Directorate agreed allocation.

Appendix 1. Work performed over Integrated Budgets

NHS Greater Glasgow and Clyde

The 2015/16 proposed budget transfer to the IJB has been determined using 2014/15 recurring funding as a baseline.

Baseline Information	Agreement to supporting documentation
Recurring funding for 2014/15 used as a baseline	Total recurring funding per directorate was agreed to general ledger for 2014/15 and to the 2014/15 financial plan as presented to the Board on 24 June 2014. All figures agreed.
Adjustments were made for known budget changes.	Total baseline budget for 2014/15 per workings noted as £1,130.07, compared to a total baseline budget for 2015/16 of ££1,143.47million, representing a minor increase of £13.4million or 0.01%. The draft IJB budgets are net of budgeted income in 2015/16, and are presently based only on recurring funding.
Reduction for CRES (cash releasing efficiency savings).	NHS Greater Glasgow and Clyde has a 3% efficiency savings target set by the Scottish Government, consistent with other NHS Scotland territorial boards. £58.1million of this is expected to be cash releasing savings, with a further £1.5million non cash releasing savings identified. Per the financial plan, a cash releasing financial challenge of £40.9million has been identified. Recurring savings proposals by divisions have identified in year savings of £33.9million leaving a £7million savings gap to be identified (non-recurringly) in the Acute services division.
2015/16 proposed integrated budget	Proposed integrated budget for 2015/16 per workings agreed to general ledger. All figures agreed. Agreed uplift and cost pressure details to the Financial Plan presented to the Board on 23 June 2015. The draft budget allocations to each IJB are currently based on 2014/15 budgeted recurring expenditure, net of budgeted income. We have agreed draft allocations to 2014/15 budgets without exception.
1.8% resource allocation	Uplift in resource allocation agreed to Scottish Government letter. This had not yet been applied to the proposed budget allocations to IJBs at the time of testing but has now been added and the funds passed on to Councils.

In the event that, pursuant to a request which NHS Greater Glasgow and Clyde has received under the Freedom of Information (Scotland) Act 2002 or the Environmental Information Regulations 2004 (as the same may be amended or re-enacted from time to time) or any subordinate legislation made thereunder (collectively, the “Legislation”), NHS Greater Glasgow and Clyde is required to disclose any information contained in this document, it will notify PwC promptly and will consult with PwC prior to disclosing such document. NHS Greater Glasgow and Clyde agrees to pay due regard to any representations which PwC may make in connection with such disclosure and to apply any relevant exemptions which may exist under the Legislation. If, following consultation with PwC, Greater Glasgow and Clyde discloses this document or any part thereof, it shall ensure that any disclaimer which PwC has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

This document has been prepared only for NHS Greater Glasgow and Clyde and solely for the purpose and on the terms in our agreement. We accept no liability (including for negligence) to anyone else in connection with this document, and it may not be provided to anyone else.

© 2015 PricewaterhouseCoopers LLP. All rights reserved. In this document, "PwC" refers to PricewaterhouseCoopers LLP (a limited liability partnership in the United Kingdom), which is a member firm of PricewaterhouseCoopers International Limited, each member firm of which is a separate legal entity.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13th January 2016

Subject: Care Inspectorate Reports for Older People's Residential Care Services Operated by West Dunbartonshire Council.

1. Purpose

1.1 To provide the Audit Committee with information regarding the most recent inspection reports for two of the Council's Older People's Residential Care Home Services.

2. Recommendations

2.1 The Audit Committee is asked to note the content of this report and the work undertaken to ensure grades awarded reflect the quality levels expected.

3. Background

3.1 Care Inspectorate inspections focus on any combination of four thematic areas. These themes are: quality of care and support, environment, staffing and management and leadership.

3.2 The services covered in this Audit Committee report are:

- Willox Park
- Langcraigs Centre

3.3 Copies of inspection reports for all services can be accessed on the Care Inspectorate website: www.scswis.com.

4. Main Issues

4.1 Willox Park

Willox Park was inspected on 28th July and 13th August 2015. The Inspector commented that the staff were committed and working hard to provide a good service. The manager was visible and clearly engaged in daily life in the home. They were receptive to continuing to make improvements to the service. The home was clean, bright and airy.

4.2 The Inspection focussed on four thematic areas with the following grades Awarded:

- For Care and Support - Grade 4 Good
- For Environment – Grade 4 Good
- For Staffing – Grade 4 Good
- For Leadership and Management – Grade 4 Good

4.3 The inspection report detailed the following requirement to be addressed:

The provider must make sure that regular assessments are carried out in relation to individual resident's needs and dependencies and that this information is used to establish the numbers of staff and the skill mix of staff on each shift.

An action plan has been submitted to the Care Inspectorate.

4.4 The table below sets out the movement in grades for this care home over the last two inspections.

Service	**Previous Grades 19th June 2014**		
Willox Park	**Quality Statements**	**Grade Awarded**	**Overall Grade**
Care & Support	1 3	5 5	**5**
Environment	2 3	5 4	**4**
Staffing	3 4	5 5	**5**
Management & Leadership	1 4	5 5	**5**

Service	**Current Grades 13th August 2015**		
Willox Park	**Quality Statements**	**Grade Awarded**	**Overall Grade**
Care & Support	1 3	5 4	**4**
Environment	2 3	4 4	**4**
Staffing	1 3	4 4	**4**
Management & Leadership	1 4	4 4	**4**

4.5 Langcraigs Centre

Langcraigs Centre was inspected on 22nd and 23rd of September 2015. The Inspector found that the service used various methods to gather the views of the people who used the service and found that the service was proactive in

supporting any concerns or issues raised. The inspector received some very positive feedback from people who used the service and their relatives about the care and support they received.

The inspector commented that staff he had spoken with during the inspection appeared professional and motivated, residents appeared well cared for and he saw that staff were attentive to their needs. The inspector noted that the service was back to a full management team and appeared well managed.

4.6 The inspection focussed on four thematic areas, with the following grades awarded.

- For Care and Support – Grade 5 Very Good
- For Environment – Grade 5 Very Good
- For Staffing – Grade 5 Very Good
- For Management and Leadership – Grade 5 Very Good

4.7 There were no requirements arising from this inspection.

4.8 The table below sets out the movement in grades for this care home over the last two inspections.

Service	**Previous Grades 23rd July 2014**		
Langcraigs Centre	**Quality Statement**	**Grade Awarded**	**Overall Grade**
Care & Support	1 3	5 4	**4**
Environment	1 2	5 4	**4**
Staffing	1 3	5 5	**5**
Management & Leadership	1 4	5 5	**5**

Service	**Current Grades 23rd September 2015**		
Langcraigs Centre	**Quality Statement**	**Grade Awarded**	**Overall Grade**
Care & Support	1 3	5 5	**5**
Environment	2 3	5 5	**5**
Staffing	2 3	5 5	**5**
Management & Leadership	2 4	5 5	**5**

4.9 The table below summarises the movement in grades for the services over their last two inspections.

Service	Previous Grades						Current Grades					
	1	2	3	4	5	6	1	2	3	4	5	6
Willox Park	**19th June 2014**						**13th August 2015**					
• Care & Support • Environment • Staff • Management & Leadership				✓	✓ ✓ ✓					✓ ✓ ✓ ✓		
Service	**Previous Grades**						**Current Grades**					
	1	2	3	4	5	6	1	2	3	4	5	6
Langcraigs Centre	**23rd July 2014**						**23rd September 2015**					
• Care & Support • Environment • Staff • Management & Leadership				✓ ✓	 ✓ ✓						✓ ✓ ✓ ✓	

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 There are no financial implications associated with this report.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no locality implications associated with this report.

9. Risk Analysis

9.1 For any services inspected, failure to meet requirements within the time-scales set out in their inspection report could result in a reduction in grading or enforcement action. This may have an impact on our ability to continue to deliver the service.

10. Impact Assessments

10.1 Not required for this report.

11. Consultation

11.1 Not required for this report

12. Strategic Assessment

12.1 The Strategic Plan 2015/16 emphasises the Partnership Board's commitment to providing high quality and appropriate care for older people; and providing quality assurance across all services

Author: Christine McNeill - Head of Community Health and Care

Date: **13th January 2016**

Person to Contact: Pauline Stevenson - Integrated Operations Manager
West Dunbartonshire HSCP
Council Offices, Garshake Road
Dumbarton, G82 3PU
E-mail**:** **pauline.stevenson@west-dunbarton.gov.uk**
Telephone: 01389 776891

Appendices: None

Background Papers: None

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13th January 2016

Subject: Care Inspectorate Reports for Support Services Operated by the Independent Sector in West Dunbartonshire

1. Purpose

1.1 To provide the Audit Committee with a routine up-date on the most recent Care Inspectorate assessments for four independent sector support services operating within the West Dunbartonshire area.

2. Recommendations

2.1 The Audit Committee is asked to note the content of this report.

3. Background

3.1 Care Inspectorate inspections focus on any combination of four thematic areas. These themes are: quality of care and support, environment, staffing and management & leadership.

3.2 The independent sector support services reported are:

- Cornerstone 'West Dunbartonshire Services 1'. Service is provided throughout West Dunbartonshire Council area.
- Carewatch Care Services – Inverclyde, North Ayrshire, Dunbartonshire, Argyll & Bute. Service is provided throughout West Dunbartonshire Council area.
- Carers Direct Ltd. - Support Service Care at Home – The service is provided in the Dumbarton and Alexandria area.
- Alternatives West Dunbartonshire Community Drug Services Housing Support Unit. The Recovery House is located in Clydebank but supports adults from across West Dunbartonshire Council area.

3.3 Some providers, who operate multiple services across Scotland, register groups of their services with the Care Inspectorate on a 'Branch' basis rather than as individual services. In this report Carewatch Care Services – Inverclyde, North Ayrshire operate in this manner.

3.4 Copies of the inspection report can be accessed on the Care Inspectorate web-site: www.scswis.com.

4. Main Issues

Cornerstone West Dunbartonshire Services 1

4.1 West Dunbartonshire Services 1 is operated by Cornerstone Community Care. They provide Housing Support, Care at Home, Day Support Opportunities and Short Breaks to adults who have learning disabilities and are living in group

accommodation or their own homes. The service was inspected on 21st May 2015 and the report published on 9th July 2015. The following grades were awarded:

- For the theme of *Care and Support* – Grade 5/Very Good.
- For *Staffing* – Grade 5/Very Good.
- For *Management and Leadership* - Grade 5/Very Good.

4.2 There were no requirements detailed in the inspection report.

Carewatch Care Services – Inverclyde, North Ayrshire, Dunbartonshire and Argyll & Bute.

4.3 Carewatch Care Services – Inverclyde, North Ayrshire, Dunbartonshire, Argyll & Bute provide a combined Housing Support and Care at Home service. The service is offered primarily to older people who require support to live independently in their own homes. The service was inspected on 2nd September 2015 and the report published on 26th October 2015. The following grades were awarded:

- For the theme of *Care and Support* – Grade 3/Adequate.
- For *Staffing* – Grade 4/Good.
- For *Management and Leadership* - Grade 3/Adequate.

4.4 There were no requirements detailed in the inspection report.

Carers Direct Ltd – Support Service Care at Home

4.5 The home support service is offered to elderly and less able people who live in their own homes. The service was inspected on 8th October 2015 and the report published on 28th October 2015. The following grades were awarded:

- For the theme of *Care and Support* – Grade 5/Very Good.
- For *Staffing* – Grade 4/Good.
- For *Management and Leadership* - Grade 5/Very Good.

4.6 The inspection report detailed the following requirement to be addressed:

- The Provider to ensure that all staff have appropriate and up-to-date training on Adult Support and Protection. No timescale was given for completion of this requirement. The provider is in the processes of addressing this for all staff.

Alternatives West Dunbartonshire Community Drug Services Housing Support Unit

4.7 Alternatives West Dunbartonshire Community Drug Services Housing Support Unit provides support and accommodation, via the Recovery House. The service was inspected on 6th October 2015 and the report published on 1st December 2015. The following grades were awarded:

- For the theme of *Care and Support* – Grade 4/Good.
- For *Staffing* – Grade 5/Very Good.
- For *Management and Leadership* - Grade 4/Good.

4.8 There were no requirements detailed in the inspection report.

4.9 The undernoted table summarises grades awarded at the last two inspections**:**

Service	Previous Grades						Current Grades					
	1	2	3	4	5	6	1	2	3	4	5	6
					29 May 2014						21 May 2015	
West Dunbartonshire Services 1 • Care & Support • Environment • Staffing • Management & Leadership					✓ ✓ ✓						✓ ✓ ✓	
					2 June 2014						2 September 2015	
Carewatch • Care & Support • Environment • Staffing • Management & Leadership					✓ ✓ ✓				✓ ✓	✓		
					4 March 2015						8 October 2015	
Carers Direct Ltd. • Care & Support • Environment • Staffing • Management & Leadership					 ✓ 	✓ ✓				✓	✓ ✓	
					28 November 2013						6 October 2015	
Alternatives • Care & Support • Environment • Staffing • Management & Leadership				 ✓	✓ ✓ 					✓ ✓	 ✓ 	

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 There are no financial implications associated with this report.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no relevant locality implications associated with this report.

9. Risk Analysis

9.1 Grades awarded to a service after a Care Inspectorate inspection are an important performance indicator for registered services. For any service assessed by the Care Inspectorate, failure to meet requirements within the time-scales set out could result in a reduction in grading or enforcement action. Consistently poor gradings awarded to any independent sector service would be of concern to the

Audit Committee, particularly in relation to the continued referral of vulnerable people by Health & Social Care Partnership services.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The West Dunbartonshire HSCP Strategic Plan 2015 -16 emphasises the importance of quality assurance amongst independent sector providers of care; and the Partnership Board's commitment to work with independent sector providers within an agreed assurance framework.

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership.

Date: 3rd December 2015

Person to Contact: Mrs Sharon Elliott
Quality Assurance Manager
West Dunbartonshire CHCP
Council Offices
Garshake Rd, Dumbarton G82 3PU
E-mail: sharon.elliott@west-dunbarton.gov.uk
Telephone: 01389 776849

Appendices: None

Background Papers: All the inspection reports can be accessed from http://www.scswis.com/index.php?option=com_content&task=view&id=7909&Itemid=727

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13th January 2016

Subject: Care Inspectorate Reports for Older People's Care Homes operated by Independent Sector in West Dunbartonshire

1. Purpose

1.1 To provide the Audit Committee with a routine up-date on the most recent Care Inspectorate assessments for three independent sector residential older peoples' Care Homes within West Dunbartonshire.

2. Recommendations

2.1 The Audit Committee is asked to note the content of this report.

3. Background

3.1 Care Inspectorate inspections focus on any combination of four thematic areas. These themes are: quality of care and support, environment, staffing, and management & leadership.

3.2 Any care home which has been awarded Grade 2 (i.e. weak) or less and/ or have requirements placed upon them will usually be inspected again within the following twelve weeks. These follow-up visits present the opportunity to demonstrate progress on the improvement action plan agreed and to have an improved grade awarded if merited.

3.3 The Health and Social Care Partnership Quality Assurance Section monitor the independent sector care homes located within West Dunbartonshire in line with the terms of the National Care Home Contract; and arrange monitoring visits to ensure continued progress is being maintained in relation to agreed improvement plans. In addition, the Health and Social Care Partnership works with independent sector providers to maintain their awareness of new developments and provide opportunities to share good practice/learning via correspondence and regular care home provider meetings.

3.4 The independent sector Care Homes reported within this report are:

- Sunningdale
- Edinbarnet
- Castle View Nursing Home

Copies of the inspection reports can be accessed on the Care Inspectorate web-site: www.scswis.com.

4. Main Issues

Sunningdale

4.1 Sunningdale is owned and managed by I & S Scotcare Limited.

4.2 The care home was inspected on 17th July 2015 and the report published on 15th October 2015. The following grades were awarded:

- For the theme of *Care and Support* – Grade 5/Very Good.
- For the theme of *Environment* – Grade 5/Very Good.
- For the theme of *Staffing* – Grade 5/Very Good.
- For the theme of *Management and Leadership* – Grade 5/Very Good.

4.3 There were no requirements detailed in the inspection report.

Edinbarnet

4.4 Edinbarnet is owned and managed by Edinbarnet Estates Limited.

4.5 The care home was inspected on 1st October 2015 and the report published on 4th November 2015. The following grades were awarded:

- For the theme of *Care and Support* – Grade 5/Very Good.
- For the theme of *Environment* – Grade 5/Very Good.
- For the theme of *Staffing* – Grade 5/Very Good.
- For the theme of *Management and Leadership* – Grade 5/Very Good.

4.6 There were no requirements detailed in the inspection report.

Castle View Nursing Home

4.7 Castle View Nursing Home is owned and managed by HC-One Limited.

4.8 The care home was inspected on 8th October 2015 and the report published on 16th November 2015. The following grades were awarded:

- For the theme of *Care and Support* – Grade 5/Very Good.
- For the theme of *Environment* – Grade 5/Very Good.
- For the theme of *Staffing* – Grade 5/Very Good.
- For the theme of *Management and Leadership* – Grade 5/Very Good.

4.9 There were no requirements detailed in the inspection report.

4.10 The table overleaf summarises the grads awarded between the last two inspections.

Service	Previous Grades						Current Grades					
	1	2	3	4	5	6	1	2	3	4	5	6
					18 July 2014						17 July 2015	
Sunningdale												
• Care & Support					✓						✓	
• Environment				✓							✓	
• Staffing					✓						✓	
• Management & Leadership					✓						✓	
					14 November 2014						1 October 2015	
Edinbarnet												
• Care & Support				✓							✓	
• Environment				✓							✓	
• Staffing				✓							✓	
• Management & Leadership				✓							✓	
					3 March 2015						8 October 2015	
Castleview Care Home												
• Care & Support					✓						✓	
• Environment				✓							✓	
• Staffing				✓							✓	
• Management & Leadership				✓							✓	

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 The National Care Home Contract provides an additional quality payment, by the Council, to Care Homes if the Care Inspectorate Inspection report awards grade of 5/Very Good or 6/Excellent in the Quality of Care and Support thematic area. There is a second additional quality payment if the high grade in Quality of Care and Support thematic area is coupled with a grading of a 5/Very Good or 6/Excellent in any of the other three thematic areas.

6.2 The National Care Home Contract also accounts for providers receiving low grades of 1/Unsatisfactory or 2/Weak in the Care Inspectorate Inspection report. If either of these grades are awarded it may trigger the withdrawal of the quality funding component, resulting in a reduction of £20 per resident per week from the weekly fee payable.

6.3 The Inspection Reports for Sunningdale and Edinbarnet have financial implications for the Partnership Board. As they received the grade of 5/Very Good for the Quality of Care and Support thematic area coupled with the grading of 5/Very Good in at least another one of the other three thematic areas in their inspection report they will continue to be paid the enhanced weekly rate for every resident Health and Social Care Partnership has placed in the home.

6.4 In an inspection of November 2013 Edinbarnet received the grades 5/Very Good in all four themes. Then in their inspection of November 2014 they received the grades of 4/Good in the inspection report. In line with the National Care Home Contract, the service was given the opportunity to correct the grades awarded. If

in this, their next inspection the grades remained at the same level or lower, the additional quality payment was to be removed. However, the grades awarded to Edinbarnet in this most recent inspection are an improvement and will result in the service continuing to receive the enhanced weekly rate for every resident Health and Social Care Partnership has placed in the home.

6.5 The Inspection Report for Castle View Nursing Home also has financial implications for the Partnership Board. As they received the improved grades of 5/Very Good in all four themes in their inspection report they will be paid the enhanced weekly rate for every resident Health and Social Care Partnership has placed in the home. Previously Castle View Nursing Home was in receipt of the single additional quality payment, as detailed in 6.1, as the Care Inspectorate Inspection had awarded the grade of 5/Very Good in the Quality of Care and Support thematic area at their March 2015 inspection.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no relevant locality implications associated with this report.

9. Risk Analysis

9.1 Grades awarded to a service after a Care Inspectorate inspection are an important performance indicator for registered services. For any service assessed by the Care Inspectorate, failure to meet requirements within the time-scales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to any independent sector Care Home would be of concern to the Audit Committee, particularly in relation to the continued referral of vulnerable people by Health & Social Care Partnership to such establishments.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The West Dunbartonshire HSCP Strategic Plan 2015 -16 emphasises the importance of quality assurance amongst independent sector providers of care; and the Partnership Board's commitment to work with independent sector providers within an agreed assurance framework.

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership.

Date: 3rd December 2015

Person to Contact: Mrs Sharon Elliott
Quality Assurance Manager
West Dunbartonshire CHCP
Council Offices
Garshake Rd, Dumbarton G82 3PU
E-mail: sharon.elliott@west-dunbarton.gov.uk
Telephone: 01389 776849

Appendices: None

Background Papers: All the inspection reports can be accessed from http://www.scswis.com/index.php?option=com_content&task=view&id=7909&Itemid=727

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13 January 2015

Subject: Care Inspectorate Report for Children & Young People's Services operated by West Dunbartonshire Council

1. Purpose

1.1 To provide members with information regarding the most recent inspection report for Craigellachie, one of the Council's own Residential Services for Children and Young People.

2. Recommendations

2.1 The Committee is asked to note the content of this report and the work undertaken to ensure grades awarded are sustained and reflect high quality of care.

3 Background

3.1 The Care Inspectorate inspections focus on any combination of four thematic areas. These themes are; quality of care and support, environment, staffing and management and leadership.

3.2 The HSCP services covered in this Committee report are as follows:

- Craigellachie Children's Unit

3.3 Copies of inspection reports for all services can be accessed on the Care Inspectorate web-site; www.scswis.com

4. Main Issues - Craigellachie Children's Unit

4.1 Craigellachie Children's House was inspected on the 21st of September 2015 and the report was published on the 27th of November 2015. The following grades were awarded:

For the theme of

- *Care and Support* – Grade 5/Very Good
- *Quality of Environment* – Grade 5/Very Good
- *Quality of Staffing* – Grade 5/Very Good.
- *Quality of Management and Leadership* – Grade 5/Very Good.

4.2 There were no requirements and 1 recommendation from this inspection.

The inspector recommended that an appropriate solution be implemented to address the limited ability of all staff to meet as a team.

With regards to this recommendation work is already underway to ensure that those staff who are unable to attend team meetings have the opportunity to contribute their views and are updated on the content and decisions reached at the meeting.

Staff are also involved in the development of a residential staff forum which will provide an opportunity for all staff across the residential estate to share good practice and discuss any issues of interest or concern. The aim of the staff forum is to support good communication, staffs development and help to promote a more cohesive process for shared decision-making and consistency of approach for young people.

4.3 Within the report the inspector noted, that there was evidence of very good relationships between young people and staff, which allowed for discussion and agreement about how young people wished to be supported.

She commented on her observations of the interactions which she believed demonstrated that young people were very confident expressing their views which were in turn listened to and acted upon by staff.

The young people told the inspector,

"***I get my point across and staff treat me really well",***

"My key worker is nice. She spends time with me when I need it. I can talk to her about things that are bothering me and she tries to help".

***"I like it here. It's normal, not stressful like at my house. The staff are really good and when we have young people's meetings we talk about what we want and the rules and stuff*"**.

The inspector praised staffs commitment to the young people and commented on how she observed young people laugh and joke with staff in a positive and relaxed manner. She recorded that overall young people were very happy with the quality of care and support provided to them by staff at Craigellachie.

Also noted were the positive opportunities within Craigellachie for young people to meet together to discuss specific aspects of how the service operates.

The inspector found the regular young people's meetings focused on issues that the young people felt were important to them, such as access to Wi-Fi and the up and coming holidays. The inspector noted that young people were encouraged to offer suggestions, one young person commented, ***"We're going on holiday but it's a surprise. I think it's Flamingo Land"***. It was also noted that independent advocacy service is positively promoted by staff

and provided young people with the opportunity for additional support, advice and guidance with someone external to the service.

4.4 All grades remain consistent with previous inspections, and reflect the high standards of care offered to our young people within Craigellachie.

4.5 The tables below sets out the movement in grades for both services over the last two inspections**:**

Home	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
	January 2015						Aug 2015					
Craigellachie Residential Home • Care & support • Environment • Staff • Management & Leadership					X X X X						X X X X	

5. People Implications

5.1 There are no people implications.

6. Financial Implications

6.1 There are no financial implications.

7. Risk Analysis

7.1 For any service inspected, failure to meet requirements within the time-scales set out in their inspection report could result in a reduction in grading or enforcement action. This may have an impact on our ability to continue to deliver the service.

8. Equalities Impact Assessment (EIA)

8.1 Not required for this report.

9. Consultation

9.1 Not required for this report.

10. Strategic Assessment

10.1 The Council's Strategic Plan 2012-17 identifies "improve life chances for children and young people" as one of the authority's five strategic priorities.

Author: Jackie Irvine - Head of Children's Health & Criminal Justice Service; Chief Social Work Officer

Date: 16th December 2015

Person to Contact: Carron O'Byrne
Manager – Looked After Children
West Dunbartonshire HSCP
Child Care Team, 6 -14 Bridge Street
Dumbarton, G82 1NT
E-mail: Carron o'byrne@wdc.gcsx.gov.uk
Telephone: 01389 772170

Appendices: None

Background Papers: The information provided in Care Inspectorate Inspection Reports Web-site address: - http://www.scswis.com/index.php?option=com_content&task=view&id=7909&Itemid=727

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13th January 2016

Subject: Transforming Care in Clydebank – Initial Agreement

1. Purpose

1.1 To present the Initial Agreement prepared for a new Clydebank Health and Care Centre.

2. Recommendation

2.1 The Partnership Board is recommended to endorse the Initial Agreement for a new Clydebank Health and Care Centre.

3. Background

3.1 Community health services in Clydebank serve 50,000 people and currently operate from five sites: Clydebank Health Centre; Hardgate Clinic; Kilbowie Road; Beardmore Resource Centre; and Goldenhill Clinic. All of the services across the five sites are being developed as increasingly integrated health and care arrangements, but the scope to fully realise those potentials significantly limited by the constraints of the existing facilities in which the operate; and the very fact that the dispersed locations of the staff and services inhibits ability to develop synergies in terms of new ways of joint working and support.

3.2 The main Clydebank Health Centre is in significantly poor repair (particularly the roof with frequent water ingress) despite considerable, costly and on-going repair work. The building allows no further expansion of GP and other services; and requests to host additional and much-needed outreach services have to be denied. The access to the centre is also increasingly problematic: it is located on a site that has restricted parking close to a school entrance; and is on a steep hill with difficult access for patients, staff and supplies. Most problematically, the significant asbestos contamination throughout the structure and fabric of the building not only limits the scope for making any improvements to the building itself and is exponentially driving up costs of repair/refurbishment at a level that is unaffordable to sustain, but is also now viewed with concern by the Health & Safety Executive.

3.3 Upgrading the current Clydebank Health Centre has been considered but is not feasible, because of the size of the site; the limitations/constraints of the building design/layout; and critically, the aforementioned significant asbestos contamination throughout the structure and fabric of the building. Despite the commitment of staff the current facilities are unable to provide the standard of patient experience set out in the national quality strategy or of a standard acceptable to either the NHSGGC Health Board or the WD HSCP Board.

3.4 The WD HSCP Strategic Plan sets out the key priorities and commitments for health and social care for the area – and includes support for a replacement health and care centre to deliver improved outcomes for the communities of Clydebank. NHSGGC has subsequently received conditional approval that a replacement Clydebank Health and Care Centre will be funded as a bundled project with Greenock Health and Care Centre funded via the West of Scotland Hub Initiative, subject to approval through the business case process.

3.5 Within West Dunbartonshire HSCP, the importance of delivering a sustainable solution to asbestos-related health & safety risks within fabric of Clydebank Health Centre has been recognised within the local Strategic Risk Register.

3.6 Such a sustainable solution is then detailed within the appended Initial Agreement that has been prepared for both the NHSGGC Health Board and then the Scottish Government's Capital Investment Group.

4. Main Issues

4.1 This Initial Agreement has been prepared in accordance with the requirements of the Scottish Capital Investment Manual (SCIM). SCIM provides guidance in an NHS context on the sector-specific processes and techniques to be applied in the development of infrastructure projects within NHS Scotland. The SCIM guidance is mandatory for all infrastructure projects

4.2 SCIM is currently under review. This work is being undertaken by a SCIM Project Group and is at an advanced stage. The Project Group has decided to pilot this guidance on a phased basis and is therefore recommending that new and existing business cases follow the revised guidance (summary provided in Appendix 2).

4.3 In accordance with SCIM guidelines the development of any new infrastructure project requires a full site options appraisal. NHSGGC have undertaken this on all recent Hub projects. Given the background to this project, the Scottish Government' Capital Investment Group agreed that Scottish Futures Trust should be invited to engage with NHSGGC to examine the available options against the project' benefits realisation and investment objectives (as detailed within the Initial Agreement). Following this process, the Queen's Quay Regeneration Development site in Clydebank was confirmed as the optimal available site for delivering on the project' investment objectives.

4.4 As per the NHSGGC governance process for infrastructure projects of this size, this Initial Agreement was considered and approved by its local Project Board in November 2015.

4.5 Following discussions with Scottish Government, NHSGGC Capital Planning have recommended that the proposals for both a new Clydebank Health and Care Centre and a new Greenock Health and Care Centre are considered

together and “bundled” into one contract to be provided by hub West Scotland as part of Scottish Governments approach to the delivery of new community infrastructure. This is primarily to maximise the benefits of procuring these two proposals as a single project. Consequently were considered and approved by the Hub Steering Group in November 2015; and have together been submitted for consideration and approval by the NHSGGC Capital Planning Group (December 2015 meeting), prior to then being considered by the NHSGGC Health Board (February 2016 meeting).

5. People Implications

5.1 As detailed within the Initial Agreement, staff affected by this proposal include those working within the following areas of service: Allied Health Professional services; Primary Care Mental Health; District Nursing; Older People’s Mental Health; Primary Care Mental Health; Community Older People’s Team; Hospital Discharge Team; Single Point of Access Receiving Team; outreach clinics (e.g. Maternity Services and Acute Clinics); and the six general practices currently based within the existing Clydebank Health Centre.

5.2 As described within the Initial Agreement, their involvement in its development includes representatives being part of Site Options Appraisal Workshops and the Design and Delivery Group, making recommendations to the Project Board and involved in the design statement planning stages.

6. Financial Implications

6.1 The Initial Agreement proposes a single and new-build facility, delivered within an overall funding envelope of £19m. NHSGGC has made provision within its capital resource limit for such a project dependant on confirmation of Hub funding, with the revenue costs calculated as break even at this time.

6.2 There are clear financial benefits to bringing both the Clydebank and Greenock projects together in a single procurement bundle. These include initial capital savings and project-life revenue savings, currently estimated to be circa £0.9m and £1.5m respectively. There is therefore a total saving to public finances of circa £2.4m by delivering the projects as a bundle.

6.3 The terms of the Queen’s Quay site’s provision by the Council means it will be delivered at a lower cost to the project, allowing current funding to be used most effectively. In locating the new facility on this prime site, the regeneration benefits of the project will be considerably enhanced and further deliver a positive effect on the heath and wellbeing of the people of Clydebank.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 A replacement health and care centre build would enable the co-location of multi-disciplinary services - including integrated health and social care teams - within a new facility giving one stop access and improved accessibility for patients to an increased range and improved quality of services (including additional acute outreach clinics); a considerably improved working environment for staff; space for community and third sector partners and carer's organisations involved in the co-production of supported self care; meeting and training space for all our staff (supported by a commitment to shared and agile technology for staff) and local community groups.

8.2 Moreover, the development of a new and enhanced health and care centre within Clydebank has already been identified as a key contribution that NHSGGC could make to the wider regeneration plans for Clydebank. As such, the proposed new health and care centre is not just about the construction of a new asset, but more importantly how such a new facility will contribute to a transformation in the type of care provided with and for local people; and the economic and social transformation of the Clydebank area more broadly.

9. Risk Analysis

9.1 The general risks for the development of the proposed Clydebank Health and Care Centre are set out in Risk Register included in the Initial Agreement.

9.2 A key financial risk is that the unitary charge payment will not be confirmed until financial close. This is mitigated by the funding mechanism for the Scottish Government revenue funding whereby Scottish Government's funding will vary depending on the funding package achieved at financial close.

9.3 The risk associated with the ESA (European System of Accounts) 10 asset classification issue was noted by the Chief Financial Officer in the Financial Report 2015/16 as at Period 6 (30th September 2015) that they presented to the previous HSCP Board meeting in November 2015; and is identified within the Risk Register included in the Initial Agreement.

9.4 The affordability analysis incorporates that funding will be sought from GP practices who are relocating to the centres. This funding will not be committed over the full 25 year period, and as such is not guaranteed over the project's life. The financial risk will remain with the HSCP over the contract's life for those elements which the HSCP has responsibility (100% "hard" facilities management, 50% lifecycle). The HSCP will address this risk through the committed funds allocated to the project.

9.5 The Project Board will continue to monitor these risks and assess their potential impact throughout the period through Outline Business Case, Full Business Case and financial close.

10. Impact Assessments

10.1 None required at this time.

11. Consultation

11.1 The Communication and Engagement Plan included within the Initial Agreement is based on the Plan devised with the community for the recently completed Vale Centre for Health and Care, the engagement process and outcomes from which were recognised as national best practice following its Office for Government Commerce Gateway Review (as previously reported to the former WD CHCP Committee).

11.2 As confirmed within the Initial Agreement, service user, carers and community representatives have been included in the Workshops and the Design and Delivery Group meetings.

12. Strategic Assessment

12.1 The WD HSCP Strategic Plan includes support for a replacement health and care centre to deliver improved outcomes for the communities of Clydebank.

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement West Dunbartonshire Health & Social Care Partnership.

Date: 3rd December 2015

Person to Contact: Soumen Sengupta – Head of Strategy, Planning & Health Improvement, Garshake Road, Dumbarton. G82 3PU.
Telephone: 01389 737321
e-mail: soumen.sengupta@ggc.scot.nhs.uk

Appendices: Transforming Care in Clydebank – Initial Agreement
Scottish Capital Investment Manual (Introduction – Draft)

Background Papers: HSCP Board Report (November 2015): Strategic Risk Register

HSCP Board Report (November 2015): Financial Report 2015/16 as at Period 6 (30th September 2015)

WD CHCP Committee Report (February 2015): The Vale Centre for Health & Care – Gateway 5 Outcome

Wards Affected: All

NHS Greater Glasgow and Clyde

West Dunbartonshire
Health & Social Care Partnership

Transforming Care in Clydebank

Initial Agreement

November 2015

Transforming Care in Clydebank

Transforming Care in Clydebank: Initial Agreement

1. Overview

1.1. West Dunbartonshire as a whole faces the considerable challenges of restructuring its economy following the decline of heavy industry, dealing with the impacts of the recession and managing a declining and ageing population. Overall, West Dunbartonshire has a worse general level of health than the Scottish average – this is also the picture within Clydebank. Clydebank has high levels of poverty and an increasing elderly population high numbers with long term conditions. This is driving growing demand for health and social care services alongside an increasing imperative to co-locate teams, integrate services and deliver seamless care.

1.2. With changing demographics and increasing levels of need, over the next ten years the health and social care landscape will change significantly. Those changing demographics (including an ageing population), an increase in demand for services, and the likelihood of more people with complex multi-morbidities – alongside reduced public sector resources – means that we have to work together to deliver services in different ways and make the most of the investment available across public sector as a whole.

1.3. In accordance with the Public Bodies (Joint Working) Act 2014, Greater Glasgow & Clyde Health Board (NHSGGC) and West Dunbartonshire Council established their local integration joint board – known as West Dunbartonshire Health & Social Care Partnership (WD HSCP) Board – in July 2015. The new WD HSCP arrangement has been built on the successes and experience of the predecessor community health & care partnership (CHCP) that had been operating effectively since October 2010. The approved HSCP Strategic Plan sets out the key priorities and commitments for health and social care for the area – and includes support for a replacement health and care centre to deliver improved outcomes for the communities of Clydebank.

1.4. Community health services in Clydebank serve 50,000 people and currently operate from five sites: Clydebank Health Centre; Hardgate Clinic; Kilbowie Road; Beardmore Resource Centre; and Goldenhill Clinic. All of the services across the five sites are being developed as increasingly integrated health and care arrangements, but the scope to fully realise those potentials significantly limited by the constraints of the existing facilities in which the operate; and the very fact that the dispersed locations of the staff and services inhibits ability to develop synergies in terms of new ways of joint working and support.

1.5 The current facilities have been assessed as not meeting the basic needs nor being able to address these business objectives - so the “Do Nothing” option is not viable. The poor repair and ongoing maintenance of the main Clydebank Health Centre in particular mean that from a repairs perspective it is “money hungry”. The asbestos that is integral to the building’s structure means that even relatively simple repairs are extremely costly; and that extension of that building is cost-prohibitive. Despite the commitment of staff the current facilities are unable to provide the standard of patient experience set out in the national quality strategy or of a standard acceptable to either the NHSGGC or the WD HSCP Board. The preferred solution is therefore a single and new-build facility, delivered within an overall funding envelope of £19 million.

1.6 A new integrated facility for Clydebank already has widespread stakeholder support, including from local politicians and the local Community Planning Partnership. Such a replacement health and care centre build would enable the

co-location of multi-disciplinary services - including integrated health and social care teams - within a new facility giving one stop access and improved accessibility for patients to an increased range and improved quality of services (including additional acute outreach clinics); a considerably improved working environment for staff; space for community and third sector partners and carer's organisations involved in the co-production of supported self care; meeting and training space for all our staff (supported by a commitment to shared and agile technology for staff) and local community groups.

1.7 Moreover, the development of a new and enhanced health and care centre within Clydebank has already been identified as a key contribution that NHSGGC could make to the wider regeneration plans for Clydebank. As such, the proposed new health and care centre is not just about the construction of a new asset, but more importantly how such a new facility will contribute to a transformation in the type of care provided with and for local people; and the economic and social transformation of the Clydebank area more broadly.

1.8 This paper sets out an initial proposal and outline costs for the development of a new integrated health and care centre for Clydebank and the wider community of West Dunbartonshire. NHSGGC has made provision within its capital resource limit for this project dependant on confirmation of Hub funding; and the revenue costs are break even at this time.

1.9 The development will be led by WD HSCP, which is responsible for the provision of all community health and social care services in West Dunbartonshire. As well as complying with the requirements of the Scottish Capital Investment Manual (SCIM), the local approach to shaping the development of this key project has been informed by the positive learning and best practice established in the successful delivery of the Vale Centre for Health and Care as recommended in the latter project's Office for Government Commerce (OGC) Gateway Review.

1.10 In accordance with SCIM guidelines the development of any new infrastructure project requires a full site options appraisal. Given the background to this project, the Scottish Government's Capital Investment Group agreed that Scottish Futures Trust should be invited to engage with NHSGGC to examine the available options against the project's benefits realisation and investment objectives. Following this process, the Queen's Quay Regeneration Development site in Clydebank was confirmed as the optimal available site for delivering on the project's investment objectives. Furthermore, the terms of the site's provision by the Council means it will be delivered at a lower cost to the project, allowing current funding to be used most effectively. In locating the new facility on this prime site, the regeneration benefits of the project will be considerably enhanced and further deliver a positive effect on the heath and wellbeing of the people of Clydebank.

2. Purpose

Strategic Case

2.1 NHSGGC is the largest NHS Health Board in Scotland and covers a population of 1.2 million people. NHSGGC's annual budget is £2.8 billion and it employs over 40,000 staff. NHSGGC's stated purpose is to deliver effective and high quality health services, to act to improve the health of the population and to do everything it can to address the wider social determinants of health which cause health inequalities.

2.2 The NHSGGC Clinical Services Strategy was approved in January 2015, providing a framework to ensure that best clinical outcomes are achieved for patients and that services are:

- Safe and sustainable.
- Patient centred.
- Integrated between primary and secondary care.
- Efficient, making best use of resources.
- Affordable, provided within the funding available.
- Accessible, provided as locally as possible.
- Adaptable, achieving change over time.

The strategy is entirely in line with NHS Scotland's strategic priorities, particularly in relation to the 2020 Vision and the Quality Strategy.

2.3 The Scottish Government's Public Bodies (Joint Working) Act (Scotland) 2014 sets out the arrangements for the integration of health and social care across the country. The approved Integration Scheme for West Dunbartonshire details the 'body corporate' arrangement by which the Health Board and the Council have agreed to formally delegate health and social care services for adults and children to a third body, which is described in the Act as an Integration Joint Board. The Integration Joint Board for West Dunbartonshire is known as the West Dunbartonshire Health & Social Care Partnership Board (WD HSCP Board), which was established on 1st July 2015 (the integration start day on which the new arrangements officially commenced). The WD HSCP Board is responsible for the operational oversight of West Dunbartonshire Health & Social Care Partnership (WD HSCP), which is the joint delivery vehicle for those integrated services delegated to the Integration Joint Board (except for NHS Acute Services); and through the Chief Officer, who is responsible for the operational management of WD HSCP.

2.4 The WD HSCP Strategic Plan sets out the key actions that will be taken forward to deliver the National Health and Wellbeing Outcomes (for adults) prescribed by the Act. Given that children and families health and social care services and criminal justice social work services have also been delegated to the WD HSCP Board, the specific National Outcomes for Children and Criminal Justice are also addressed within the Strategic Plan. Across all of service areas, the WD HSCP's delivery model reflects a collective commitment to:

- Optimal outcomes for individual service users.
- A client-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services.
- Effective and safe services that draw upon the best available evidence and local feedback from service users.
- Equalities-sensitive practice.
- Acceptability of service provision informed through constructive engagement with local stakeholders – including staff, community groups and elected representatives

- Affordable and efficient services that continue to be reflective of the relative demands across the West Dunbartonshire population as a whole.

2.5 Scottish Ministers have confirmed that Strategic Plans will take account of all resources available to the WD HSCP, including capital assets owned by the NHSGGC on behalf of Scottish Ministers; and that the responsibility for such capital assets and the associated running costs will continue to sit with NHSGGC.

2.6 WD HSCP Board and NHSGGC are key partners within Community Planning West Dunbartonshire. Its aim is to work in partnership to improve the economic, social, cultural and environmental well being of West Dunbartonshire for all who live, work, visit and do business there. Its 2014-17 Single Outcome Agreement (SOA) for West Dunbartonshire focuses on the following interconnected priorities:

- Employability and Economic Growth.
- Supporting Safe, Strong and Involved Communities.
- Supporting Older People.
- Supporting Children and Families.

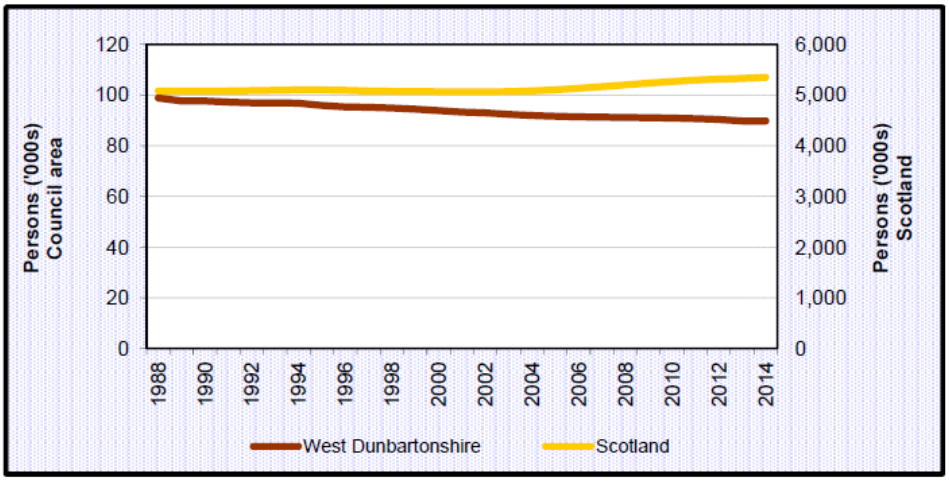
2.7 Community health services in Clydebank serve 50,000 people and currently operate from five sites: Clydebank Health Centre; Hardgate Clinic; Kilbowie Road; Beardmore Resource Centre; and Goldenhill Clinic. All of the services across the five sites are being developed as increasingly integrated health and care arrangements, but the scope to fully realise those potentials significantly limited by the constraints of the existing facilities in which they operate; and the very fact that the dispersed locations of the staff and services inhibits ability to develop synergies in terms of new ways of joint working and support.

2.8 The current arrangements do not support the transformations in services that our local population requires. The option that best supports the strategic direction of the Health Board, the WD HSCP Board and the local Community Planning Partnership is to bring all of those existing services – as well as "new" (including shared care) provision that has traditionally been provided within NHS Acute Hospitals outwith the locality – into a single and modern facility.

Economic Case

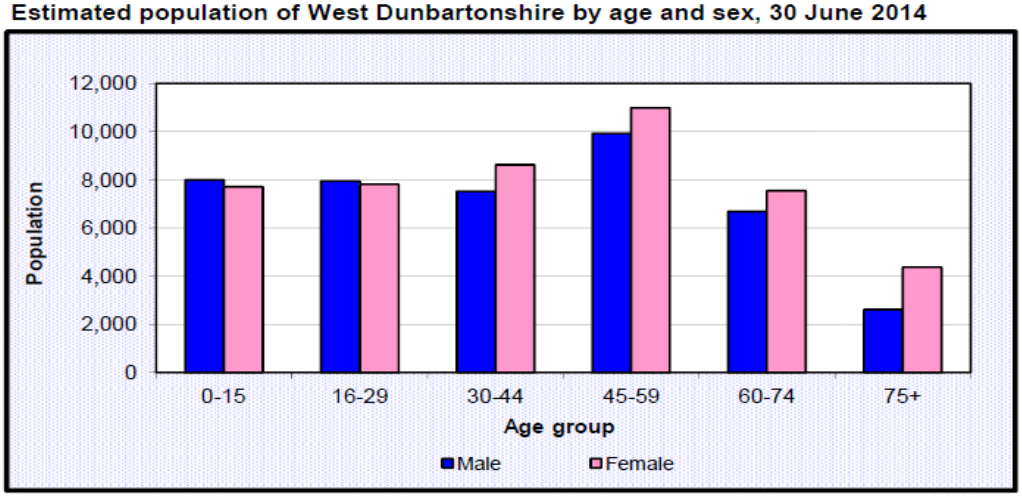
2.9 According to the National Records for Scotland, in 2014 population for West Dunbartonshire was 89,730 - a decrease of 0.1 per cent from 89,810 in 2013. The population of West Dunbartonshire accounts for 1.7 per cent of the total population of Scotland. The graph overleaf shows that the local population has been declining in numbers whilst the overall Scottish population has been increasing.

Estimated population of West Dunbartonshire and Scotland, 1988-2014



2.10 In West Dunbartonshire, 17.6 per cent of the population are aged 16 to 29 years. This is smaller than Scotland where 18.3 per cent are aged 16 to 29 years. Persons aged 60 and over make up 23.6 per cent of West Dunbartonshire. This is smaller than Scotland where 24.0 per cent are aged 60 and over. The graph below shows that West Dunbartonshire's population overall is skewed more towards older age groups This means a potentially smaller proportion of working aged people against a higher proportion of older people who are likely to have greater health and social care needs – unless action is taken to successfully attract working age families into the area.

Estimated population of West Dunbartonshire by age and sex, 30 June 2014



2.11 West Dunbartonshire as a whole faces the considerable challenges of restructuring its economy following the decline of heavy industry, dealing with the impacts of the recession and managing a declining and ageing population. Over the next ten years the health and social care landscape will change significantly. The changing demographics, an increase in demand for services, and the likelihood of more people with complex multi-morbidities – alongside reduced public sector resources – means that we have to work together to deliver services in different ways and make the most of the investment available across public sector as a whole.

2.12 In scoping the options for re-provision of services, it has been confirmed that the future model of service provision needs to be delivered from premises that are fit-for-purpose; and through a development that delivers on the following business objectives:

- Improve local access to a greater range of modernised services.
- Increase integration of multi-disciplinary teams and services.
- Improve safety and quality of facilities in which services delivered and based.
- Increase capacity and adaptability of facilities in which services delivered and based.
- Contribute to economic regeneration of Clydebank as a whole.

2.13 The current facilities have been assessed as not meeting the basic needs nor being able to address these business objectives - so the "Do Nothing" option is not viable. The poor repair and ongoing maintenance of the main Clydebank Health Centre in particular mean that from a repairs perspective it is "money hungry" - backlog maintenance is costed at £557,090. The asbestos that is integral to the building's structure means that even relatively simple repairs are extremely costly; and that extension of that building is cost-prohibitive. The preferred solution is therefore a single and new-build facility, delivered within an overall funding envelope of £19 million.

Commercial, Financial and Management Cases

2.14 As confirmed through discussions with the Scottish Government and Scottish Futures Trust this Project will be developed based on the hub revenue financed model. A high level time line has been produced as follows:

Submission of Initial Agreement	January 2016
Site Options Appraisal	September 2015
Submit Outline Business Case	August 2016
Submit Full Business Case	July 2017
Financial Close	October 2017
Construction	January 2018

2.15 The Governance and Project Management arrangements are based on previous Hub approved schemes; and local experience from recent health and care centre developments in Eastwood and Maryhill will help us improve these areas. As well as complying with the requirements of the SCIM, the local approach to shaping the development of this key project has been further informed by the positive learning and best practice established in the successful delivery of the Vale Centre for Health and Care as recommended in the latter project's OGC Gateway Review.

Summary of Objectives

2.16 In delivering the national, health board and local priorities above, a new Clydebank Health and Care Centre – built to the right specification and in the right location - will:

- Improve (one stop) local access to a greater range of modernised services – including additional acute outreach services.
- Increase integration of multi-disciplinary teams and health and social care services.
- Improve safety and quality of facilities in which services delivered and staff are based.
- Increase capacity and adaptability of facilities in which services delivered and based, including for community groups, third sector partners and carer's organisations involved in the co-production of supported self care.
- Contribute to economic regeneration – and revitalisation - of Clydebank as a whole.

3. Strategic Background

3.1 In considering new ways of working we have considered who is affected by our proposal and worked to engage their views at an early stage. We have also considered how our objectives align with and help to deliver the wider strategic NHS priorities, both at national, NHSGGC and local levels. Finally, we have taken account of the key external factors that influence or are influenced by our proposal.

We are confident that the anticipated benefits described above and throughout the Initial Agreement will be realised, and that this will deliver genuinely improved outcomes for the people of Clydebank.

3.2 Who is Affected?

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
Organisation	NHSGGC and the WD HSCP Boards are fully supportive of this proposal, with Keith Redpath (HSCP Chief Officer) taking the lead role in its development as Senior Responsible Officer and chair of the Project Board. NHSGGC Board members approved this proposal at the Quality & Performance Committee meeting on 20th January 2015. WD HSCP Board member's endorsed this proposal within their approved Strategic Plan that was approved at their meeting of 1st July 2015. This proposal is also incorporated into the NHSGGC Property Asset Management Plan.	This Initial Agreement has been approved by the Project Board in November 2015, and submitted to the following for approval: Hub Steering Group (November 2015); NHSGGC Capital Planning Group (December 2015); and NHSGGC (December 2015).
Service or Department	The project is jointly co-ordinated within WD HSCP by Chris McNeill (Head of Community Health & Care) and Soumen Sengupta (Head of Strategy, Planning & Health Improvement). Their shared responsibilities include: • Overall direction and guidance for the project to ensure it continues to meet the stated business requirements. • Oversee the development of the Initial Agreement and Business Cases. • Chair monthly Design and Delivery Group meetings. • Liaise with corporate support/technical specialists, both internal and external.	This Initial Agreement was approved by the Project Board in November 2015.

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
	• Supervise identified project managers to ensure that the project produces the required products within the specified time, cost, quality, scope risk and benefits. • Ensure the preparation of highlight reports, and engaging with all services, stakeholders and external suppliers involved. • Advise the Project Board of any deviations from the project plan.	
Staff / Resources	Staff affected by this proposal include those working within the following areas of service: • Six general practices. • Allied Health Professional services. • Outreach clinics (e.g. Maternity Services and Acute Clinics). • Primary Care Mental Health. • District Nursing. • Older People's Mental Health. • Primary Care Mental Health. • Community Older People's Team. • Hospital Discharge Team. • Single Point of Access Receiving Team. Engagement is being undertaken across these areas to ensure that staff perspectives inform the design of the build; recommendations to the Project Board; and communication with the wider workforce and other stakeholders.	Staff representatives have participated in the Design and Delivery Group and Project Board meetings. Their feedback was incorporated into this proposal as it was developing. The most recent Design and Delivery Group dates were: • 11th September 2015 • 6th October 2015 • 20th October 2015 The most recent Project Board dates were: • 12th October 2015 • 30th November 2015
Patients / service users	Patients and service users representatives who this proposals affects and with whom engagement has been undertaken include: • The HSCP Locality Engagement Network for Clydebank • Community Planning Partners • West Dunbartonshire Carers Centre • West Dunbartonshire Councils for Voluntary Service • West Dunbartonshire Access Panel	Patient / service user and carers groups have participated meetings and workshops. Their feedback has been incorporated into this proposal as it was developing.

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
	Their involvement in its development includes being part of Site Options Appraisal Workshops and the Design and Delivery Group, making recommendations to the Project Board and involved in the design statement planning stages. The Project Communication and Engagement Plan is based on the Plan devised with the community for the recently completed Vale Centre for Health and Care, the engagement process and outcomes from which were recognised as national best practice following its OCG Gateway Review.	
General public	We have begun this process by adopting a coproduction approach as reflected by our Delivery Group. Our stakeholders are required to feed back to their constituent parts and seek the opinions of their members and feed these into the Design and Delivery Group. In addition, we are committed to consulting the wider community at different stages of this proposal, through such groups as the local Access Panel and the Community Planning Partnership Community Alliance. We will use a range of methods to consult including: • WD HSCP website and other relevant websites. • Information screens in Health Centres and other public offices. • Through engagement with group meetings. • Use of local media to keep the wider community informed of its progress and invite further comments. Once the Outline Business Case has been agreed we will develop an Arts Strategy, which will provide the opportunity for further involvement of potential service users of and the general public to shape the design, layout and surrounding environment. *See Appendix G - Communication and Engagement Plan*	Outcomes from engagement with community groups and other stakeholders have influenced the proposal by shaping and ordering the strategic priorities. This has also been fed back to those involved via the Design and Delivery Group.

NHS Scotland's Strategic Priorities

3.3 The Scottish Government has set out its vision for the NHS in Scotland in the strategic narrative for 2020.

> **Our vision is that by 2020** everyone is able to live longer healthier lives at home, or in a homely setting.
> We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of readmission.
>
> ***Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision***

3.4 Underpinning the narrative is the Quality Strategy, with the three central ambitions that care should be person centred, safe and effective. The quality outcomes and 2020 vision are the major national drivers of NHS targets and strategic direction for the period 2013-16 and beyond, including the HEAT targets for which the Health Board will be held to account each year. NHS Scotland's strategic investment priorities are aligned to the Quality Strategy as:

- Person centred.
- Safe.
- Effective quality of care.
- Health of population.
- Value and sustainability.

3.5 We will deliver these priorities through our commitment to the NHSGGC Clinical Services Strategy; the West Dunbartonshire Community Planning Partnership Single Outcome Agreement; and the national outcomes reflected within the WD HSCP Strategic Plan, i.e.:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and Social Care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of health and social care services.

3.6 To ensure that we are responding to the core strategic investment priorities, we will monitor the effectiveness of our new ways of working based on the following table.

NHS Scotland Strategic Investment Priority	How the proposal responds to this priority	As measured by
Person Centred	Enable speedy access to modernised and integrated Primary Care and Community Health and Social Care Services. Improve access to primary care services that are person centred, safe and clinically effective. Self-management of Long Term Conditions (LTCs) will increase the proportion of people with intensive needs being cared for at home.	Improved GP Access – 48 hour access / advance booking Reduced hospital bed days on key LTCs (COPD/Asthma/ Diabetes/CHD) Reduced hospital bed days lost to delayed discharges Levels of homecare provision
Safe	Multidisciplinary team working will support holistic care and anticipatory care plans (ACPs). Rationalisation of services into a single location will reduce lone working for staff, particularly out of hours. A new-build would be easier to clean, thus supporting the Patient Safety Programme.	Number of ACPs in place Reduced number of instances of staff lone working, particularly out of hours. Reduced Healthcare Acquired Infections
Effective Quality of Care	Co-locating multi- disciplinary services - including integrated health and social care teams - within a new facility will improve the care journey and experience for patients, carers and visitors, giving one stop access and improved accessibility to an increased range and improved quality of services. This will include the delivery of pre and post acute services; and allow for expansion in post discharge rehabilitation and reablement.	Fewer delayed discharges (including Adults With Incapacity - AWI) Fewer hospital bed days: COPD/Asthma/ Diabetes/CHD

NHS Scotland Strategic Investment Priority	How the proposal responds to this priority	As measured by
Health of Population	Service users will benefit from a single point of access to integrated community teams. This will improve service co-ordination and ensure that service users receive the best possible care from the professional with the skills best suited to their needs. Enable GP led multi-disciplinary teams to develop Anticipatory Care Planning and review for a range of conditions, particularly in Older Adult Mental Health, the frail elderly, those with long term conditions and maternity services. Delivering shared care services – this is particularly important in Clydebank following the closure of the Western Infirmary and the long distances to the nearest Ambulatory Care Hospital.	Number of ACPs in place Increased number of patients with supported self-management Inter-service referral rates increased. Reduced time lag for diagnostic results. Earlier diagnosis for key conditions
Value & Sustainability	Operating out of a reduced number of buildings will be more energy efficient which will reduce the carbon footprint and running costs. A new-build to modern standards will significantly reduce this further. Delivering a safe high quality physical environment for patients, clients and staff – visible investment in the health of Clydebank people sends a message that we value their health and that they should too. Staff working agile will be equipped with the latest technology allowing them access to the same information they would have in the office but now electronically from patient's home or whilst agile. Improved Information Governance through use of latest technology (which therefore reduces the likelihood of data breach).	Emissions data Running costs (taking account of previously used but now decommissioned buildings too) Proportion of staff working agile Number of data breaches.

Strategies to which the Proposal Responds

3.7 This proposal directly responds to the NHS Quality Strategy that care should be person centred, safe and effective. Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

3.8 NHSGGC's purpose as set out in the Health Board's Corporate Plan 2013-16 is to deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities.

3.9 The proposal also supports the NHSGGC Clinical Services Strategy; the West Dunbartonshire Community Planning Partnership Single Outcome Agreement; and the national outcomes reflected within the WD HSCP Strategic Plan.

3.10 The development of a new and enhanced health and care centre within Clydebank has already been identified as a key contribution that NHSGGC – as a pro-active member of the local Community Planning Partnership - could make to the wider regeneration plans of the Council for Clydebank.

External Factors

3.11 In considering the need to work differently we have re-assessed our ability to respond to a range of key national resources, including:

- Reshaping Care for Older People.
- Getting It Right for Every Child.
- The Delivery Framework for Adult Rehabilitation in Scotland.
- National Unscheduled Care Programme.
- Scottish Patient Safety Programme.
- Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities.
- Best Preventative Investments for Scotland – What the Evidence and Experts Say.
- Creating Places - Policy Statement on Architecture and Place.
- A Long-Term Vision for Active Travel in Scotland 2030.
- Achieving a Sustainable Future: Regeneration Strategy.

3.12 NHSGGC and the WD HSCP Board strongly recognise that the determinants of health and health inequalities go far beyond health and care services, and new ways of working needed to be developed. Our evidence-based approach has been to work collaboratively with a wide range of local Community Planning Partners, in addition to developing our own services – and that approach will be re-emphasised through the delivery of this project, not least in relation to its contribution to the regeneration of Clydebank.

3.13 The aim of the Community Planning West Dunbartonshire is to work in partnership to improve the economic, social, cultural and environmental well being of West Dunbartonshire for all who live, work, visit and do business here. Single Outcome Agreements are the means by which the Community Planning Partnership agrees its strategic priorities for the local area, express those priorities as outcomes to be delivered by the partners, either individually or jointly, and show how those outcomes should contribute to the Scottish Government's relevant National Outcomes.

3.14 The 2014-17 Single Outcome Agreement for West Dunbartonshire focuses on the following interconnected priorities:

- Employability and Economic Growth.
- Supporting Safe, Strong and Involved Communities.
- Supporting Older People.
- Supporting Children and Families.

3.15 As a key partner within Community Planning West Dunbartonshire, we are committed to:

- Ensuring that community planning takes a streamlined approach to delivering outcomes.
- Demonstrating an appreciation that our priorities and outcomes are inter-connected.
- An emphasis on early intervention and prevention across all of our priorities.
- Pro-active and rigorous self-evaluation and scrutiny of activities across community planning partners as a driver for continuous improvement.

3.16 With changing demographics and increasing levels of need, over the next ten years the health and social care landscape will change significantly. The changing demographics, including an ageing population, an increase in demand for services, and the likelihood of more people with complex multi-morbidities – alongside reduced public sector resources – means that we will have to work in different ways to maximise the assets that are inherent in our communities. This will include patients themselves and the scope for appropriate and supported self-management; carers as equal partners in care; third sector organisations and services, and the full range of Community Planning partners who have a stake in improving health and reducing inequalities.

3.17 By working in more integrated ways, we envisage taking advantage of new technologies that will:

- Support a single patient/client record that allows practitioners to see the person in entirety rather than as a presenting illness or an episode of care.
- Streamline pathways through community health and social work and hospital based services.
- Improve communication across multi-disciplinary teams, or across the supports needed for patients with multi-morbidities.
- Streamline appointment booking.
- Use text messaging for appointment reminders as a matter of course, to reduce Did Not Attends (DNAs).
- Transfer diagnostics and other test results quickly and securely, thus improving accuracy and timeliness of diagnosis.
- Improve opportunities for agile working, thereby freeing up space for clinical or therapeutic uses rather than administrative functions.
- Promote new forms of collaboration that reduce the need for physical meetings and travel.
- Support culture change to enable greater organisational agility.

3.18 There is also potential for a new-build health and care centre to become a community hub, thereby further contributing to social regeneration in Clydebank.

3.19 Clearly the health issues and inequalities evident in Clydebank remain a significant challenge and focus. Overleaf is a summary of key statistics taken from the Scottish Public Health Observatory (ScotPHO) Health and Well-Being Profiles 2014, which illustrates some of the challenges faced in improving health and wellbeing in West Dunbartonshire.

ScotPHO
Period: 2013

Health & Wellbeing Profiles (West Dunbartonshire)

Printed Date: 11-JUN-2015 15:09

Domain		Indicator	Period	Number	Measure	Type	National Average	'Worst' Scotland Comparator 'Best'
Life Expectancy & Mortality	1	Male life expectancy [18]	2011	n/a	74.1	yrs	76.6	
	2	Female life expectancy [18]	2011	n/a	78.7	yrs	80.8	
	3	Deaths all ages [12]	2012	1,060	1,387.4	sr4	1,187.5	
	4	All-cause mortality among the 15-44 year olds. [12]	2012	45	141.0	sr4	105.3	
	5	Early deaths from CHD (<75) [12]	2012	62	81.9	sr4	60.7	
	6	Early deaths from cancer (<75) [12]	2012	162	212.7	sr4	173.4	
Behaviours	7	Estimated smoking attributable deaths [3,13,16]	2012	184	413.2	sr4	325.9	
	8	Smoking prevalence (adults 16+) [3,14]	2013	142	27.0	%	23.0	
	9	Alcohol-related hospital stays [15]	2013	832	975.9	sr4	704.8	
	10	Deaths from alcohol conditions [17]	2011	29	32.8	sr4	23.8	
	11	Drug-related hospital stays [12,15]	2012	99	113.9	sr4	116.6	
	12	Active travel to work [3,14]	2013	23	11.0	%	16.0	
Ill Health & Injury	13	Patients registered with cancer [12]	2012	575	714.7	sr4	634.1	
	14	Patients hospitalised with chronic obstructive pulmonary disease (COPD) [12,15]	2012	572	705.8	sr4	659.9	
	15	Patients hospitalised with coronary heart disease [12]	2012	445	553.8	sr4	440.3	
	16	Patients hospitalised with asthma [12]	2012	108	116.8	sr4	91.2	
	17	Patients with emergency hospitalisations [12]	2012	7,438	8,653.4	sr4	7,500.2	
	18	Patients (65+) with multiple emergency hospitalisations [12]	2012	904	6,142.6	sr4	5,159.5	
	19	Road traffic accident casualties [12]	2012	47	53.3	sr4	63.2	
Mental Health	20	Population prescribed drugs for anxiety/depression/psychosis [3]	2013	17,783	19.8	%	17.0	
	21	Patients with a psychiatric hospitalisation [12]	2012	278	322.0	sr4	291.6	
	22	Deaths from suicide [17]	2011	15	16.4	sr4	14.5	
Social Care & Housing	23	Adults claiming incapacity benefit/severe disability allowance/ employment and support allowance	2013	6,085	6.8	%	5.1	
	24	People aged 65 and over with high levels of care needs who are cared for at home [3]	2013	399	40.7	%	34.7	
	25	Children looked after by local authority [3]	2013	347	18.3	cr2	14.4	
	26	Single adult dwellings	2013	17,439	38.9	%	37.7	
Education	27	Average tariff score of all pupils on the S4 roll [13]	2012	n/a	182.0	mean	193.0	
	28	Primary school attendance	2010	6,227	94.4	%	94.8	
	29	Secondary school attendance	2010	5,075	90.1	%	91.1	
	30	Working age adults with low or no educational qualifications [3]	2013	10,500	18.6	%	12.6	△
Economy	31	Population income deprived	2013	17,310	19.3	%	13.2	
	32	Working age population employment deprived	2013	10,165	17.4	%	12.2	
	33	Working age population claiming Out of Work benefits	2013	10,985	18.8	%	13.0	
	34	Young people not in employment, education or training (NEET). [3]	2013	460	10.6	%	7.8	
	35	Children Living in Poverty	2012	4,645	22.8	%	15.3	
	36	People claiming pension credits (aged 60+)	2013	2,490	11.9	%	7.7	
Crime	37	Crime rate	2013	5,208	58.0	cr2	40.5	
	38	Prisoner population [3,13]	2012	199	273.5	sr4	171.2	
	39	Referrals to Children's Reporter for violence-related offences [3]	2013	16	2.1	cr2	2.1	
	40	Domestic Abuse [3]	2012	1,518	168.0	cr9	113.1	
	41	Violent crimes recorded [3]	2013	139	15.5	cr9	12.7	
	42	Drug crimes recorded [3]	2013	1,090	121.4	cr9	66.9	
Environment	43	Population within 500 metres of a derelict site	2013	54,800	60.7	%	29.7	
	44	People living in 15% most 'access deprived' areas	2013	5,034	5.6	%	15.0	
	45	Adults rating neighbourhood as 'a very good place to live' [3,14]	2013	n/a	45.0	%	55.0	
Women's & Children's Health	46	Teenage pregnancies [12]	2011	136	49.2	cr2	44.6	
	47	Mothers smoking during pregnancy [12]	2012	244	24.9	%	20.0	
	48	Low birth weight [12]	2012	19	2.0	%	2.0	
	49	Babies exclusively breastfed at 6-8 weeks [12]	2012	144	15.0	%	26.5	
	50	Child dental health in primary 1	2013	597	61.1	%	66.7	
	51	Child dental health in primary 7	2013	269	32.9	%	47.7	
	52	Child obesity in primary 1	2013	108	11.3	%	10.1	
Immunisations and Screening	53	Breast screening uptake [12]	2011	2,799	69.3	%	72.5	
	54	Bowel screening uptake [12]	2011	7,543	51.8	%	55.1	
	55	Immunisation uptake at 24 months - 5 in 1 [12]	2013	1,030	97.9	%	98.2	
	56	Immunisation uptake at 24 months - MMR [12]	2013	995	94.6	%	95.3	

Notes:

3. Data available down to council (local authority) area only.
12. Three-year average number, and 3-year average annual measure.
13. Indicator based on HB boundaries prior to April 2014.
14. Two-year combined number, and 2-year average annual measure.
15. All 6 diagnosis codes used in the analysis; please see the technical report for more information.
16. Two-year average number, and 2-year average annual measure
17. Five-year average number, and 5-year average annual measure
18. Three year average for health boards, local authorities and Scotland. Five year average intermediate geographies

Spine Chart Key:

% =percent
cr2 =crude rate per 1,000 population
cr9 =crude rate per 10,000 population
mean=average
sr4 =age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.
yrs =years

Spine Chart Key:

- Statistically significantly 'worse' than National average
- Statistically not significantly different from National average
- Statistically significantly 'better' than National average
- Statistically significant difference compared to National average
- △ No significance can be calculated

3.20 West Dunbartonshire as a whole faces the considerable challenges of restructuring its economy following the decline of heavy industry, dealing with the impacts of the recession and managing a declining and ageing population. Overall, West Dunbartonshire has a worse general level of health than the Scottish average – this is also the picture within Clydebank. The indicator that shows this most explicitly is average life expectancy which is 3 years below the national average for men and 1.8 years below the national average for women. Much of this is due to the significantly higher levels of death from Cancer, Coronary Heart Disease (CHD) and Cerebrovascular Disease (CVD). There are statistically significant higher level of deaths attributable to smoking and alcohol and a greater prevalence of smoking and women smoking while pregnant. Clydebank has high levels of poverty and an increasing elderly population high numbers with long term conditions. This results in a growing demand for health and social care services alongside an increasing imperative to co-locate teams, integrate services and deliver seamless care.

3.21 The development of the West Dunbartonshire Integration Scheme, which forms the governance basis of the WD HSCP Board, afforded an opportunity for us to consider how we work with communities. We are committed through that Scheme to work with two localities within West Dunbartonshire: Clydebank; and Alexandria & Dumbarton. Our new ways of working will apply across the whole of West Dunbartonshire, with staff and services within each locality learning from the other.

3.22 A new-build facility would fit well with the locality model that has been put in place, and would contribute significantly to partnership working to grow and diversify the local economy; and attract and stabilise the population through continuous improvements to:

- The quality of design in the built environment.
- Better quality housing.
- Vibrant town centres.
- More and better jobs.

3.23 As well as complying with the requirements of the SCIM, the local approach to shaping the development of this key project has been informed by the positive learning and best practice established in the successful delivery of the Vale Centre for Health and Care as feedback in the latter project's OGC Gateway Review:

"*While it is encouraging that there were so few negative events, many stakeholders identified positive learning from the delivery of the project. This included community engagement, user involvement in design, degree of (West Dunbartonshire) CHCP senior management involvement, detailed design of built environment to promote interaction between service teams and to encourage education and training, and further opportunities for integration of health, social and community care*".

In praising the above, the Gateway Review highlighted that this learning should be used on other similar projects and with other project teams.

4. Why is this Proposal a Good Thing?

4.1 There are many reasons why we need to do things differently:

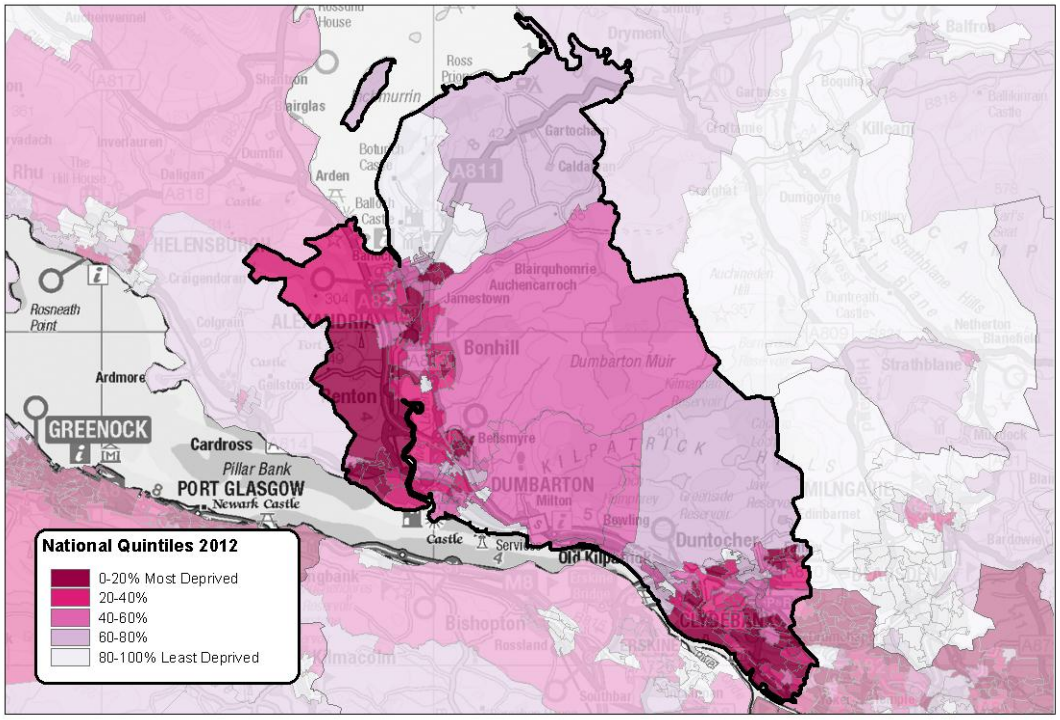
- To support effective and high-quality care, promoting patient centred services delivered within a "one stop shop".
- To help ensure that professional relationships are forged and sustained to robustly tackle inequalities and challenge any associated stigmas.
- To promote inter-disciplinary learning and continuous improvement.
- To provide a facility that is easier to clean, making healthcare acquired infections much less likely, and therefore making care and treatment safer.
- To support integrated working across partners within our local Community Planning Partnership.
- To provide a platform for sustaining and expanding clinical services, in line with the future model of primary care and the NHSGGC Clinical Services Strategy.
- To enable shifting the location of services out of hospitals and into communities, helping to make sure that people receive the right care at the right time, in the right place and delivered by the right person. Such an approach represents better use of our resources (supporting value and sustainability) and the aspirations of the WD HSCP Strategic Plan.

<u>What are the Current Arrangements?</u>

4.2 Community health services in Clydebank serve 50,000 people and operate from five sites: Clydebank Health Centre; Hardgate Clinic; Kilbowie Road; Beardmore Resource Centre; and Goldenhill Clinic.

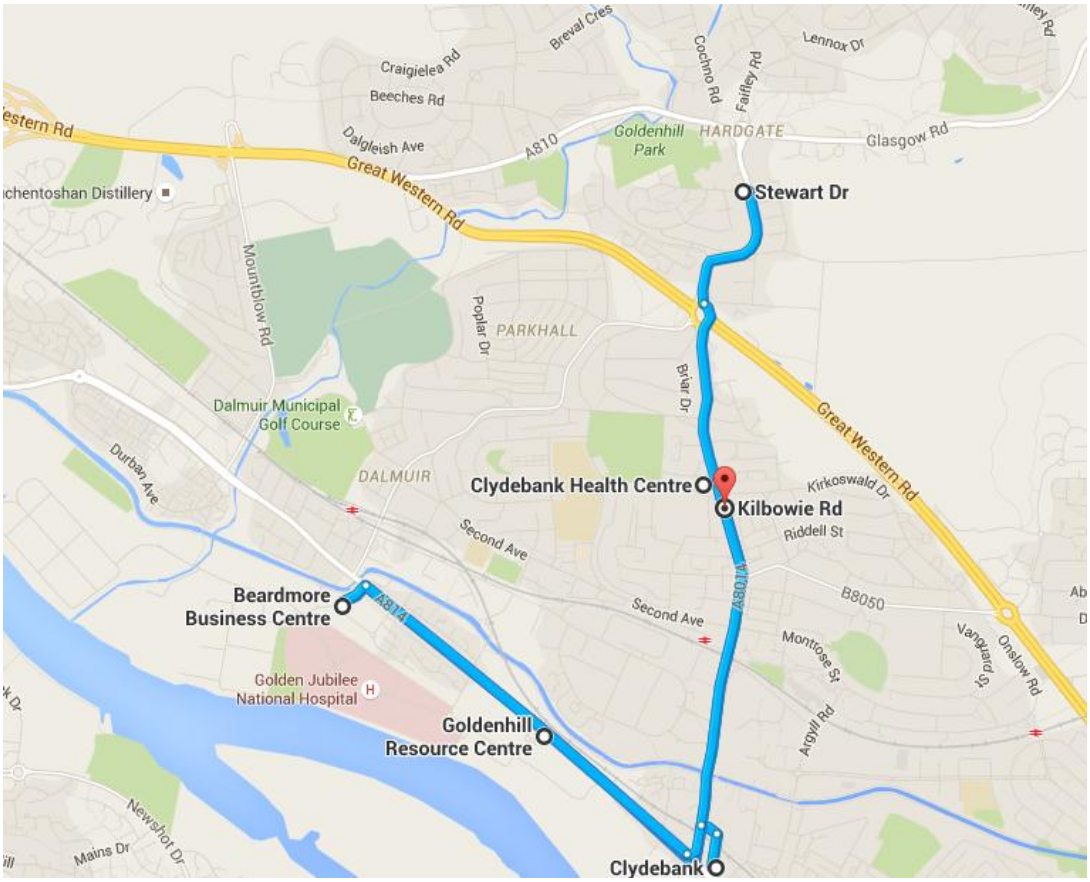
Clydebank Health Centre – 3808m^2	238 staff 6 GP practices – total registered list size of 41,585. Allied Health Professional (AHP) Services Outreach clinics (e.g. Maternity Services; Acute Clinics) Primary Care Mental Health District Nursing Older People's Mental Health Services Primary Care Mental Health Team Community Dental Health
Hardgate Clinic – 560m^2	60 staff Community Older People's Team and Adult Services Older People's Mental Health Consultant Base
Kilbowie Road (WDC) – 100m^2	30 staff Range of integrated services, including Hospital Discharge Team and Single Point of Access Receiving Team
Beardmore Resource Centre – 360m^2	40 staff Learning Disability Services
Goldenhill Clinic – 360 m^2	30 staff Adult Mental Health Services

4.3 Most patients who use the present Clydebank Health Centre facility reside within the boundaries of the West Dunbartonshire local authority.



Reproduced by permission of Ordnance Survey on behalf of HMSO. © Crown copyright and database right (2012). All rights reserved. Ordnance Survey Licence number 100024655.

4.4 The five sites previously mentioned are located as follows.



4.5 All of the services across the five sites are being developed as increasingly integrated health and care arrangements, but the scope to fully realise those potentials significantly limited by the constraints of the existing facilities in which the operate; and the very fact that the dispersed locations of the staff and services inhibits ability to develop synergies in terms of new ways of joint working and support.

4.6 The main Clydebank Health Centre is in significantly poor repair (particularly the roof with frequent water ingress) despite considerable, costly and on-going repair work in previous years (backlog maintenance is costed at £557,090). The building allows no further expansion of GP and other services; and requests to host additional and much-needed outreach services have to be denied. The access to the centre is also increasingly problematic: it is located on a site that has restricted parking close to a school entrance; and is on a steep hill with difficult access for patients, staff and supplies. Most problematically, the significant asbestos contamination throughout the structure and fabric of the building not only limits the scope for making any improvements to the building itself and is exponentially driving up costs of repair/refurbishment at a level that is unaffordable to sustain, but is also now viewed with concern by the Health & Safety Executive.

4.7 Upgrading the current Clydebank Health Centre has been considered but is not feasible, because of the size of the site; the limitations/constraints of the building design/layout; and critically, the aforementioned significant asbestos contamination throughout the structure and fabric of the building. Despite the commitment of staff the current facilities are unable to provide the standard of patient experience set out in the national Quality Strategy; or of a standard acceptable to either NHSGGC or the WD HSCP Board.

4.8 Through the Property Asset Management System we were involved in a feasibility study from late 2013 to early 2014. That process identified Clydebank as being in need of a replacement health centre. The accommodation has no room to expand due to the footprint and site constraints. As a result the existing facility has failed to keep pace with the requirements of modern community and primary care provision. This has in turn limited the ability of GP practices to provide a full range of services. In addition there is no flexibility to extend the range of wider community services provided from the site. More than a year has passed since that process was concluded, so it was timely to revisit our options through the SCIM process. As part of that SCIM process, we carried out an Achieving Excellence Design Evaluation Toolkit (AEDET) workshop in September 2015 (the outputs detailed in Appendix A).

4.9 New ways of working, supported by a new-build health and care facility, will improve the patient care pathway through the provision of integrated services which will provide seamless care supported by a range of agencies working in partnership for people with complex health and social problems. This will also apply to the improvement of services for people with a range of diseases which cause premature death or reduce people's functioning or quality of life (e.g. CHD, cancer and diabetes); support the drive to address health issues at the earliest time possible; and also reduce attendances at Accident & Emergency Services.

4.10 Early intervention and prevention are priorities for NHSGGC and the WD HSCP Board as we focus on chronic disease management in and supporting greater self-management through community care and primary care.

4.11 The high rates of mental illness in West Dunbartonshire have been recognised for a number of years, with integrated mental health services established even before our CHCP arrangements were put in place. Our mental health services work well but the indicators in the table below show that we are still above the national average for mental illness in the community as well as psychiatric hospitalisations.

4.12 Our new models of working will maximise the opportunities for patients to access Tier Zero services provided by local Third Sector organisations, thereby supporting early intervention and patient empowerment. We believe that this will represent significant progress in generating the culture change needed for truly person-centred care. .

4.13 The term *shifting the balance of care* has traditionally been used to describe structured programmes to reduce the number of hospital beds in favour of less expensive care home beds. However, the use of this term now more frequently also encompasses supporting people to remain in their own homes, moving other services out of hospital if they don't need to be there; and into communities where they can be less intimidating and easier to access.

4.14 By putting services in logical locations based on the patient's perspective, we will promote better engagement – particularly of the most vulnerable – and bring about better outcomes. We believe that if we work differently, our services will help reduce inequalities, promote independence and will be quicker, more personal and closer to home. The shift needs to ensure that fewer people are cared for in settings which are inappropriate for their needs, and that staff as well as patients understand the patient pathways across all services, and can navigate them easily. More carers will be supported to continue in their caring role and more people will be able to die at home or in their preferred place of care.

4.15 Clearly as people grow older the likelihood of them needing some additional support can increase. In West Dunbartonshire, the data show relatively poor healthy life expectancy, linked inextricably to inequalities. Wider social changes have an impact on our demographic profile too, including the growth in single person households (impacting on the need for and availability of familial or unpaid carers), and the growth in numbers of people with dementia.

4.16 Our proposed new ways of working will aim to deliver better quality, appreciating of the assets that are inherent in our older people themselves (in terms of their abilities to engage in supported self-management of LTCs); communities (such as the caring potential of neighbours, or the social networking opportunities that can often be developed with a little support from statutory or voluntary sector partners); and family members who often want to be equal partners in care, but might require some additional input to make this possible. Co-location of teams (e.g. district nursing and homecare) will enhance team working ensuring effective communication and timely discharge from hospital. This will also allow patients to be seen by the right practitioner at the right time and in an accessible local environment.

4.17 It should be noted that hospital admissions are above the national average for COPD and for emergency admissions. Our proposed new way of working will aim to reduce this by providing more comprehensive patient pathways that access the full menu of supports that will be appropriate for each individual patient.

4.18 Having a comprehensive range number of services under one roof will reduce travel and improve access for service users and staff (noting that many staff are local residents). We see high staff sickness absence rates within key staff groupings within the WD HSCP, and if our staff can themselves access support more easily, attendance rates should improve - meaning full capacity to support the wider community as well.

4.19 Good practice requires us to measure our performance over time, to ascertain if what we do and how we do it is making a difference (either positively or negatively). In developing our future delivery model we have identified a suite of key performance measures to gauge our impact. The following tables provide a selection of high level indicators for the previous CHCP to provide an overview of demand and performance.

Indicator	2013/14	2014/15	
	Value	Value	Target
Percentage of children who have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review	76.1%	76.1%	75%
Number of adult mental health patients waiting more than 28 days to be discharged from hospital into a more appropriate setting, once treatment is complete	1	0	0
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	92.6%	92.2%	90%
Primary Care Mental Health Team average waiting times from referral to first assessment appointment (Days)	28	16	14
Number of adult mental health patients waiting more than 14 days to be discharged from hospital into a more appropriate setting, once treatment is complete	1	0	0
No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013	2	0	0
No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015	5	1	0
Average waiting times in weeks for musculoskeletal physiotherapy services	9	16	9
Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	95%	95%	91.5%
Number of patients in anticipatory care programmes	1,024	1,645	1,200
Percentage of identified patients dying in hospital for cancer deaths	27%	29%	35%
Percentage of identified patients dying in hospital for non-cancer deaths	49.6%	38%	40%
Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	41%	39.2%	40%
Percentage of people receiving free personal or nursing care within 6 weeks of confirmation of 'Critical' or 'Substantial' need	100%	100%	100%
Crude rate of people aged 75+ in receipt of Telecare per 100,000	22,666	23,994	22,410
Percentage of adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes	51%	55%	55%
Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	98.2%	98%	96%
Number of patients on dementia register	613	638	672

Indicator	2013/14	2014/15	
	Value	Value	Target
Total number of homecare hours provided as a rate per 1,000 aged 65+	642.3	590.5	695
Percentage of homecare clients aged 65+ receiving personal care	82.7%	93%	82%
Percentage of people aged 65 and over who receive 20 or more interventions per week	51.3%	31%	45%
Percentage of people aged 65 or over with intensive needs receiving care at home	40.71%	40.2%	51%
Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	85%	87%	86%
Number of carers of people aged 65+ known to CHCP	1,348	1,446	1,680

4.20 The following tables show at a high level, a comparative snapshot of the different (former) CH(C)P areas demand for and impact on NHS Acute Services, in particular delayed discharges, emergency attendances and admissions (noting that the time periods are different than for the previous table).

Crude rate of new A&E attendances per 100,000 against the agreed local targets

	Apr 14 - Mar 15	2014-15 Target	Variance %
East Dunbartonshire CHP	1589	2888	-45.0%
East Renfrewshire CHCP	1896	2888	-34.3%
Glasgow City CHP	2784	2888	-3.6%
Inverclyde CHCP	3066	2888	+6.2%
Renfrewshire CHP	2787	2888	-3.5%
West Dunbartonshire CHCP	1815	2908	-37.6%

Relative number of Emergency Admissions aged 65+ per 1,000 (Apr 14 - Mar 15)

	Rate of unplanned admissions per 1,000
East Dunbartonshire CHP	248
East Renfrewshire CHCP	225
Glasgow City CHP	315
Inverclyde CHCP	313
Renfrewshire CHP	305
West Dunbartonshire CHCP	282

Relative percentage of GP referrals to A&E

	Apr 14 – Mar 15
East Dunbartonshire CHP	10.0%
East Renfrewshire CHCP	13.8%
Glasgow City CHP	10.0%
Inverclyde CHCP	6.8%
Renfrewshire CHP	6.8%
West Dunbartonshire CHCP	9.7%

4.21 Improving quality, efficiency and effectiveness is a major strategic priority for the HSCP in line with the national Clinical and Care Governance Framework; and overseen by our Clinical and Care Governance Group, which is chaired by our Chief Officer and co-vice chaired by the HSCP Clinical Director and the Council Chief Social Work Officer. Our focus will continue to be on ensuring that care is person-centred, safe, and clinically and cost effective. A key part of this is ensuring all service users, carers and staff have the opportunity and confidence to share their experience and that we listen, learn and report back the changes implemented as a result. We need to continue our shift towards defining clearer quality outcomes; and embedding this in our performance management systems, focusing on experience of care as well as treatment.

What is the Need for Change?

4.22 The proposal is to develop new ways of working that maximise the connections between a wide range of professionals, providers and other supports. The best way to do this, is through a modern purpose built facility designed to deliver the investment objectives (4.23).

Cause of the need for change	Effect of that cause on the Organisation	Need for action now
Future service demand	Existing capacity is unable to cope with current or future projections of demand. There is no natural flow between clinical areas to maximise a multidisciplinary approach.	Multidisciplinary working is has been impeded by the constraints of the layout. Patient demand cannot be met due to constraints of accommodation.
Dispersed service locations	Existing service arrangements affect service access and travel arrangements. Currently managing the upkeep and backlog maintenance of old buildings, most of which are no longer fit for purpose.	Service access is currently fragmented for this locality when compared with other catchment areas.
Ineffective service arrangements	The current Health Centre was built at a time when the NHS was more focused on less complex episodes of illness and treatment; and less recognition of the need for privacy, respect and dignity as integral to the delivery of health services. It is no longer acceptable to have key services on upper floors if the lifts are unreliable, for example and while we have this situation, some sections of our communities have poorer access to services.	More integrated approaches are not supported by dispersed teams, particularly when the patient has to navigate across a number of sites and locations to access the range of supports needed.
Service arrangements not person centred	The existing Health Centre facility does not have interior flexibility to re-shape clinical areas and accommodate related teams or services. This means that patients need to navigate an often complex array of locations to receive multi-disciplinary support. As more and more people are living with multiple LTCs and wishing to be more active	People will be discouraged from engaging with our services as it can be complicated and expensive. This increases the risks of individuals coming to services late in their disease progression; treatment options being more limited, and outcomes being less good than they could have been.

Cause of the need for change	Effect of that cause on the Organisation	Need for action now
	in the management of their own health, our existing service arrangements present more barriers than solutions.	
Accommodation with high levels of backlog maintenance and poor functionality	Increased safety risk from outstanding maintenance. Clydebank Health Centre is now nearing the end of its useful life in terms of suitability for service provision. There has been a programme of works to address the need to remove asbestos, and therefore more routine works have had to be de-prioritised, further adding to the backlog (backlog maintenance is currently costed at £557,090).	There is currently no room to expand the facility due to footprint of the building and site constraints. As a result the existing facility has failed to keep pace with the requirements of modern primary care health provision.

What Do We Want to Achieve?

4.21 Our refreshed HSCP arrangements in West Dunbartonshire benefit from the successful joint working and service delivery developed through the previous CHCP arrangements. We believe that there is much more to achieve in Clydebank through working differently, with a wide range of partners and with the people of Clydebank themselves. However our current accommodation in Clydebank does not support the levels of integrated working that we want to achieve; and we believe that a new development will provide the right environment for transformation in the medium and flexibility for the future.

4.22 As well as complying with the requirements of the Scottish Capital Investment Manual (SCIM), the local approach to addressing the above has been informed by the positive learning and best practice established in the successful delivery of the Vale Centre for Health and Care as feedback in the latter project's OCG Gateway Review.

4.23 The investment objectives for the project are as follows:

Effect of that cause on the organisation	What needs to be achieved to overcome this need? (Investment Objectives)
Stifling effect of inequalities on population of Clydebank	The primary determinants of health are well recognised as being economic, social and environmental. Within West Dunbartonshire we are formally committed to a determinants-based approach to health inequalities, with our local-term goal being to have tackled population-level health inequalities as a result of our having collectively addressed its root causes through the local Community Planning Partnership – by stimulating sustainable economic growth and employment; promoting educational attainment and aspiration; and supporting community cohesion and self-confidence. *INVESTMENT OBJECTIVE 1:* *Contribute to economic regeneration of Clydebank as a whole.*

Effect of that cause on the organisation	What needs to be achieved to overcome this need? (Investment Objectives)
Existing service arrangements affect service access and travel arrangements	Our current arrangements have developed based on the location of buildings rather than the natural flow of services and how they should be used. Patients frequently have to travel between locations to access the full range of support they need, and staff use up valuable clinical time travelling between these locations too. The location of the current health centre means that travelling by car is the most convenient mode for most, and for those without access to a car, the alternatives are costly and inconvenient - and this disproportionately affect those most vulnerable to poor health outcomes. To overcome this, we require improved access to primary care and associated services that are patient centred, safe and clinically effective. *INVESTMENT OBJECTIVE 2:* *Improve local access to a greater range of modernised services.*
Inefficient service performance	Since our CHCP arrangements were put in place in 2010 there has been a much greater emphasis on joint working. This has not just been with the Council, but also the wider community planning partnership and local voluntary sector organisations. To help us build on this approach, key services (including but not restricted to health services) need to be located together, and their relationships with good overall health and wellbeing made explicit. *INVESTMENT OBJECTIVE 3:* *Increase integration of multi-disciplinary teams and services.*
Service is not meeting current or future user requirements	Current arrangements dispersed over a number of locations do not meet modern requirements or expectations for good, supportive care that promotes independent living. To meet user requirements for equitable and clear service pathways and connections, we need facilities that can provide a natural flow of services, and reinforce the services' relationships with each other. To achieve this, we need a modern fit for purpose accessible facility that will facilitate and promote interagency and interdisciplinary working, and address health inequalities by having better integrated teams. Community and primary care staff – including those working within general practice - need access to professional development and training, and facilities to support this would be built into new arrangements. *INVESTMENT OBJECTIVE 4:* *Increase capacity and adaptability of facilities in which services delivered and based.*
Increased safety risk from outstanding maintenance and inefficient service performance	Improve safety and effectiveness of accommodation by providing accommodation that will deliver improved energy efficiency, reducing CO2 emissions in line with the Government's 2020 target and contributing to a reduction in whole life costs. Meet statutory requirements and obligations for public buildings. The current backlog maintenance is compounded due to the asbestos in the current building, making repairs so costly that there is insufficient capital funding to undertake most repairs. The roof leaks in many places and parts of the interior drop off from time to time, occasionally causing injury to patients or staff. *INVESTMENT OBJECTIVE 5:* *Improve safety and quality of facilities in which services delivered and based.*

Measureable Benefits

4.25 By addressing these needs:

- We will local access to a greater range of modernised services. We will reduce travel costs for patients; and travel costs to the organisation through removing the need for staff to be moving between premises as part of their work. Staff time spent travelling will also be reassigned to clinical or client work, thereby increasing patient/client-facing capacity.
- We will increase integration of multi-disciplinary teams and services. Patients will be more likely to access all components of their care plan if this can be done under one roof - so quality of care will improve, DNAs will reduce and outcomes will be maximised.
- We will increase capacity and adaptability of facilities in which services delivered and based. Pressure on hospital services will be reduced as the new model will provide access to shared care and acute outreach clinics within the new Centre.
- We will improve safety and quality of facilities in which services delivered and based. We will be able to decommission a number of disparate buildings that currently deliver components of support but are no longer fit for purpose. This should reduce revenue costs and capital charges in the future, and remove running costs that are generally high due to the age and poor repair of many of these buildings.
- We will contribute to the economic regeneration of Clydebank as a whole, and thus the wellbeing of communities as a whole. The development of a new and enhanced health and care centre within Clydebank has already been identified as a key contribution that NHSGGC – as a pro-active member of the local Community Planning Partnership - could make to the wider regeneration plans of the Council for Clydebank.

4.26 These benefits are important because they will help us to deliver our ambition of transforming care, and they are in line with NHS Scotland's 2020 Vision. In particular, by addressing these needs and delivering the investment objectives, we will create a mixed-economy campus environment that fosters a culture of putting the patient/client at the centre of every interaction. Services will find it easier to work across disciplines, and staff will gain a better understanding of what other supports need to be in place from a whole person perspective, and importantly, how to ensure that their patients can access everything they need to achieve the best possible outcomes.

4.27 This improved access will particularly focus on those most vulnerable to poor outcomes (SIMD1), and by achieving these improvements we will also improve the overall health of our population, given the large proportion that are from the most deprived quintiles.

4.28 These benefits directly support the aims of:

- The NHS Quality Strategy.
- The NHSGGC Corporate Plan and Clinical Services Strategy.
- The WD HSCP Strategic Plan.
- The West Dunbartonshire Community Planning Partnership Single Outcome Agreement.

4.29 Patients/service users and staff will experience the following:

- Improved access to and range of services.
- Improved patient, carer and visitor experience.
- Greater integration of service provision.
- Greater integrated team working.
- Improved quality of care, including meeting decontamination requirements.
- Better use of information and communication technology.
- Improved physical work environment for staff.

- High quality education and learning facilities for staff and students.
- Improved environmental management and sustainable development contribution.
- Modern parking and drop off facilities, plus enhanced access for pedestrians, cyclists and those using public transport.
- Improved space utilisation and enhance adaptability for future change.

Risks

4.30 The main project risks and mitigation factors are identified at a high level at the Initial Agreement stage. As the project develops through the Outline Business Case and Full Business Case stages a more detailed and quantified risk register will be prepared. The main risks at this stage, along with mitigating actions, are highlighted in Appendix D.

Constraints or Dependencies

4.31 The proposal to develop the new service model is planned to be delivered via funding from the Hub initiative. As such it must meet the criteria for award of funds from the Hub initiative, and meet the timescale set by the Hub West Steering Group.

4.32 A summary of the key constraints identified is noted as follows:

- *Financial*
  Improvements must be delivered within the finances available, and the Project Board need to be assured that capital and ongoing revenue funding is in place and is sufficient.

- *Quality*
  Compliance with all current health guidance must be delivered.

- *Sustainability*
  Achievement of BREEAM (Building Research Establishment Environmental Assessment Methodology) Health "Excellent" for new build.

- *Dependencies*
  This Initial Agreement focuses on the case for a new way of working that brings together a wide range of services related to health and care outcomes; and that reduces the number of disparate service delivery locations. Taking this option forward is dependent upon the transfer and rationalisation of those services onto a single site.

5. Preferred Solution

The Do Nothing Option

5.1 All of the services across the five sites identified earlier are being developed as increasingly integrated health and care arrangements, but the scope to fully realise those potentials significantly limited by the constraints of the existing facilities in which the operate; and the very fact that the dispersed locations of the staff and services inhibits ability to develop synergies in terms of new ways of joint working and support.

5.2 The main Clydebank Health Centre is in significantly poor repair (particularly the roof with frequent water ingress) despite considerable, costly and on-going repair work in previous years. The building allows no further expansion of GP and other services; and requests to host additional and much-needed outreach services have to be denied. The access to the centre is also increasingly problematic: it is located on a site that has restricted parking close to a school entrance; and is on a steep hill with difficult access for patients, staff and supplies. Most problematically, the significant asbestos contamination throughout the structure and fabric of the building not only limits the scope for making any improvements to the building itself and is exponentially driving up costs of repair/refurbishment at a level that is unaffordable to sustain, but is also now viewed with concern by the Health & Safety Executive.

5.3 Through the Property Asset Management System we were involved in a feasibility study from late 2013 to early 2014. That process identified Clydebank as being in need of a replacement health centre. The accommodation has no room to expand due to the footprint and site constraints. As a result the existing facility has failed to keep pace with the requirements of modern primary care health provision. This has in turn limited the ability of GP practices to provide a full range of services. In addition there is no flexibility to extend the range of wider community services provided from the site.

Strategic Scope of Option	Do Nothing
Service provision	Do Nothing does not meet any of the investment objectives noted at 4.24. The existing centre is inadequate, of poor fabric with poor access and unfit for future service provision.
Service arrangements	The service arrangements envisaged for the new way of working cannot be accommodated in existing premises. The service arrangements we aspire to are designed to maximise the relationships between different services that impact on health outcomes, so are crucial to the investment objectives.
Service provider and workforce arrangements	To do nothing will prevent the new ways of working for the workforce i.e. agile working, new improved electronic systems and referral access to other services. Current arrangements will not deliver a reduction in referrals to hospital services.
Public and service user expectations	The public and service user expectations are very clear that there is a need for premises that will provide improved access to services and patient centre care. Service user expectations for supported self-management are difficult to realise when supports are located in a number of buildings that are not within easy reach of each other. A key investment objective is therefore to have services co-located, and the Do Nothing option cannot deliver this.

Service Change Proposals

5.4 Despite the commitment of staff the current facilities are unable to provide the standard of patient experience set out in the national Quality Strategy; or of a standard acceptable to either NHSGGC or the WD HSCP Board. In order to deliver the intended benefits the proposals for a new Centre are being developed and designed to enable and support:

- Improved services meeting the local demographic needs.
- Service redesign, of which it is an integral part.
- Easy access, especially by public transport.
- Opportunities for greater collaboration with partners.
- Visibility of the importance of wellbeing.
- Leverage for wider area regeneration.

5.5 As well as complying with the requirements of the SCIM, the local approach to shaping the development of this key project has been informed by the positive learning and best practice established in the successful delivery of the Vale Centre for Health and Care as feedback in the latter project's OGC Gateway Review: "*While it is encouraging that there were so few negative events, many stakeholders identified positive learning from the delivery of the project. This included community engagement, user involvement in design, degree of (West Dunbartonshire) CHCP senior management involvement, detailed design of built environment to promote interaction between service teams and to encourage education and training, and further opportunities for integration of health, social and community care*". In praising the above, the Review highlighted that this learning should be used on other similar projects and with other project teams.

5.6 We have adopted a coproduction approach as reflected by our Design and Delivery Group. Our stakeholders are required to feed back to their constituent parts and seek the opinions of their members and feed these into the Design and Delivery Group. In addition, we are committed to consulting the wider community at different stages of this proposal, through such groups as the local Access Panel and the Community Planning Partnership Community Alliance. We will use a range of methods to consult including:

- WD HSCP website and other relevant websites.
- Our information screens in Health Centres and other public offices.
- Through engagement with group meetings.
- Use of local media to keep the wider community informed of its progress and invite further comments.

5.7 As part of the development of the Outline Business Case, we will begin to engage with stakeholders and contractors – most notably the architects – to develop key themes for an Arts Strategy, which will provide the opportunity for further involvement of staff, service users and the local community to contribute creative ideas for the design, layout and surrounding environment.

5.8 In terms of deliverability, we are confident that replacing the current estate with a rationalised and integrated health and care centre will result in sufficient revenue savings to cover future revenue costs of a new-build.

Developing a Shortlist

5.9 In considering how the new way of working can be achieved, it has already been identified that the current Clydebank Health Centre has limitations that will significantly compromise delivery. The specific limitations have been considered and detailed at the AEDET

workshops, and a range of solutions have since been discussed at the Project Board, based on the investment objectives and the parameters defined SCIM. It has been agreed that to do nothing is not a feasible option due to the poor repair of the existing building; its considerable and growing backlog maintenance; and the growing needs of the local population. The table highlights the main points from the Project Board deliberations.

Strategic Scope of Option	**Proposed Solution 1** Extend existing facilities within constraints of existing sites	**Proposed Solution 2** New Health Centre on existing site	**Proposed Solution 3** Develop new build integrated facility on new site
Service provision: *Changes to the functional size and layout would support activity that could provide different outcomes and benefits. (Investment Objectives 2, 3, 4 and 5)*	The existing footprint is too small to allow changes to the extent that would be needed.	The existing footprint is too small to allow changes to the extent that would be needed.	A new build would be on a site that is large enough to allow changes to the extent that would be needed.
Service arrangements: *Changes to service activity and demand to achieve the model could be undertaken to fit the proposed solution. (Investment Objectives 2, 3 and 4)*	Accommodation constraints would require a reduced version of the model, and alternative arrangements would have to be made for increasing demands for provision.	Accommodation constraints would require a reduced version of the model, and alternative arrangements would have to be made for increasing demands for provision	A new build would be designed to deliver the new model for the existing population, with potential population growth or growth in need factored in.
Service provider and workforce arrangements*: The new working model includes partnership with statutory and voluntary sector providers and a focus on agile working whenever possible. (Investment Objectives 3 and 4)*	There is insufficient space in the current building for partners. The current configuration is not supportive of agile working.	The current car park footprint would not support a building large enough to accommodate current services plus partners. A new health centre could be configured to support agile working.	A new build would be customised to support and accommodate these aspects of the model way of working.
Supporting assets: Improved outcomes can potentially be achieved through maximising the connections and relationships between the supporting assets and contributing to	The opportunities to maximise the impacts and synergies between supporting assets cannot be readily achieved in the constrained environment of the	The opportunities to maximise the impacts and synergies between supporting assets cannot be readily achieved in the constrained environment of the	A new build would be customised to support and accommodate these aspects of the model way of working; and built on a location with

Strategic Scope of Option	Proposed Solution 1 Extend existing facilities within constraints of existing sites	Proposed Solution 2 New Health Centre on existing site	Proposed Solution 3 Develop new build integrated facility on new site
wider regeneration. (Investment Objectives 1, 2, 3, 4 and 5)	current health centre, which is isolated from other public sector developments.	current health centre land footprint, which is isolated from other public sector developments.	strong links to other regeneration developments.
Public & service user expectations: Requirement for public buildings are clean, safe, fit for purpose, support wellbeing and promote community confidence. (Investment Objectives 1, 2, 3, 4 and 5)	The current building has a significant maintenance backlog that will only grow in the future. Repairs are becoming more expensive due to asbestos issues.	The current site does not have sufficient footprint to allow a building that will meet all of these aspirations.	A new build would be designed and customised to support and accommodate these aspects of the model way of working.

Indicative Costs

5.10 While developing a short-list of proposed solutions, the Project Board has considered indicative costs. As part of this process the Do Nothing option was also costed (as this cannot be considered a cost-neutral option, not least as the backlog maintenance is currently costed at £557,090).

Costs in £millions	Do Nothing Carry on with existing arrangements	Proposed Solution 1 Extend existing facilities within constraints of existing sites	Proposed Solution 2 New Health Centre on existing site	Proposed Solution 3 Develop new build integrated facility on new site
Capital cost (or equivalent value)	0	£9.6m	£19.3m	£19.0m - £20.1m
Whole of life capital costs	£16.4m	£47.6m	£66.6m	£65.6m
Whole of life operating costs	£6.6m	£8.2m	£9.9m	£9.9m
Estimated Net Present Value of Costs	£14.6m	£26.1m	£30.3m	£29.2m - £30.8m

5.11 The breakdown of the whole of life capital and operating have been, where relevant, been developed using similar cost categories used in the Generic Economic Model, and as described in the Option Appraisal Guide i.e.:

- Property and opportunity costs – included.
- Capital and lifecycle costs – included.

- Clinical services costs – current assumption is that there will not be any extra costs but any savings identified in the future will be included at Outline Business Case stage.
- Non-clinical operating costs - current assumption is that there will not be any extra costs but any savings identified in the future will be included at Outline Business Case stage.
- Building running costs – included.
- Net contribution / costs - GPs (subject to clarification / guidance).
- Transitional costs – there will be no decant or double running costs.
- Externalities – there are no externalities.

5.12 In line with the Generic Economic Model we have excluded VAT and inflation, and as per the Green Book, the level of appraisal is proportionate to the size and stage of the project.

5.13 The capital costs noted have been prepared based on high level costs using £/m^2 rates using historic information. Allowances have been made for demolition of the existing health centre in Proposed Solution 2 since this would be required to create a car park. Option 2 also makes allowance for additional preliminary costs to reflect prolongment of the contract period by 12 weeks to deliver the demolition and car park works.

Initial Assessment of Proposed Solutions

5.14 The table below sets out the key approaches considered to deliver the investment objectives.

Strategic Scope of Option	Proposed Solution 1 Extend existing facilities within constraints of existing sites	Proposed Solution 2 New Health Centre on existing site	Proposed Solution 3 Develop new build integrated facility on new site
Advantages (Strengths & Opportunities)	Retains services on a site known to patient population.	Retains services on site known to patient population. Site owned by NHSGGC.	All investment objectives can be met. Facility can be purpose built without disruption to delivery of existing services. Ideally identify a site that is part of a broader public realm development and can be developed on a co-operative basis.
Disadvantages (Weaknesses & Threats)	Key investment objectives can only be met in a limited manner. Limited space around building. Any development would reduce parking further. Internal modification very difficult/expensive due to clasp construction and the need to manage asbestos. Very disruptive to achieve.	Key investment objectives can only be met in a limited manner. Limited space around building. Any new-build would need to occupy car park and would be constrained in its design. Site would not achieve increased parking numbers required. Costs would be high due to constrained working area and prolonged due to phased nature of contract.	Procurement of land may bring risks to costs / timescales unless can identify a site that is part of a broader public realm development and can be developed on a co-operative basis.

Does it meet the Investment Objectives (Fully, Partially, No, n/a)			
Investment Objectives	**Proposed Solution 1 Extend existing facilities within constraints of existing sites**	**Proposed Solution 2 New Health Centre on existing site**	**Proposed Solution 3 Develop new build integrated facility on new site**
Investment Objective 1: Contribute to economic regeneration of Clydebank as a whole.	No	No	Yes
Investment Objective 2: Improve local access to a greater range of modernised services.	No	No	Yes
Investment Objective 3: Increase integration of multi-disciplinary teams and services.	No	No	Yes
Investment Objective 4: Increase capacity and adaptability of facilities in which services delivered and based.	Partial	Partial	Yes
Investment Objective 5: Improve safety and quality of facilities in which services delivered and based.	No	Partial	Yes

Are the indicative costs likely to present value for money and be affordable? (Yes, maybe / unknown, no)			
	Proposed Solution 1 Extend existing facilities within constraints of existing sites	**Proposed Solution 2 New Health Centre on existing site**	**Proposed Solution 3 Develop new build integrated facility on new site**
Value for Money and Affordability	No - This option does not meet the investment objectives.	No - This option does not meet the investment objectives.	Yes - This option is capable of delivering all of the investment objectives. A review of potential sites has been undertaken by key stakeholders from NHSGGC Capital Planning, WD HSCP and leads from the Council's planning and technical team. Five potential sites were identified for rating against an agreed scoring matrix with Scottish Futures Trust (Appendix B).
Preferred / Possible / Rejected	**Rejected**	**Rejected**	**PREFERRED**

5.15 From the table above it is clear that Proposed Solutions 1 and 2 would not meet all of the investment objectives – and, at best, they would result in a compromised design solution due to the limitations of the land available to develop. The site is defined by existing roads, with no opportunity for expansion or for a parallel build whilst the current health centre continues to operate. On this basis these options were rejected.

5.16 Proposed Solution 3 has the ability to meet the investment objectives and is identified as the preferred option, since it is the only option that delivers all of the investment objectives and is able to do so in a manner that can provide an optimal design solution and be delivered in a manner that offers value for money.

Design Quality Objectives

5.17 In September 2015 an AEDET assessment of the existing Clydebank Health Centre building was carried, facilitated by Health Facilities Scotland. The workshop was attended by clinical and other staff, managers, and public (including carers) representatives. The outcome of this was documented in an AEDET Assessment which is included in Appendix A, with the summary provided overleaf.

5.18 The AEDET assessment highlighted the areas where the existing building worked well:

- Internal space has been well utilised.

5.19 The AEDET assessment also highlighted those areas where the existing building was seen as being inadequate, notably:

- Lack of space.
- Poor quality environment internally – staff and patients/service users.
- Poor layout internal.
- Poor access to the building.
- Sustainability

5.20 A follow-on workshop series was undertaken later in September 2015 to develop a Design Statement for any new facility. This was facilitated by Architecture & Design Scotland, and was attended by broadly the same group of stakeholders who undertook the AEDET Assessment. The Design Statement is included in Appendix E. The workshop highlighted the key aspects that any new design should deliver:

- To be clearly accessible for the communities that it is designed to serve.
- To be straightfoward to navigate for all, with clear wayfinding and lines of sight.
- To foster a safe and calming environment, including through good use of natural light and ventilation.
- To promote a sense of community amongst staff within and across disciplines/services, encouraging dialogue, collaborative working and joint learning.
- To convey a welcoming and considerate impression, internally and externally – to express a “civic feel”.

Category	Benchmark	Target
Use	1.2	4.5
Access	1.1	4.7
Space	1.7	4.8
Performance	1.0	4.6
Engineering	1.3	3.6
Construction	0.0	4.2
Character and Innovation	1.4	4.7
Form and Materials	1.4	4.9
Staff and Patient Environment	1.3	4.6
Urban and Social Integration	1.6	4.9

6. Readiness to Proceed

Commercial Case

6.1 The Commercial Case assesses the possible procurement routes which are available for a project. Normally these include Frameworks Scotland, Non Profit Distributing (NPD) and Hub revenue models. NHSGGC have consulted with Scottish Futures Trust and the advice is that the project should be developed based on the Hub revenue financed model. A summary of the key project dates is provided in the table below.

Submission of Initial Agreement	January 2016
Site Options Appraisal	September 2015
Submit Outline Business Case	August 2016
Submit Full Business Case	July 2017
Financial Close	October 2017
Construction	January 2018

6.2 The approach to the management and methodology of the project is based on the overriding principles of the Hub initiative where NHSGGC and WD HSCP will work in partnership with the appointed Private Sector Development Partner to support the delivery of the project in a collaborative environment that the "Territory Partnering Agreement", and "DBFM (Design, Build, Finance, and Manage) Agreement" creates.

6.3 A Project Board has been established to oversee the initiative and is chaired by the WD HSCP Chief Officer, who is also the Project Sponsor. The Project Board comprises representatives from the senior management of WD HSCP and NHSGGC (including Capital Planning and Finance); the services that will be operating within the new Centre; and West Dunbartonshire Council. The Project Board represents the wider ownership interests of the project and maintains co-ordination of the development proposal.

6.4 The Project Board reports to the NHSGGC Hub Steering Group, which oversees the delivery of all NHSGC Hub projects. It includes representatives from other Project Boards within NHSGGC, Capital Planning, Facilities, Finance, Hub Territory and Hub Co.

6.5 While the Project Board will provide strategic leadership and oversee delivery, a Design and Delivery Group has also been established to manage the day-to-day detailed information and tasks required to brief and deliver the project.

6.6 The project will be supported by a series of sub-groups and task teams as required and identified in the Guide to Framework Scotland published by Health Facilities Scotland.

6.7 The representatives from NHSGGC Capital Planning and Finance have been involved in a number of Hub developments - including the Eastwood and Maryhill Projects - and have a wealth of experience to provide this development. As well as complying with the requirements of the SCIM, the local team within the HSCP leading this project has benefited from their experience and positive learning in successfully delivering the Vale Centre for Health and Care (as acknowledged in the latter project's OGC Gateway Review).

6.8 In relation to the appointment of the Design Team this work is ongoing at present with progress to date noted below:

- Architect – Anderson Bell Christie
- Cost Adviser – Sweett Group
- Structural Engineer – MSPS

- Mechanical & Electrical –TUV Sud – Wallace Whittle

Financial Case

6.9 NHSGGC has received conditional approval that a replacement Clydebank Health and Care Centre will be funded as a bundled project with Greenock Health and Care Centre funded via the West of Scotland Hub Initiative, subject to approval through the business case process.

6.10 NHSGGC has made provision within its capital resource limit for this project dependant on confirmation of the Hub funding.

6.11 The table below represents indicative capital and revenue costs and funding the project. The revenue costs are break even at this time. Future development of the revenue implications will be undertaken in the development of the Outline Business Case. There are no financial contributions from external partners in this project.

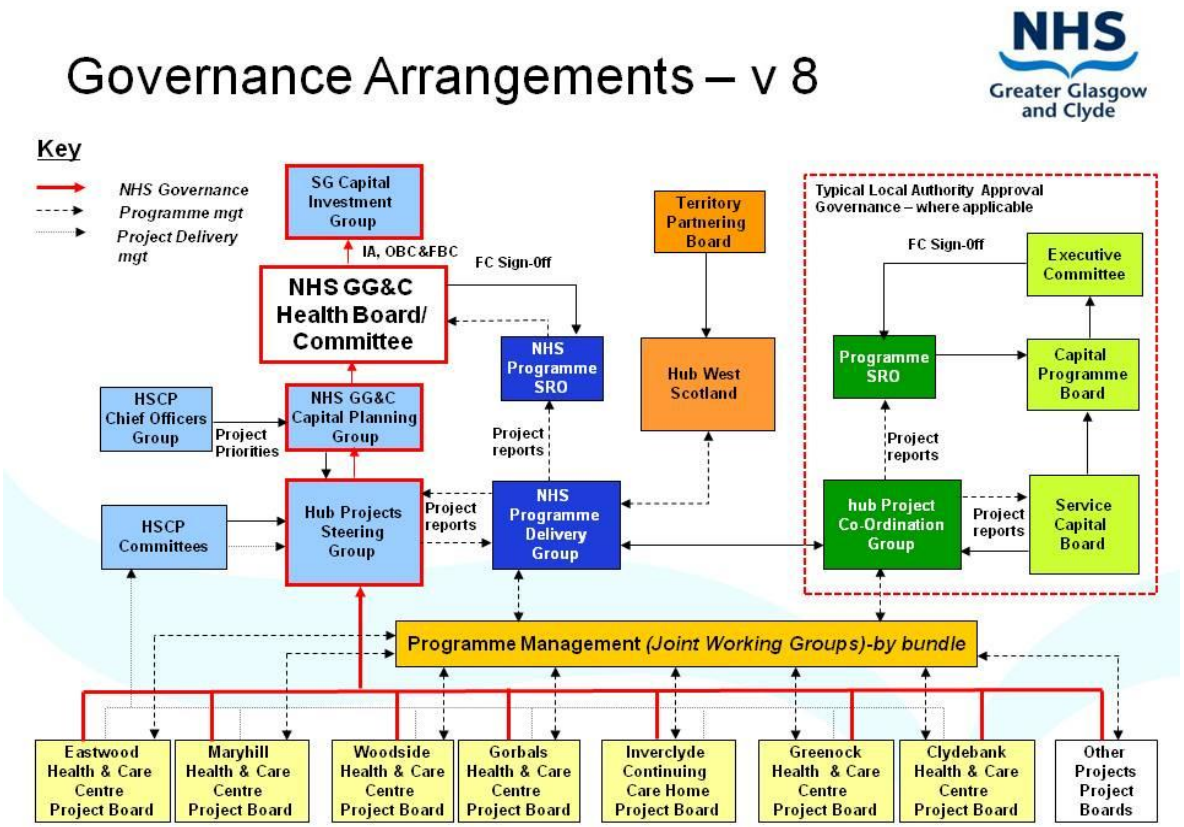
Capital	£'000
Costs	
Site Acquisition	0
Equipment	950
Sub Debt	190
Total Capital Cost	**1,140**
Funded by -	
Formula Capital	**1,140**
Revenue	£'000
Costs	
Annual Service Payment	2,069
Running Costs	476
Depreciation Equipment	95
IFRS Depreciation	760
Total Costs	**3,400**
Funded by -	
SG Funding	1,880
IFRS - SGHCD	760
Existing Revenue Budgets	515
Additional GP Funding	73
Review of Estate/Redesign	122
Council Revenue Funding	50
Total Funding	**3,400**
Surplus	**0**

Management Case

6.12 The NHSGGC Hub Project Steering Group has established governance and reporting structure which will be implemented to deliver this project. The structure is illustrated in the diagram below and has been used to successfully manage the NHSGGC Hub projects to date. Project Boards report and approve through to the Hub Steering Group to the NHS Capital Planning Group and then NHSGGC.

6.13 Programme Delivery Group is responsible and accountable to the Senior Responsible Officer (SRO) for successful delivery of the programme of Hub projects. The Delivery Group will work alongside the Hub Steering Group and the existing governance arrangements, but with a day to day role to focus on delivery, working directly through key interfaces with HubCo West Scotland.

6.14 The Clydebank Health and Care Centre Project Board reports to the NHSGGC Hub Steering Group which oversees the delivery of all NHSGGC Hub projects. The Project Board is chaired by the WD HSCP Chief Officer, and comprises representatives from the senior management of WD HSCP and NHSGGC (including Capital Planning and Finance); the services that will be operating within the new Centre; and West Dunbartonshire Council. The Project Board represents the wider ownership interests of the project and maintains co-ordination of the development proposal.



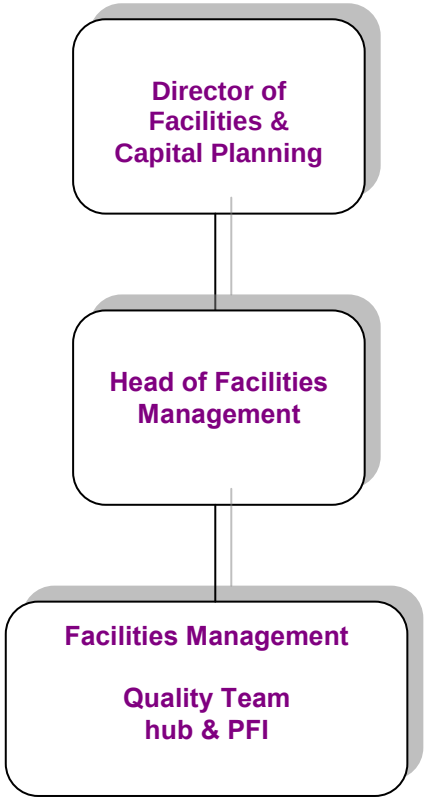
Clydebank Health and Care Centre		
Parties	NHSGGC Hub West Scotland	NHSGGC HubCo
Project Sponsor	Keith Redpath	WD HSCP
Project Director	Chris McNeill	WD HSCP
Capital Planning Project Manager	Ian Docherty	NHSGGC
Finance Managers	Marion Speirs	NHSGGC
Private Sector Development Partner – Project Manager	Gary Smithson	HubCo
Private Sector Development Partner - Tier 1 contractor	To be appointed	
Legal	Procurement Process underway	
Financial	Procurement Process underway	
Technical	Procurement Process underway	
Architectural Adviser	Part of TA team	
M&E Adviser	Part of TA team	
Civil/ Structural Adviser	Part of TA team	

6.15 The Hub Project Steering Group has developed a revised governance and reporting structure which impacts on this project. The key change has been to establish a Programme Delivery Group (PDG), which will have overall responsibility and accountability to the Senior Responsible Officer (SRO) for successful delivery of the programme of hub projects. The PDG team will work alongside the Hub Steering Group and the existing governance arrangements, but with a day to day role to focus on delivery, working directly through key interfaces with Hub West Scotland and Local Authority leads.

6.16 NHSGGC has created an expert team to support the operational management of its Hub and Private Finance Initiative (PFI) contracts, with the aim of ensuring that there is a consistent, appropriately informed and robust approach to contract management across the Health Board area. Areas of activity include:

- Detailed knowledge of contract documentation, service specification requirements, performance requirements – reactive, planned preventative maintenance (ppm) and life cycle, Paymech, contract variation and the overarching legal framework in which the contracts operate.
- Provide a link to national contract support initiatives and activity, including Scottish Futures Trust.
- Locally, supporting managers dealing with the operational interface and co-ordinating the Boards approach to technical evaluation of performance in terms of quality, statutory ppm, condition and lifecycle.
- Provide a presence at all Paymech and Liaison Committee meetings to reinforce consistency and focus.
- The team is directly managed by the Head of Facilities within the NHSGGC Facilities & Capital Directorate.

Indicative Reporting Structure:



6.17 Five key roles have been identified comprising:

- Senior Responsible Officer - David Louden
- Overall Project (Programme) Director - Keith Redpath
- Commercial Lead - Tony Curran
- Finance Lead - Jeanne Middleton
- Technical Lead - John Donnelly
- Facilities Management PFI/NPD Lead – Karen Connolly

6.18 Readiness to Proceed CHECKLIST

Clydebank Health and Care Centre	
Is the reason made clear why this proposal needs to be done now?	Section 2 Section 4
Is there a good strategic fit between this proposal, NHS Scotland's Strategic priorities, the Health Board's and the HSCP Board's own strategies?	Section 3
Have the main stakeholders been identified and are they supportive of the proposal?	Section 3 Appendix B
Is it made clear what constitutes a successful outcome?	Section 4 Appendix C
Are realistic plans available for achieving and evaluating the desired outcomes and expected benefits to be gained, including how they are to be monitored?	Section 4 Appendix C
Have the main project risks been identified, including appropriate actions taken for mitigating against them?	Section 4 Appendix D
Does the project delivery team have the right skills, leadership and capability to achieve success?	Section 6
Are appropriate management controls explained?	Section 6
Has provision for the financial and other resources required been explained?	Section 6

6.19 The proposal should be taken forward now due to the condition of the building and the overcrowding of staff accommodation which is preventing multi-disciplinary professional teams working together. Stakeholders involved include the six GP practices; community health and social care services; NHS Acute Services; service users and carers; and Community Planning partners (including the Council and community representatives).

6.20 In accordance with SCIM guidelines the development of any new infrastructure project requires a full site options appraisal. NHSGGC have undertaken this on all recent Hub projects. Given the background to this project, the Scottish Government's Capital Investment Group agreed that Scottish Futures Trust should be invited to engage with NHSGGC to examine the available options against the project's benefits realisation and investment objectives. Appendix B summarises the process and outcome of the workshop. Following this process, the Queen's Quay Regeneration Development site in Clydebank was confirmed as the optimal available site for delivering on the project's investment objectives. Furthermore, the terms of the site's provision by the Council means it will be delivered at a lower cost to the project, allowing current funding to be used most effectively. In locating the new facility on this prime site, the regeneration benefits of the project will be considerably enhanced and further deliver a positive effect on the heath and wellbeing of the people of Clydebank.

7. Is This Still a Priority?

7.1 With changing demographics and increasing levels of need, over the next 10 years the health and social care landscape will change significantly. Those changing demographics (including an ageing population), an increase in demand for services, and the likelihood of more people with complex multi-morbidities – alongside reduced public sector resources – means that we have to work together to deliver services in different ways and make the most of the investment available across public sector as a whole.

7.2 The current facilities have been assessed as not meeting the basic needs nor being able to address these business objectives - so the Do Nothing option is not viable. The poor repair and ongoing maintenance of the main Clydebank Health Centre in particular mean that from a repairs perspective it is “money hungry”. The asbestos that is integral to the building’s structure means that even relatively simple repairs are extremely costly; and that extension of that building is cost-prohibitive. The preferred solution is therefore a single and new-build facility, delivered within an overall funding envelope of £19 million. NHSGGC has made provision within its capital resource limit for such a project dependant on confirmation of Hub funding, with the revenue costs calculated as break even at this time.

7.3 A replacement health and care centre build would enable the co-location of multi-disciplinary services - including integrated health and social care teams - within a new facility giving one stop access and improved accessibility for patients to an increased range and improved quality of services (including additional acute outreach clinics); a considerably improved working environment for staff; space for community and third sector partners and carer’s organisations involved in the co-production of supported self care; meeting and training space for all our staff (supported by a commitment to shared and agile technology for staff) and local community groups.

7.4 Moreover, the development of a new and enhanced health and care centre within Clydebank has already been identified as a key contribution that NHSGGC could make to the wider regeneration plans for Clydebank. As such, the proposed new health and care centre is not just about the construction of a new asset, but more importantly how such a new facility will contribute to a transformation in the type of care provided with and for local people; and the economic and social transformation of the Clydebank area more broadly.

7.5 We are confident that the anticipated benefits described above and throughout this Initial Agreement will be realised; and that this will deliver genuinely transformed care for the people of Clydebank.

APPENDICES

APPENDX A -	AEDET Workshop
APPENDIX B -	Site Options
APPENDIX C -	Benefits Realisation Plan (Draft)
APPENDIX D -	Risk Register
APPENDIX E -	Design Statement
APPENDIX F -	Programme Schedule
APPENDIX G -	Communication and Engagement Plan

APPENDIX A - AEDET WORKSHOP

Functionality

	Use	Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1	2	YES
A.02	The design facilitates the care model	1	2	YES
A.03	Overall the design is capable of handling the projected throughput	1	1	YES
A.04	Work flows and logistics are arranged optimally	1	1	
A.05	The design is sufficiently adaptable to respond to change and to enable expansion	1	1	YES
A.06	Where possible spaces are standardised and flexible in use patterns	1	1	YES
A.07	The design facilitates both security and supervision	1	1	YES
A.08	The design facilitates health promotion for staff, patients and local community	2	1	YES
A.09	The design has a clear strategy to respond to changing needs and functions	1	1	YES
A.10	The benchmarks in the Design Statement in relation to building USE are met	0		

	Access	Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	2	1	YES
B.02	There is adequate parking for visitors/ staff cars/ disabled people	2	1	YES
B.03	The approach and access for ambulances is appropriately provided	1	1	YES
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	1	YES
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	1	YES
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	1	YES
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	1	YES
B.08	Car parks should not visually dominate entrances and green routes	1	2	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	0		

	Space	Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	1	YES
C.02	The ratio of usable space to total area is good	1	5	YES
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	2	2	YES
C.04	Any necessary isolation and segregation of spaces is achieved	2	2	YES
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	2	1	YES
C.06	There is adequate storage space	1	1	YES
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	1	YES
C.08	The relationships between internal spaces and the outdoor environment work well	1	1	YES
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	0		

Build Quality

	Performance	Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	1	YES
D.02	The building and grounds are easy to clean	1	1	YES
D.03	The building and grounds have appropriately durable finishes	1	1	YES
D.04	The building and grounds will weather and age well	1	1	YES
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	2	1	YES
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	1	YES
D.07	The design minimises maintenance and simplifies this where it will be required	1	1	YES
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	0		

	Engineering	Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	1	
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	1	
E.03	The engineering systems are energy efficient	1	1	YES
E.04	There are emergency backup systems that are designed to minimise disruption	1	3	YES
E.05	During construction disruption to essential services is minimised	0		
E.06	During maintenance disruption to essential healthcare services is minimised	1	1	YES
E.07	The design layout contributes to efficient zoning and energy use reduction	1	1	YES

	Construction	Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0		
F.02	Temporary construction work is minimised	0		
F.03	The impact of the building process on continuing healthcare provision is minimised	0		
F.04	The building and grounds can be readily maintained	0		
F.05	The construction is robust	0		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	0		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	0		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	0		
F.09	The construction contributes to being a good neighbour	0		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	0		

Impact

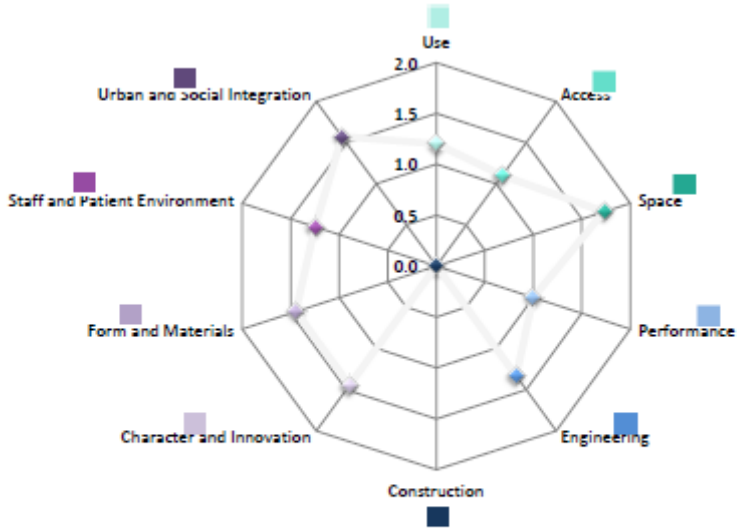
	Character and Innovation	Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	2	3	YES
G.02	The building and grounds are interesting to look at and move around in	1	1	YES
G.03	The building, grounds and arts design contribute to the local setting	1	1	YES
G.04	The design appropriately expresses the values of the NHS	1	1	
G.05	The project is likely to influence future designs	1	1	
G.06	The design provides a clear strategy for future adaptation and expansion	1	1	YES
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	2	1	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	0		

	Form and Materials	Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	2	2	YES
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	2	1	YES
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	2	2	YES
H.04	The external materials and detailing appear to be of high quality and are maintainable	1	1	YES
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	1	YES
H.06	The design maximises the site opportunities and enhances a sense of place	1	1	YES
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	0		

	Staff and Patient Environment	Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	2	1	YES
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	1	YES
I.03	The design maximises the opportunities for access to usable outdoor space	1	1	YES
I.04	There are high levels of both comfort and control of comfort	1	1	YES
I.05	The design is clearly understandable and wayfinding is intuitive	2	1	YES
I.06	The interior of the building is attractive in appearance	1	1	
I.07	There are good bath/ toilet and other facilities for patients	1	2	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	2	2	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	1	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	0		

	Urban and Social Integration	Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	3	
J.02	The design contributes positively to its locality	1	1	
J.03	The building and grounds design lift the spirits and raise aspirations	2	1	YES
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1	3	YES
J.05	There is a clear vision behind the design, its setting and outdoor spaces	2	1	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	0		

AEDET Refresh Benchmark Summary



		Benchmark
	Use	1.2
	Access	1.1
	Space	1.7
	Performance	1.0
	Engineering	1.3
	Construction	0.0
	Character and Innovation	1.4
	Form and Materials	1.4
	Staff and Patient Environment	1.3
	Urban and Social Integration	1.6

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

Ref	Note
A.01	Very poor, functions reaqsonably well but dated. Getting to the building is poor. Access to building is mixed. Access to rooms not ideal.capacity issue.
A.02	community services model poor. Space issues, cannot be expanded some elements 3
A.03	not anymore as no scope of expansion
A.04	
A.05	not at all no scope of expansion
A.06	big problem some clinic rooms left handed difficutl and awkward to see patients,
A.07	security is poor, easy for people to to go to areas
A.08	no natural light in some areas, no space to do any health promotion activities.
A.09	no natural light in some areas, unpleasent environment, poor ventilation
A.10	
B.01	not suitable access from carpark, outside enviornment provide difficult access to building, lift access poor, drop off zone is not ideal,
B.02	definitely not, can never fulfill the need, often full, carpark is used by others who actually not using HC,
B.03	no
B.04	not safe, very narrow road to access building, also service access is inbetn the carpark and building so is inconvenient at times.
B.05	no it is not very uneven and access to the building for pedestrians is not suitable as ground not level.
B.06	no
B.07	not used fully
B.08	
B.09	patient been able to get through one full jouney and better ambulance access,
C.01	room sizes are very generous, waiting rooms are small,
C.02	space is overally utilised, very well used. Expansion overtime and worked well with it.
C.03	not really, overly complexed
C.04	converted into cl and waiting areas
C.05	none
C.06	none
C.07	none
C.08	few rooms have poor ventilation
C.09	
D.01	and then care has to go and look for parking space.
D.02	automatic door at west thomson street has no weather barrier, cannot be closed when it is too windy or open sometimes.
D.03	roof of the building is in poor state of repai and has been water damaged over the years,
D.04	building has aged well but has its own restictions, roof is beyond repair and hasbeen temporarily fixed over years.
D.05	not every room has natural light,
D.06	not really, overly complexed
D.07	lot of issues related to maintenance due to its clasp nature and strict asbestos regulations. Not cost effective at all as everything has to be done under controlled conditions
D.08	
E.01	
E.02	
E.03	no energy efficiency as old system of heating which cannot be chnaged and has no individual controls
E.04	ups for phones, remote GP IT backup, plug in points,
E.05	
E.06	extra cost , under controlled condition as due to its clasp nature
E.07	systems are not efficient in use, e.g. no zoning, heating is either all on or off.

Ref	Note
G.01	when it was opened it was quite sufficient, but over the years not fit for purpose.
G.02	not really
G.03	doesnot have any appeal looks old and dated
G.04	
G.05	
G.06	no scope of expansion
G.07	
G.08	
H.01	staff welcoming but building doesnot.
H.02	not appropriate
H.03	kilbowie rd is functional but carpark entrance is not ideally located
H.04	external material is difficult to maintain as we have leaks when it rainy heavy.
H.05	it has aged well but
H.06	it used to when it inittially opened, now no further scope of expansion clinically or office accomodation.
H.07	
I.01	not appropriate, reception has no privacy, also some consulting rooms face into waiting areas which lacks privacy
I.02	lot of rooms have no natural daylight,
I.03	no outside space
I.04	poor heating in winter and too hot in the summer as not enough natural ventillation.
I.05	
I.06	
I.07	disabled toilets are good but not general toilets
I.08	no contact/ space for informal clinical consultations, good staff room,
I.09	not applicable
I.10	
J.01	
J.02	
J.03	not really
J.04	local people use it for lot of reasons- toilets, carpark
J.05	

Weighting

High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring

Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

1 AEDET Target (& Benchmark) to be set at IA Stage and must be submitted for NDAP as ANNEX 1 to the Design Statement
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Site Options Paper, New Clydebank Health and Care Centre - 27th October 2015

1. Purpose

In accordance with SCIM guidelines the development of any new infrastructure project requires a full site options appraisal. NHS GG&C have undertaken this on all recent hub projects. In this instance due to background we sought guidance from SCIG on whether this would be necessary given the clear planning support, political support and additional regeneration benefits that would accrue from locating on the Queen's Quay site. It was agreed that the Board would seek confirmation from Scottish Health Council (SHC) that it was satisfied in relation to community consultation requirements, and that Scottish Futures Trust (SFT) should be invited to test whether a full options appraisal would be required to ensure value for money was delivered through the project. This paper summarises the process and outcome of the workshop held to test this.

2. Approach

A review of potential sites was undertaken by key stakeholders from NHS Capital Planning, West Dunbartonshire Health & Social Care Partnership leaders and leads from WDC's planning and technical team. The requirement is for a site capable of accommodating circa 2500m2 footprint and 200 car parking spaces in Clydebank. This requires a site of circa 3 acres. Five potential sites were identified: the existing HC site (expanded), Queens Quay site and three sites of former schools. The sites were examined by Anderson Bell Christie (ABC) architects, who have been selected to deliver the project. They tested each site for capacity to accommodate the requirements physical requirements.

3. Benefits Realisation

In order to deliver the benefits for which it is being built the Centre must enable and support:

- Improved services meeting the local demographic needs.
- Service redesign, of which it is an integral part.
- Easy access, especially by public transport.
- Opportunities for greater collaboration with partners.
- Visibility of the importance of wellbeing.
- Leverage for wider area regeneration.

Upon reviewing the available sites it became clear that due to the dispersed nature of the population served by the centre (circa 50,000 people) a location on primary public transport routes would be essential. It became clear that whilst two of the school sites could easily accommodate the physical requirements, their location within residential areas was not sufficiently visible to the wider community, nor easily accessible by public transport.

It was also clear that the existing health centre location, whilst on a main route, was divorced from the centre of Clydebank. Not only would this site require significant compromise in design development options due to the long narrow nature of the site, it crucially lacked the potential for the collaboration that is essential to meet the service redesign objectives.

Only two sites had the potential to meet the benefits realisation requirements: these were Queens Quay and the former St Andrews School at North Douglas Street.

4. Site Assessment

A set of site selection criteria were then discussed which had been developed to align with the Investment Objectives:

1. Public and Staff Access – 30%.
2. Co-location with other public services – 20%.
3. Contribution to regeneration – 20%.
4. Environmental Quality – 20%.
5. Future Expansion – 10%.

By comparing both remaining locations against these key criteria a round of consensus scores were awarded by the group against each site. The weighted total of these scored 97% vs 67%, producing a preferred option by a wide margin. Whilst it was agreed that the St Andrews site could be developed satisfactorily, albeit at a cost, on every criteria Queens Quay offered a significantly stronger response. It was apparent that due to the long-term planning exercise, undertaken by WDC, the key requirements had effectively been designed into the masterplan, leading to very high scores in each category.

5. Finance

In discussion WDC outlined the known contamination issues at both front-runner sites. In the case of Queens Quay the site will be remediated and levelled by the developer, which would reduce hub development costs. The development agreement also requires the developer to provide the key infrastructure elements of spine access road and utilities as part of an enabling works element. On the St Andrews site it was clear that road improvements would be required, and remediation would need to be addressed through the hub development.

WDC has undertaken to provide the Queens Quay site to NHS free of charge. The St Andrews site would need to be acquired in the normal way using agreed DV valuations.

6. Regeneration

Queens Quay is West Dunbartonshire Council's key regeneration project. Its aim is to provide a better environment for the people of Clydebank and importantly to attract new residents and families to a regenerated riverside location. At the heart of the plan is public investment which to date has seen the relocation of West Of Scotland College to a riverside location, the redevelopment of Clydebank Town Hall and gallery, and currently the development of a new leisure centre, which is under construction. The Council has further committed to locating its new residential care-home and day facility on the site too. The location of the town's principle health facility in this location is seen as the final fundamental investment to consolidate what has been committed to date.

7. Conclusion

From examining the available options against the project's benefits realisation and investment objectives, Queen's Quay most clearly meets all of the criteria. Further, the terms of the site's provision by WDC means it will be delivered at a lower cost to the project, allowing current funding to be used most effectively. In doing so, it will also underpin a significant regeneration project which will have a positive effect on the heath and wellbeing of the people of Clydebank.

On this basis it is proposed that the new Health & Care facility at Clydebank is located on the Queens Quay site.

APPENDIX C – BENEFITS REALISATION PLAN (DRAFT)

Benefits Realisation Plan								
1. Identification						*2. Impact (RAG)*		
Ref. No.	***Main Benefit***	***Financial / Non-Financial***	***As measured by:***	***Baseline Measure***	***Target Measure***	***Impact (size)***	***Importance***	***Likelihood***
1.	It will improve quality of life through the care provided by the co-location of integrated teams enabling speedy access to, modernised services.	Non-financial	Number of ACPs in place Reduce the number of acute bed days consumed by each long term conditions (crude bed days rate per 100,000) Increase number of people with diagnosis of dementia on the dementia register	2015/16 Outturns	+ 10% by 2020 - 10% by 2020 TBC			
2.	It will improve support to people to live independently	Non-financial	Number of people receiving homecare during annual census week. Number of Homecare hours per 1,000 population aged 65+ Percentage of Homecare clients aged 65+ receiving Personal Care	2015/16 Outturns	TBC TBC TBC			
3.	It will increase the proportion of people with intensive needs being cared for at home.	Non-financial	Percentage of Homecare clients aged 65+ receiving Personal Care Number of people supported by community staff to die at home	2015/16 Outturns	TBC TBC			
4.	It will ensure timely discharge from hospital.	Non-financial	Number of acute bed days lost to Delayed Discharge (inc AWI)	2015/16 Outturns	TBC			
5.	It will improve the functional suitability of the healthcare estate.	Non-financial Financial	BREEAM rating. Reduce running costs.	2015/16 Outturn	Excellent TBC			
6.	It will improves access services and contribute to regeneration of Clydebank	Non-financial Financial	TBC	TBC	TBC			

Benefits Realisation Plan							
1. Identification		**3. Control**		**4. Realise**			
Ref. No.	**Main Benefit**	**Who Benefits?**	**Who is responsible?**	**Investment Objective**	**Dependencies**	**Support Needed**	**Date of Realisation**
1.	It will improve quality of life through the care provided by the co-location of integrated teams enabling speedy access to, modernised services.	Service Users and Carers	Practitioners	2,3,4 and 5	Stakeholder buy-in	New Centre	From completion onwards
2.	It will improve support to people to live independently.	Service Users and Carers	Practitioners	2,3,4 and 5	Stakeholder buy-in	New Centre	2020
3.	It will increase the proportion of people with intensive needs being cared for at home.	Service Users and Carers	Practitioners	2,3,4 and 5	Stakeholder buy-in	New Centre	2020
4.	It will ensure timely discharge from hospital.	Service Users and Carers	Practitioners	2,3,4 and 5	Stakeholder buy-in	New Centre	2020
5.	It will improve the functional suitability of the healthcare estate.	Service Users, Carers and Practitioners.	Management	2,3,4 and 5	New Centre	New Centre	From completion onwards
7.	It will improves access services and contribute to regeneration of Clydebank	Organisation	Management	1 and 5	New Centre	New Centre	From completion onwards

APPENDIX D – RISK REGISTER

			1. Identification				3. Control	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Owner	Proposed Treatment / Mitigation	Action Taken
CLIENT / SERVICE RISKS								
1.0	**Business risk**							
1.1	Independent Contractors disengage with the Project	**Financial**	5	3	Med	Hub West	Provide clear financial information at earliest opportunity and engage with discussion re space	Meetings arranged
1.2	Client doesn't have the capacity or capability to deliver the project	**Non - Financial**	4	2	Low	NHS/ Hub West	Develop appropriate governance arrangements for the project including resource planning and individual skills review	NHS and Hub West have reviewed resources and are satisfied.
1.3	The project's objectives are not clearly defined	**Non - Financial**	5	2	Med	NHS	Set out clear objectives for the project as part of the Initial Agreement, linking them to clearly defined & measurable benefits and outcomes	Complete
1.4	The anticipated benefits from the project are not achieved following project completion	**Non Financial**	5	2	Med	NHS	Set out a realistically achievable benefits realisation plan as part of the Initial Agreement	Benefits realisation plan drafted and subject to refinement through engagement process.
1.5	Different stakeholders have different expectations of the outcome of the project	**Non Financial**	5	3	Med	NHS	Consult with all stakeholders to gain a consensus on the strategic brief for the project at IA stage and project brief at OBC stage	Communication and Engagement Plan developed.
1.6	Poor stakeholder involvement will result in a lack of support for project	**Non - Financial**	3	2	Low	NHS	Prepare and implement an appropriate communication and engagement plan, which includes engaging with all appropriate stakeholders at appropriate stages of the project	Communication and Engagement Plan developed.
1.7	Funding arrangements remain unclear in relation to ESA 10, creating uncertainty and delay.	**Financial**	4	4	High	SG	Seek assurances and underwriting to early stage work by SG to allow progress in advance of final solution.	Discussions on-going.

			1. Identification				3. Control	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Owner	Proposed Treatment / Mitigation	Action Taken
2.0	**Reputational risk**							
2.1	Adverse publicity occurs due to an operational issue	**Non - Financial**	4	2	Med	NHS	Review ongoing operational arrangements associated with the project and ensure that any specific risks are encapsulated into the project risk register	Risk register will be reviewed on a regular basis by Project Board
2.2	Communication strategy does not consider public perception / consultation feedback / media interest / parliamentary interest / organisational reputation	**Non - Financial**	4	2	Medium	NHS	Ensure that the communication and engagement plan covers these issues	Communication and Engagement Plan developed and subject to review.
3.0	**Demand risk**							
3.1	Demand for the service does not match the levels planned, projected or presumed	**Non - Financial**	5	2	Med	NHS	Carry out sensitivity testing of assumptions behind service demand projections to understand and manage any underlying risks	On-going
4.0	**Occupancy risk**							
	Failure to agree lease terms with Independent contractors i.e. GPs	**Financial**	5	3	Med	NHS	Early discussion with GPs detailing estimated lease\running costs	On-going
5.0	**Operational risk**							
5.1	The available accommodation is unable to support the proposed service model	**Financial**	4	2	Med	All	New service model arrangements should be considered and properly tested at the early design planning stages of a project and then further tested throughout the development of the project	On-going
6.0	**Decant risk**							
6.1	Unable to decant staff / clients from one site to another in a timely manner	N\A	N\A	N\A	N\A	N\A	N\A	N\A

APPENDIX E - DESIGN STATEMENT

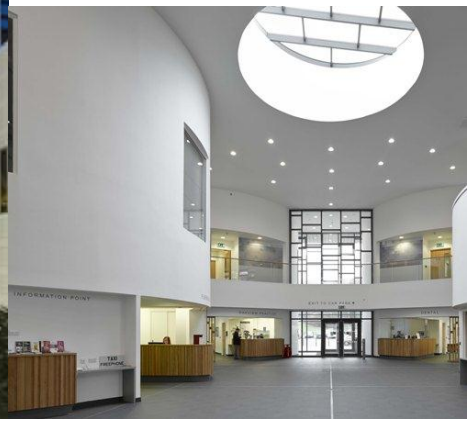
In order to deliver the investment objectives and benefits described within the Initial Agreement, the new Clydebank Health and Care Centre development must possess the following attributes.

In reading the text below, the journeys and environments described are for all people, and the use of best practice in relation to inclusive design (physical accessibility, sense sensitive design and design for cognitive impairments) will be part of the detailed briefing (to follow) of how these experiences are to be achieved.

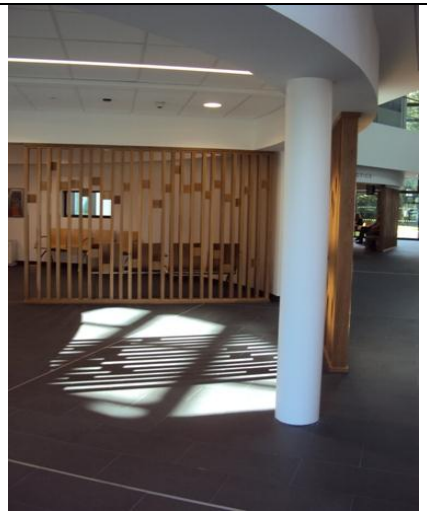
1 Non Negotiables for Service Users

Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like*
1.1 It must be easier to get to the new facility than the existing one and the experience of arriving must feel safe and welcoming.	• The entrance must be close to public transport; within 5min of bus stops with routes serving a broad number of housing schemes and 10 min from train station. • Pedestrian routes (from street and within parking) should have priority over vehicle routes, be easily accessible (barrier free standard, not steep) and direct with line of sight to the entrance, supported by signage to reassure. They must be well lit and observable (you can see people in nearby buildings and they can see you) so that you don't feel you're alone or no-one would spot if there's a problem. Walking routes from the street and public transport must not be dominated by parking. Any routes within the site longer than 5min must have rest points included. • Parking areas must be easy and intuitive to use, with the layout designed to manage different levels of need and to discourage misuse. Disabled parking and pick-up/drop-off spaces to be within 20 metres of the entrance, clearly overlooked by staff areas and have different surface treatment (more like pedestrian areas) to signal different use. • Soft/green landscaping to be incorporated into external routes and spaces to provide shelter and welcome. 

	   
1.2 The facility (both building and grounds) must feel part of Clydebank, with an open/public feel that encourages, and copes well with, use both to access services and for other reasons (community use, recreation etc). It must be welcoming, with some open useable space, not institutional, clinical or overpowering in its impression.	• External areas, such as parking, landscape and paving areas, must be designed to have a civic feel and allow use by the community both 'out of hours' (use of larger areas such as parking for events etc) and (for landscape/paving areas) during normal operation without impacting use/privacy of the building. • Clear intuitive way finding from out with the site to indicate presence of facility and route to it(even during hours of darkness).

	  
1.3 All service users – irrespective of which service(s) they're using that day -must arrive into the same space. This must be light and welcoming, with direct view to help, and a clear route to the service being sought.	• Welcoming reception desk visible on entry that can check you into most services and guide you to other areas such as GP, Community services. • Route to each service should be clearly visible/ signposted. Stairs and lifts clearly marked for ease of access. • The Main entrance / foyer should be designed to be able to deal with heavy traffic within the during peak times.   
1.4 Walking routes for service users – both to and between services - must be short, easy, pleasant and intuitive.	• Routes to have line of sight connection between destination points for each part of the journey so the way can be understood. Any stairs and lifts needed to be visible from the initial orientation point. • Routes/destination points to have good day lighting and identity (a space, view or installation that you would recognised when seen again), supported by signage for reassurance. • Waiting areas within 10m of all consulting/treatment rooms to reduce walking distance for patients and allow option of staff

	collection for initial assessment of mobility/health.  
1.5 The ‘check in’ experience must provide for personal preferences and privacy. Reception facilities must be open and calm to promote trust and confidence.	• Electronic check in at main arrival space, close to someone who can help if you’re experiencing problems. • Reception desks to manage security unobtrusively (they must not to have glazing/barriers, but use deep lunge desks and easy escape to safety), and be acoustically separated from admin areas to reduce noise. Heating and ventilation must be managed to allow staff to sit in comfort. • There must be space close by to take any sensitive conversations. • Waiting areas should not be immediately adjacent to receptions so that all discussions cannot be easily overheard.   

	
1.6 The waiting experience must allow for personal preferences and provide a comfortable, safe, calm and reassuring environment with distractions and access to information. (*see also 2.? for other uses of this space*)	• Waiting areas must have good daylight, fresh air and views to external green space. • There must be options for where you wait, allowing people to wander and still feel connected, join in social groups, occupy children in play, or sit more quietly. • The spaces must deal well with noise (lower it) so that the place feels calm. • Staff areas must be visible (to feel connected with the appointment and safe) and there must be no hidden corners. • There should be access to safe external space for a breath of fresh air and a secured place for children to run around (courtyard). • wifi access/information points should be available for longer patient waiting times.
1.7 Consulting and treatment areas must feel private and inspire confidence.	• Fixtures/surfaces/furnishing must feel of good quality – that they will last and look/be clean and convey professional impression. • There must be good sound separation to other building areas. To be supportive of open and confidential/ sensitive discussions, assessments & treatments. • Daylight and natural ventilation must be able to be maintained alongside privacy of conversations.

2 Non Negotiables for Staff

Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like*
2.1 Staff must be able to arrive and leave reliably and safely.	• Routes to be to standard with ease of access. • Discrete staff entrance away from main public areas which allows them easy access to staff changing facilities and staff room. • Equipment store adjacent to drop-off area or where staff can bring and park their vehicle. Staff entrance should be well lit and secure out of hours.
2.2 The layout of the facility must maximise the potential for out of hours/community use.	• Entrance areas, meeting rooms, waiting areas and external spaces to be located and designed together to be used flexibly for community events and special functions such patient group sessions/ advice clinics/ no smoking groups/ baby clinics.
2.3 The facility must be designed to encourage staff out of individual rooms and to come together to share learning/experiences develop support and combat isolation.	• IT system to support hot-desking and ability to work on admin tasks in meeting/staff social spaces. • Meeting and social spaces to be placed where accessible to all services and designed to encourage use • Staff room to be located where it is easy to access.

2.4 The external environment must be designed to maximise its therapeutic use, both for formal therapies and social/respite uses.	• No unusable courtyards. External spaces to be briefed to use for formal and informal physiotherapy (requiring privacy from public areas). • Social and respite purposes for service users. • Third sector and out of hours secured use.
2.5 The design of the facility must support staff wellbeing and personal needs.	• The grounds and facilities should encourage green travel and exercise (showers, bike racks) • space must be available for quiet support conversations and counselling • Staff rest areas must be away from public spaces to allow staff to feel off duty. There must be a space staff can get a breath of fresh air in their day. • Lockers and changing areas must be positioned so that they are easily accessed as part of normal routes around the building.
2.6 materials and waste must be able to be managed unobtrusively.	• Delivery and waste collection entrance should be separate. • FM and facilities areas should be away from public/ patient areas.

3 Non Negotiable for Visitors

Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like*
3.1 The facility must support the communication of health promotion and information on services for those visiting to support carers/ patients or in maintaining their own well being	• Display information through screens and information points. Information should be updated regularly and timely. • Information stands by Health improvement teams on up-to-date information.

4 Alignment of Investment with Policy

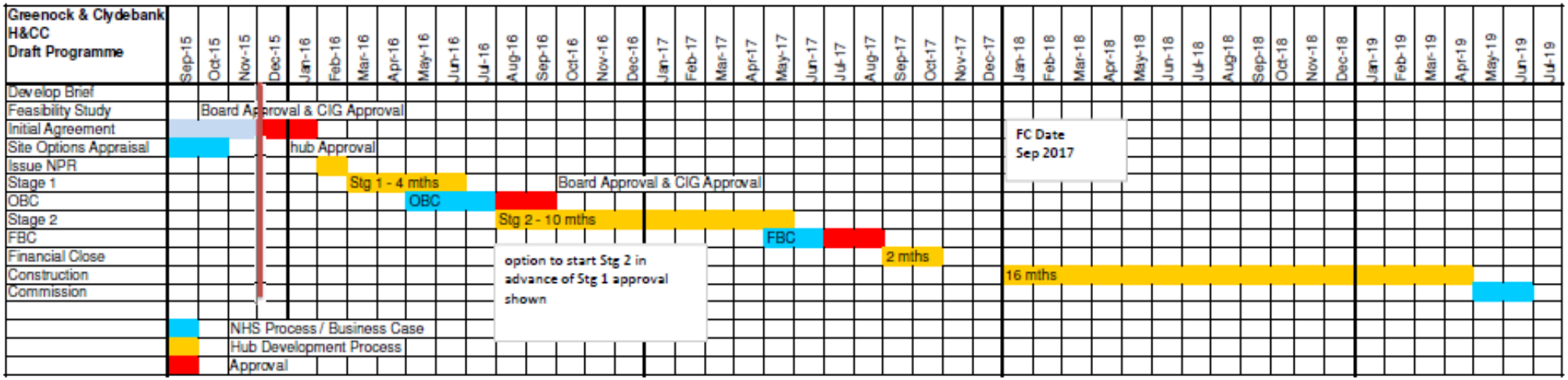
Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like*
4.1 The development (both building and external) through its location and appearance contribute to regeneration of Clydebank.	The facility will be a part of regeneration of Queen's Quay and will be a facility to be used by local population to be easily accessible & available to use. Continuous community engagement and involve health improvement team for various health promotion activities.
4.2 Flexibility/ Adaptability for growing/ aging/ changing population	The building design and construction will enable flexibility. Safety, accessibility and equality will be the foundation of the design and construction. Will also have Build usable grounds/ courtyards; lot of green space to reduce CO2 emissions that will encourage physical activity for community and staff as well. There will be repeated group sessions involving all users from community and existing building to develop space internal / external to develop areas to achieve flexibility and soft spaces for all. We will also have changing places/ toilets for severely disabled and bariatric members of the community.
4.3 Sustainability	Building will promote health, social, environmental and economic sustainability. It will be based on current BREEAM at all stages.

The above statement was drafted through the participation of the following stakeholders/groups:
Karen McElwee - Practice Manager, Red Wing; Dr Bell - GP, Red Wing; Pauline MacWhirter - Practice Manager, Red Wing; Ralph Cunningham - GP, Blue Wing; Jane McNiven - Practice Manager, Green Wing; Neil Murray - GP, Green Wing; Beverley McCartney - Practice Manager, Orange Wing; Katrina Moffat - GP, Orange Wing; Murray Fleming - GP , Yellow Wing; Irene True - Practice Manager, Purple Wing; Dr Rai - GP, Purple Wing; Valerie McIver - District Nursing; Jackie Hamill - Health Visiting; Tracy Cassidy and Fiona Wright - Physiotherapy Team Leaders; David Bisset - Podiatry Team Leader; Mary Angela McKenna – Older People Operations Manager; Wendy Cox - Mental Health Services; Lynne McKnight - Integrated (Adult Services) Operations Manager; Kim McNab - Carers of West Dunbartonshire; Anne MacDougall - Clydebank Locality Engagement Network; Jackie Maceira - Access Panel.

Decision Point	Authority of Decision	Additional Skills or other perspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information needed to allow evaluation.
Site Selection	Decision by Health Board with advice from Project Board	Comment to be sought from National Design Assessment Process (NDAP) to inform Boards Consideration	Risk / benefit analysis considering capacity of the sites to deliver a development that meets the criteria above.	Site feasibility studies (inc. sketch design to RIBA Stage B) for alternate sites or completed masterplan (for site with the potential for multiple projects). Cost Estimates (both construction & running costs) based on feasibility
Completion of brief to go to market	Decision by Health Board with advice from Project Board	Peer review by colleague with no previous connection to project	Is the above design statement included in the brief? Can the developed brief be fulfilled without fulfilling the above requirements?	
Selection of Delivery / Design Team	Decision of HUBco Operations & Supply Chain Director with input from NHSGGC PM.	HUBCo , Participant (NHSGGC) & Territory Programme Manager	The potential to deliver 'quality' of the end product in terms of the above criteria shall be greater that the aspects of the quality of service in terms of delivery. Compliance with service standards (such as PII levels) shall be criteria for a compliant bid and not part of the quality assessment.	Sketch 'design approach' submitted with bid (the stage & detail of these to be appropriate to procurement route chosen). Representatives will visit 2 completed buildings by Architects in shortlisted team.
Selection of early design concept from options developed	Decision by Health Board with advice from Project Board	Comment to be sought from NDAP	Assessment of options using AEDET or other methodology to evaluate the likelihood of the options delivering a development that meets the criteria above.	Sketch proposals developed to RIBA Stage C coloured to distinguish the main use types (e.g.circulation treatment and staff facilities).
Approval of Design Proposals to be submitted to Planning Authority	Decision by Health Board with advice from Project Board		Assessment of options using AEDET or other methodology to evaluate the likelihood of the options delivering a development that meets the criteria above.	
Approval of Detailed Design proposals to allow construction	Decision by Health Board with advice from Project Board		Assessment of options using AEDET or other methodology to evaluate the likelihood of the options delivering a development that meets the criteria above.	
Post Occupancy Evaluations	Consideration by Health Board – lessons to SGHD		Assessment of completed development by representatives of the stakeholder groups involved in establishing the investment objectives.	

APPENDIX F – PROGRAMME SCHEDULE

hub - Draft Greenock & Clydebank Timeline - Dec 2015 2



APPENDIX G - COMMUNICATION AND ENGAGEMENT PLAN

Purpose: To pro-actively support the Project Board to deliver and realise all of the specified benefits identified for this project (as articulated within the approved Vision and Design Statement for the Centre and its Benefits Realisation Plan).

At the heart of this strategy is an appreciation that the successful delivery of this project hinges on providing credible assurance and fostering enthusiastic support amongst a wide set of stakeholders (i.e. those individuals/groups/constituencies with varying degrees of interest and influence in the project).

The strategy has four sequential components, which feed back into the benefits realisation plan separately agreed, i.e.:

- Identifying stakeholders
- Analysing stakeholders
- Effective communication
- Assessing effectiveness

In accordance with NHS CEL (Chief Executive Letter) 4 (2010) *Informing, Engaging And Consulting People In Developing Health And Community Care Services*, effective communication and engagement is recognised as a core element of stakeholder management within this project. As such, the requirement here is not solely to communicate in order just to inform or raise awareness, but to also:

- Generate confidence in and enthusiasm for the project and thereby foster a receptive and positive *authorising environment* for the project at each key decision point.
- Solicit high quality observations/suggestions/feedback on the design and site plan so as to ensure an optimal end product as per the Design Statement.
- Ensure that the varying expectations of different stakeholders are realistically tempered and fairly balanced throughout.

The approach for communication and engagement with respect to the Clydebank Health and Care Centre Project builds on the best practice utilised during the development and delivery of the award winning Vale Centre for Health and Care as emphasised in the feedback and recommendations from the latter project's OCG Gateway Review:

"*While it is encouraging that there were so few negative events, many stakeholders identified positive learning from the delivery of the project. This included community engagement, user involvement in design, degree of CHCP senior management involvement, detailed design of built environment to promote interaction between service teams and to encourage education and training, and further opportunities for integration of health, social and community care". In praising the above, the Review highlighted that this learning should be recorded and shared both to learn how this facility can be a catalyst for further change for services provided from it, as well as for use on other projects and with other project teams*."

Securing, sustaining and justifying trust is at the heart of this approach, which means that the process, the products and those explicitly associated with delivery need to make the effort to demonstrate themselves to be credible amongst stakeholders in order to be perceived and treated as credible by said stakeholders.

Key points to remember:

- Stakeholder groups are not homogenous.
- Stakeholder groups overlap in "membership"; and will interact (and influence) one another (i.e. the boundaries between groups are porous).
- The "agendas" and expressed views of stakeholders can change over time.
- The degree of interest and influence that any one stakeholder group has in the project will change over the course of the project.
- Communication is not just about clear transmission, but being thoughtfully receptive and respectfully responsive as a matter of routine.
- Constructive and informed dialogue with stakeholders will both assist with realistic expectation management and (importantly) with developing a high quality design: on-going testing of and feedback on the design is an important quality assurance element.
- Stakeholder management is not a on-off or peripatic activity: it is an on-going process involving a combination of reciprocally reinforcing formal and informal interactions.
- All of the stakeholders identified (below) also have a varying interests and/or influence in relation to other (and different) areas of the HSCP's operations (and indeed in many cases that of NHSGGC as a body corporate).
- A number of the stakeholder groups identified (e.g. HSCP Board as well as a number of individual members of some groups) have a role in the formal governance and/or wider scrutiny of the HSCP's operations.

The latter two bullet points are particularly worthy of emphasis as how well this strategy is enacted not only has implications for this project, but for other issues/areas of "live" concern for the HSCP. As such stakeholder management has to be undertaken with due cognisance to the rest of the HSCP's work and plans.

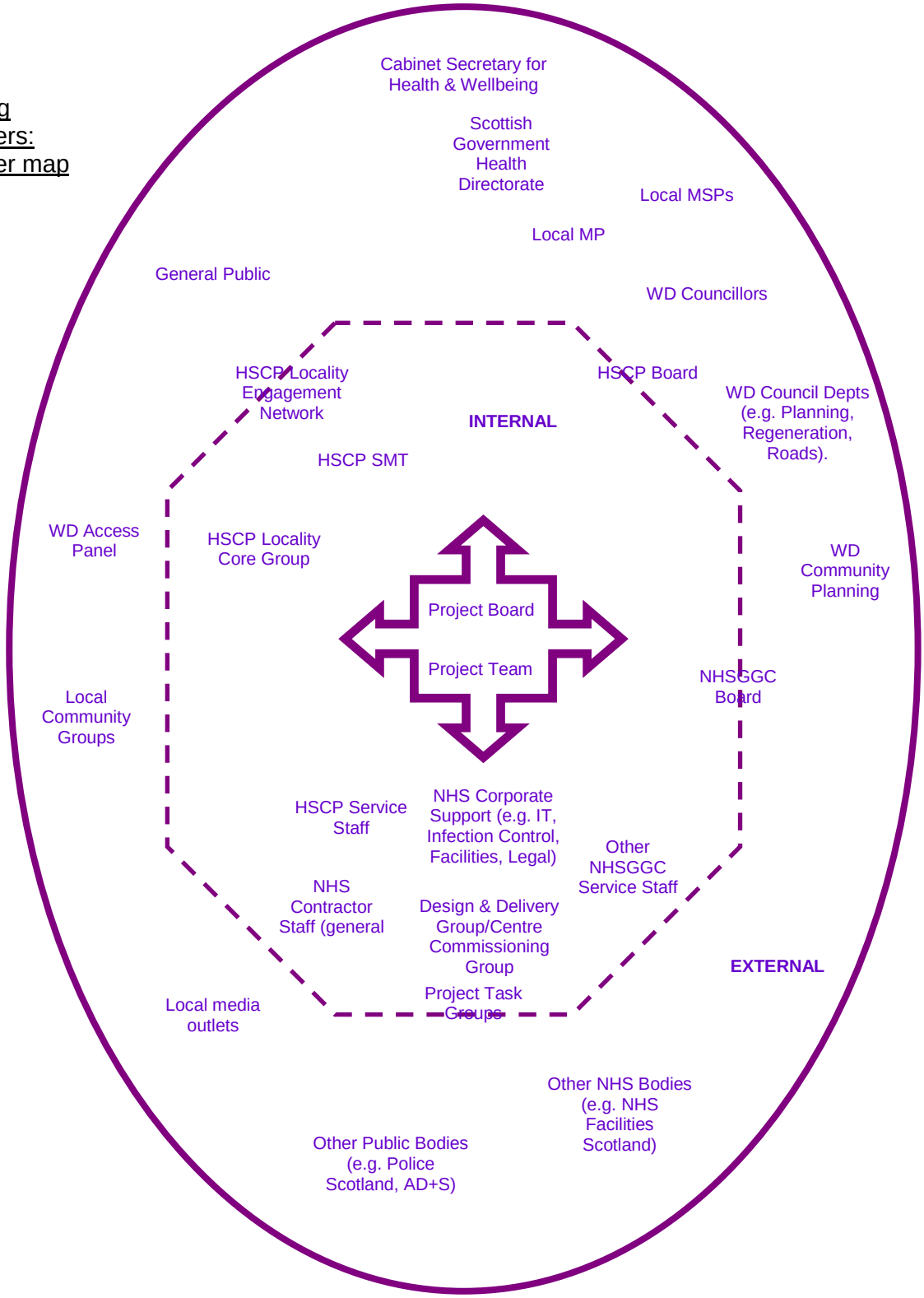
Lack of attention to the content of this strategy may result in the following "failures", any one of which may create risk for the project i.e.:

- Engaging with stakeholder too late so their views cannot be considered without substantial revision and delay.
- Inviting stakeholders to participate too early resulting in a complicated decision making process that causes delays.
- Inviting the wrong stakeholders to participate thereby reducing the value of the contribution and leaving the door open to damaging external criticism.
- Treating the participation of stakeholders as insignificant and inconsequential resulting in poor stakeholder "buy-in" when needed.

Failure to deliver this project properly will also create proportionate risk for the HSCP, given that the Centre is identified as its top capital priority within its Strategic Plan and a key component of the HSCP contributing to the NHSGGC Clinical Services Strategy. Given the high visibility associated with this project, failure to deliver will also generate a high degree of reputational risk for both the HSCP and NHSGGC.

Important as the process of communication and engagement is, it must be remembered that building a *winning coalition* of the sort necessary to achieve the intent and purpose set out above is heavily dependent on the actual quality of the product, e.g. how "good" the design is for the Centre. It is more realistic to build support for, create enthusiasm and secure positive participation in a design if it captures the imagination as something fit-for-purpose, bespoke and special.

Indentifying Stakeholders: Stakeholder map



Communication and Engagement Plan

Strategic Activity	*Which Stakeholders to Approach by Which Means*				
	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
	Promise: we will keep you involved.	*Promise: we will keep you informed, listen to you, and provide feedback on how your input influenced the decision.*	*Promise: we will work with you to ensure your concerns are considered and reflected in the alternatives considered and provide feedback on how your input influenced the decision.*	*Promise: we will incorporate your advice and recommendations to the maximum extent possible.*	*Promise: we will implement what you decide.*
Organising participation. *Creating ideas for action/improvement.* *Building a winning coalition around project.* *Implementing, monitoring and assessing success of actions.*	Local media outlets; Access Panel; General public.	WD Councillors; Local MP; Local MSPs; WD CPP; HSCP Locality Group; Local community groups.	HSCP Service staff; NHS Contractor staff (general practice); Other NHSGGC Service Staff (Acute Services); Locality Engagement Network.	Design & Delivery /Centre Commissioning Group; Project Task Groups; HSCP Board; HSCP SMT; WD Council; NHSGGC Corporate Support; Other NHS bodies; Other Public bodies; WD Access Panel.	Cabinet Secretary for Health & Wellbeing; Scottish Govt Health Directorate; NHSGGC Health Board; Project Board.

Note: The Project Team are not included in the matrix above as it is that group's responsibility to execute it (under the leadership of the identified HSCP officer). However, the Plan recognises lines of communication that critically need to operate within the components of this group.

Stages of consultation with wider public (CEL4 2010)

Planning	
Need for Change	Identify stakeholders/ Establish Project Group
	EQIA
	Communication Plan
Informing	
Inform potentially affected people of planned timetable for engagement, reasons for change and background info	Carry out communication and engagement to inform the engagement and development of options and proposed benefits
	Evaluation of engagement
Engaging	
Development of models with Key stakeholders and Option Appraisal process	Develop options with stakeholders, including patients, service users, carers
	Develop options appraisal process. Agree criteria around weighing options, scoring
	Agree preferred option for consultation and feedback
	EQIA on preferred option
	Seek Approval from Project Board and Scottish Government.
	Seek approval from Scottish Health Council
Consulting	
Major Service Change	Plan for a 3 month consultation period with timescale of analysis of results and report to relevant Boards and committee meetings.
	Produce Consultation Document which is accessible with information on options including the financial implications. Advise on how options appraisal was conducted.
Feedback	
Provide feedback to stakeholders and interested parties on outcome	Explain results of consultation and final process Explain how views were taken into account Provide reasons for not accepting any widely held views Outline plans for implementation and further opportunities for engagement Evaluation of engagement and any action to be followed up Seek ministerial approval (Advice from Scottish Health Council)

Assessing Effectiveness

The following indicators have been identified as headline “measures of success” in relation to stakeholder management:

- Staff/service attendance and participation at routine meetings and at dedicated events – numbers, degree of input and positivity of feedback responses.
- Number of opportunities to present at routine meetings (e.g. community groups) - degree of input and positivity of feedback responses.
- Public turnout for and participation at dedicated events – numbers, degree of input and positivity of feedback responses.
- Nature of feedback from Project Board, and WD HSCP Board.
- Nature of local press coverage.
- Response to proposals by WD HSCP Board, NHSGGC, WD Community Planning Partnership and Scottish Government.

SCOTTISH CAPITAL INVESTMENT MANUAL

Introduction

DRAFT DOCUMENT

1 Introduction

The Scottish Capital Investment Manual (SCIM) provides guidance in a NHS context on the sector-specific processes and techniques to be applied in the development of infrastructure and investment programmes and projects within NHSScotland.

It provides guidance on the various stages of infrastructure development from inception to post project evaluation and review. It guidance covers not only the technical issues around investment appraisal and procurement but also the project management and governance arrangements required to support the development of such programmes and projects.

The principles set out in SCIM are applicable to the development of all infrastructure investment schemes regardless of their size and complexity and shall be applied by all NHSScotland Bodies. It will thus provide an audit trial and assurances that appropriate steps have been followed in investment decision making process.

The SCIM has been revised to update the practices and processes associated with the development and approval of capital and revenue projects within NHSScotland. These changes mainly result from the development of improved approaches and techniques which support the development of investment schemes across NHSScotland.

In developing the revised SCIM recognition has been made of the guidance that currently exists on a Scottish, UK and international basis with a view to drawing together best practice that can be applied within an NHSScotland context.

2 Links to the Strategic Planning Process

The business case process should not be regarded as the start of the planning process, but more the link between the formative strategic planning processes (as described below) and the decision making process towards investment. The main purpose of these strategic planning processes, which will set the context behind most investment needs, is described in the diagram below:

Strategic & Investment Planning Process - Pre-Business Case Stages

	Purpose	Key Reference Documents
Service Planning Stage	• Provides the link to a Board's strategic plan / clinical strategy. • Confirms the need for service change • Engages with appropriate stakeholders as part of the decision making process. • Engages with Scottish Health Council re impact of service change on patient care.	• Informing, Engaging & Consulting People in Developing Health & Community Care Services – CEL (4) 2010 www.sehd.scot.nhs.uk/mels/**CEL2010**_04.pdf • Identifying major service change. • Involving Patients, Carers and the Public in Option Appraisal for Major Health Service Changes. http://www.scottishhealthcouncil.org/publications/guidance.aspx
Local Delivery Plan	• Sets out the Board's plan / contract for delivering on NHSScotland's Improvement Priorities and LDP Standards. • Develops a 3-5 year financial plan and a 5 year capital plan. • Outlines a workforce implementation plan and approach towards community planning.	• NHSScotland LDP Guidance 2015-16 http://www.scotland.gov.uk/Topics/Health/Quality-Improvement-Performance/NHSScotland/LDPGuid1516
Asset Management Strategy	• Sets out the Board's strategy for managing its assets. It will include where needed the rationale underpinning investment proposals targeted at improving the condition and performance of its assets aligned to the LDP and service plans.	• Strategic Property & Asset Management Guidance for NHSScotland (PAMS) http://www.hfs.scot.nhs.uk/publications/1290096744-Developing%20a%20Property%20and%20Asset%20Management%20Strategy%20-%20PAMS%20-%20for%20web.doc.pdf

Business Case Process

3 Overview of the Business Case Process

A quality business case process brings together the evidence required to support an NHS Board in its decision making at key stages and provides assurance to other stakeholders, including the public and Scottish Ministers, around the basis for such decisions and the robustness of the evidence and processes that underpin such key decisions. There are four main stages, the purpose of which is described in the diagram below:

Strategic & Investment Planning Process - Business Case Stages

	Purpose	Key Reference Documents
Strategic Assessment	• Informs Scottish Government of an intended investment proposal • Checks that suitable stakeholder engagement has taken place • Enables Scottish Government to consider the policy and strategic fit, and priority of a proposal	• Strategic Assessment guide [Hyperlink to be added]
Initial Agreement	• Confirms objectives and provides the evidence base supporting the need for change • Sets out the initial benefits realisation plan • Compares alternative strategic / service solutions against doing nothing • Identifies a preferred strategic / service solution(s) • Confirms the Board's readiness to proceed	• Initial Agreement guide [Hyperlink to be added]
Outline Business Case	• Identifies and appraises alternative options for implementing the preferred strategic / service solution(s) • Tests the value for money and affordability of delivering these options • Identifies a preferred option • Sets out the arrangements for delivering the preferred option and realising benefits • Confirms a readiness to proceed to the next stage	• Outline Business Case guide [Hyperlink to be added]
Full Business Case	• Confirms the management, commercial and financial arrangements in place to deliver the project • Sets out the contractual details of the project which the Board is being asked to sign-off	• Full Business Case guide [Hyperlink to be added]

3.1 The Business Case Stages

Further details of the main focus of each business case stage are described below:

The overarching purpose of the **Strategic Assessment** stage is to briefly outline the need for service change and describe early thoughts on a potential investment solution. It will become an integral component of a Board's Property & Asset Management Strategy (PAMS) for all new investment proposals, prior to submission the Scottish Government for review and approval to proceed. It will inform Scottish Government of the need for investment and present an opportunity to check that suitable stakeholder engagement has already taken place at the service planning stage. It will also be used by Scottish Government to consider the policy and strategic fit, and priority of a proposal.

The **Initial Agreement** stage will confirm the need for investment and demonstrate that this is a good thing to do. It will identify the preferred strategic / service solution(s) proposed to realise the benefits that will arise from the change. It shall only be developed once a proposal's Strategic Assessment has been accepted, and will provide the evidence base in support of the need for investment.

The **Outline Business Case** stage will identify the preferred option for implementing the strategic / service solution confirmed at Initial Agreement stage. It will demonstrate that the preferred option optimises value for money and is affordable. It will also set out the supporting commercial and management arrangements to be put in place to successfully implement that option.

The **Full Business Case** stage will set out the agreed commercial arrangements for the project whilst also confirming that it remains value for money, is affordable, and that the organisation is ready to proceed towards implementation of that option. It will be developed within the final procurement phase of the project and record the detailed assessment and/or negotiations with potential service providers / suppliers prior to the formal signing of contracts.

3.2 Scalability and Delegated Authority

The business case process is intended to be scalable and flexible to ensure that the analytical effort is fit for purpose and matches the scale and type of decision required. The level of detail required will be dependent upon the scale, risk and nature of the investment proposal. It should, however, meet the expectations and information needs of SGHSCD's Capital Investment Group who can be consulted for further advice on these expectations.

The following sets out the current delegated limits with regards to business case submission and subsequent approval process for all NHSScotland bodies. It is supported by CEL 32 (2010) Annex C:

<table>
<tr><th rowspan="2">NHS Board</th><th rowspan="2">Delegated Limit (£m)</th><th colspan="3">Approval Process</th></tr>
<tr><th>Capital Value <£1m</th><th>Capital Value £1-5m</th><th>Capital Value >£5m</th></tr>
<tr><td>Borders</td><td>1.0</td><td rowspan="14">FBC approved locally</td><td rowspan="6">SA, IA & FBC to CIG</td><td rowspan="14">SA, IA, OBC & FBC to CIG</td></tr>
<tr><td>Dumfries & Galloway</td><td>1.0</td></tr>
<tr><td>Orkney</td><td>1.0</td></tr>
<tr><td>Shetland</td><td>1.0</td></tr>
<tr><td>Western Isles</td><td>1.0</td></tr>
<tr><td>Special Boards and NSS</td><td>1.0</td></tr>
<tr><td>Ayrshire & Arran</td><td>1.5</td><td rowspan="8">SA, IA & FBC to CIG above D.L.</td></tr>
<tr><td>Fife</td><td>1.5</td></tr>
<tr><td>Forth Valley</td><td>1.5</td></tr>
<tr><td>Highland</td><td>1.5</td></tr>
<tr><td>Grampian</td><td>3.0</td></tr>
<tr><td>Lanarkshire</td><td>3.0</td></tr>
<tr><td>Tayside</td><td>3.0</td></tr>
<tr><td>Greater Glasgow</td><td>5.0</td></tr>
<tr><td>Lothian</td><td>5.0</td></tr>
</table>

All hub & NPD projects will require a Strategic Assessment, Initial Agreement, Outline Business Case, & Full Business Case (all require SGHSCD approval).

Further details, including the approval process for IM&T projects, and delegated authority for approvals is available on the Scottish Govenment's SCIM website:

http://www.scim.scot.nhs.uk/

3.3 Responsibility for Producing the Business Case

The 'ownership' and responsibility for the investment planning process rests with the NHSScotland body developing or leading the development of the programme/ project in question.

Issues of governance are dealt with in the SCIM Programme and Project Organisation Guide. For significant investments, NHSScotland Bodies should appoint a Senior Responsible Owner (SRO) for the project's direction at Board level. The process should also involve the NHSS Body's board-level environmental or sustainability champion, a key role promoted in the Environmental Management Policy Action Plan (2008).

Under no circumstances should responsibility for the direction and lead production of the business case be 'outsourced' to external consultants. However, external consultants could be considered where the necessary skills and resources are not available in house.

Similarly, the production of the business case should not be regarded as an adjunct to the project manager's role, and a hurdle to jump for approval purposes. Instead, it must be viewed as a fundamental part of the overall investment planning process, which requires advice and guidance from business managers, clinicians, users and technicians involved in the scheme.

3.4 Stakeholder Engagement and Communication

The Scottish Health Council rightly advocates the importance of involving patients, carers and the public in the planning process leading to changes in local health services and guidance on how this process should be managed at Service Planning stage is available on their website:
http://www.scottishhealthcouncil.org/publications/guidance.aspx

Experience also shows that each business case stage is best developed through a number of multi-stakeholder workshops at the critical phases of its development.

The following workshops are recommended for the business case process:

1. Strategic Assessment (SA) stage: development of the SA template identifying the need for change, benefits to be gained and links to NHSScotland's Strategic Investment Priorities.

2. Initial Agreement (IA) stage: determine that the proposal is a good thing to do by confirming the need for change, identifying the investment objectives, benefits to be realised and risks to be managed.

3. Initial Agreement (IA) stage: identify the preferred strategic / service solution by developing a list of potential solutions, assessing their suitability and then confirming the preferred solution.

4. Outline Business Case (OBC) stage: identify appropriate implementation options for delivering the preferred strategic / service solution(s) and carry out an option appraisal exercise to confirm the preferred option.

5. Outline Business Case (OBC) stage: determine proposals for change management, benefits realisation, risk management, commissioning arrangements, and the project evaluation process to be followed.

The need for further meetings and workshop events involving stakeholders shall be determined locally. These should be planned ahead and carefully managed to ensure that outcomes are optimised and continued support for the project is

maintained.

3.5 Project Assurance

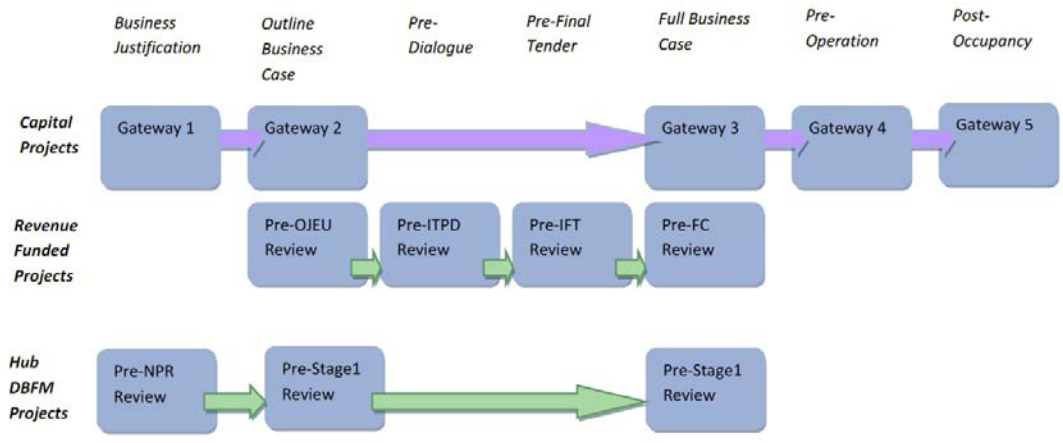
In respect of Scottish Government funded projects and programmes, the two main models of independent project assurance are Gateway Reviews and Key Stage Reviews.

Gateway reviews are managed by Scottish Government's Programme and Project Management Centre of Expertise (PPM-CoE) and all Key Stage Reviews are managed by Scottish Futures Trust (SFT)

It is mandatory for all programmes and projects with a total budget of £5m+ inclusive of fees and VAT to be considered by PPM-CoE for Gateway Review. All NPD and hub projects will undergo a Key Service Review.

An Independent Assurance Framework (IAF) was formally rolled out for health related projects in July 2012 which seeks to identify upfront the most appropriate validation plan for each project, ensuring, where possible, that reviews provide maximum benefit and minimum burden.

The following diagram sets out the IAF stages for health related projects:



The option remains for the Senior Responsible Officer to instigate a Gate 0 assessment which is specifically designed for programmes.

Further details are available on the Independent Assurance process on the

Programme and Project Management Centre of Expertise website:

http://www.scotland.gov.uk/Topics/Government/ProgrammeProjectDelivery/IAOverview

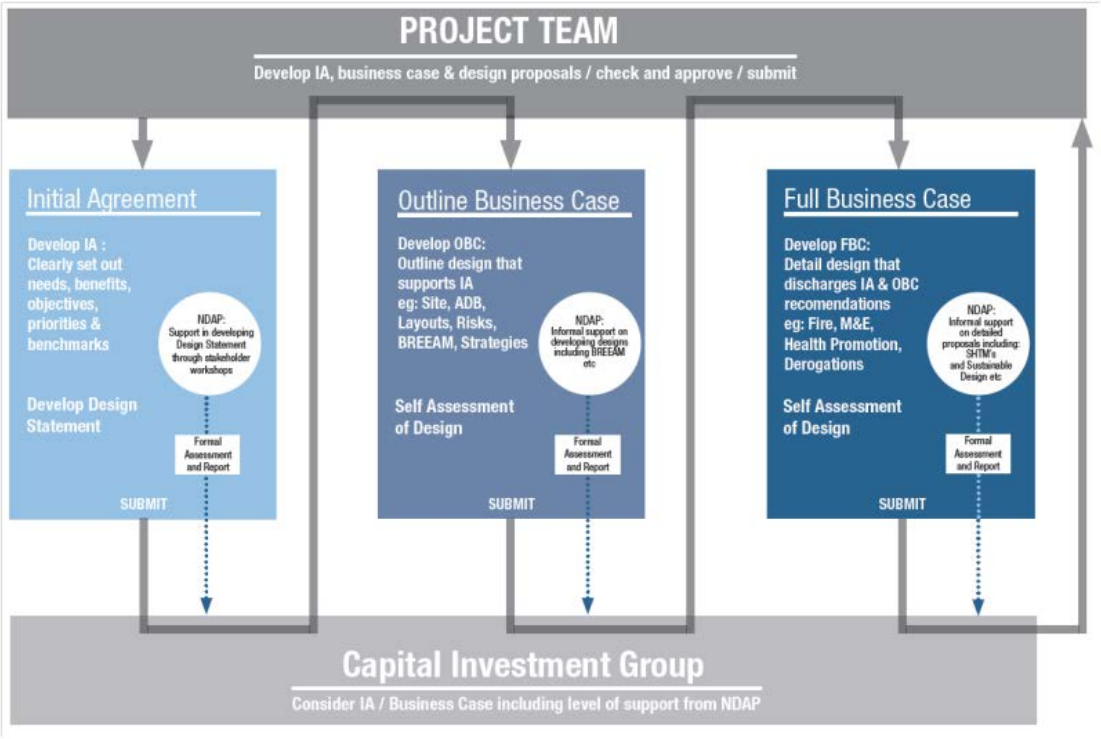
4 Links to Design Process

The assessment of design quality is an integral part of the business case approval process which aims to ensure that the outcomes of designed development projects meet the Government's strategic objectives and expectations for public investment.

The requirement to refer projects to the NHSScotland Design Assessment Process applies to all projects that are to be considered by Capital Investment Group (CIG). It is expected however that Boards will develop 'design statements' and utilise the self assessment methodologies on all development projects.

The Design Statement, which is to be produced by the Boards for each project prior to the submission of the Initial Agreement (IA), is central to the consideration of design matters within the business case approvals process as it is this document that establishes the design criteria against which the project will be assessed. The benchmarks set by the Board will also be assessed to ensure that they are in line with the expectations established in national policy.

The following flow diagram shows the key NDAP activities and information flow at each Business Case stage. Early engagement and dialogue with Project Teams in NDAP is key to reducing surprises / risks at the Formal Report stage.


PROJECT TEAM
Develop IA, business case & design proposals / check and approve / submit
Initial Agreement
Develop IA : Clearly set out needs, benefits, objectives, priorities & benchmarks
NDAP: Support in developing Design Statement through stakeholder workshops
Develop Design Statement
Formal Assessment and Report
SUBMIT
Outline Business Case
Develop OBC: Outline design that supports IA eg: Site, ADB, Layouts, Risks, BREEAM, Strategies
NDAP: Informal support on developing designs including BREEAM etc
Self Assessment of Design
Formal Assessment and Report
SUBMIT
Full Business Case
Develop FBC: Detail design that discharges IA & OBC recomendations eg: Fire, M&E, Health Promotion, Derogations
NDAP: Informal support on detailed proposals including: SHTM's and Sustainable Design etc
Self Assessment of Design
Formal Assessment and Report
SUBMIT
Capital Investment Group
Consider IA / Business Case including level of support from NDAP

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13 January 2016

Subject: Integrated Care Fund Mid Year Report

1. Purpose

1.1 To provide Committee with an update on the use of the Integrated Care Fund (ICF) for the first half of the 2015-16 financial year.

2. Recommendations

2.1 The Committee is asked to note the report.

3. Background

3.1 In April 2015 Partnerships were advised of the requirements for the new Integrated Care Fund. The fund builds on the work of the Change Fund for Older People and seeks the development of further work for people of all ages with long term conditions and multi-morbidity.

3.2 The financial allocation was therefore raised from £1.02m to £1.99m with confirmed funding for 3 years.

4. Main Issues

4.1 Specific consultation which was undertaken in response to the national guidance for local partnerships found clear support supporting people to stay at home by:

- Providing reablement and rehabilitation for home care clients.
- Providing a home based pharmacy service.
- Providing support to carers including peer support.
- Nursing support for anticipatory care planning.
- Providing additional respite provision and co-ordination through the respite booking bureau.
- Providing a primary care dementia service.
- Providing additional support for hospital discharge and rehabilitation.

4.2 In relation to what new services would contribute to older or multi morbid patients being able to stay at home for longer, clear support was voiced for:

- Promoting self management and providing support.
- Enabling seamless patient/ carers centred services.

- Anticipatory care management of health and social care needs.
- Integrated approach to housing and health care including the development of accessible housing for older people and people with a disability.
- Support service designed around the needs of people with multiple health care issues including easier access to information and navigation to other supports.

4.3 In relation to the themes required within the local Integrated Care Fund Plan to meet the national principles set for the programme, there was clear support for

- COPD, Dementia and Diabetes being the top long term conditions to address.
- Investment was seen to be required in relation to focussed primary care provision and specialist nurses who can respond quickly and who have good links into hospital specialist consultants.
- A focus on primary prevention in relation to smoking, obesity including access to healthy food and healthy meals for children and families was suggested.
- A focus on self management and independence and confidence and maintaining people at home safely.

4.4 It was also recognised that there was a need to continue to support the integration agenda across health and social care, working with the CHCP and then HSCP to understand and make best use of resources within the community and across with NHS acute/ secondary care.

4.5 The Integrated Care Fund plan has adopted those key work streams undertaken as part of Older People Change Fund programme which have been identified as being are directly transferable to a broader age group that (like older people) demonstrate high levels of health and social care need as a result of multi morbidity and inequalities. The actions reflect a collective commitment to:

- Optimal outcomes for individual service users.
- A client-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services.
- Effective and safe services that draw upon the best available evidence and local feedback from service users.
- Equalities-sensitive practice.
- Acceptability of service provision informed through constructive engagement with local stakeholders – including staff, community groups and elected representatives.
- Affordable and efficient services that continue to be reflective of the relative demands across the West Dunbartonshire population as a whole.

4.6 The half yearly submission from the Scottish Government is attached at Annex A.

5. People Implications

5.1 Investment in additional staff has been necessary to build on the work of our core teams.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 Although the work streams are delivered across the authority, locality groups review and prioritise the activities associated with the plan.

9. Risk Analysis

9.1 None.

10. Impact Assessments

10.1 Monitoring of expected outcomes against actual is undertaken monthly.

11. Consultation

11.1 Consultation with Locality Groups and with the ICF Reference Group for next years funding will commence in January.

12. Strategic Assessment

12.1 The ICF forms part of the IJB Strategic Plan.

Author: Christine McNeill - Head of Community Health and Care

Date: 18 December 2015

Person to Contact: Christine McNeill
West Dunbartonshire HSCP
Council Offices, Garshake Road
Dumbarton, G82 3PU
E-mail**:** Chris.McNeill@ggc.scot.nhs.uk
Telephone: 01389 737356

Appendices: None

Background Papers: None

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13th January 2016

Subject: Audit Scotland Report on NHS in Scotland 2015

1. Purpose

1.1 To bring to the Audit Committee's attention the recently published Audit Scotland report on NHS in Scotland 2015.

2. Recommendation

2.1 The Partnership Board is recommended to note the findings of the Audit Scotland report.

3. Background

3.1 Audit Scotland undertakes a number of audits for the Auditor General for Scotland and the Accounts Commission as part of a wider public audit model. This includes reports on significant issues of public interest; and overview reports on specific sectors.

3.2 The Audit Scotland annual report on how the NHS in Scotland is performing is appended. It analyses the performance of the NHS during 2014/15 and comments on its future plans.

4. Main Issues

4.1 The Audit Scotland Report contends that the Scottish Government has not made sufficient progress towards achieving its 2020 vision of changing the balance of care to more homely and community-based settings. While its cites some evidence of new approaches to delivering healthcare, its assessment is that it will be unlikely that all the necessary changes will be in place by 2020.

4.2 In June 2015, the Cabinet Secretary for Health, Wellbeing and Sport confirmed that the Scottish Government and NHS boards had not made sufficient progress quickly enough towards delivering the 2020 vision. At the same time, the Scottish Government announced plans to launch a new national conversation on the future of healthcare in Scotland. The Scottish Government decided to consider a longer-term plan, beyond 2020, because it wanted: more progress and pace towards achieving the vision; and to expand the current focus of the vision.

4.3 In developing a revised long-term plan, Audit Scotland are of the view that the Scottish Government will need to engage widely with clinical representatives, councils, new integration authorities, community planning partnerships, patients and the wider public. The Scottish Government will also need to

outline milestones and indicators of planned progress and how it plans to measure this between now and 2020, and beyond to 2030. Audit Scotland also stress that in doing so, the Scottish Government should learn from the slow progress made so far in achieving the 2020 vision and ensure the new approach includes any lessons learned.

5. People Implications

5.1 None associated with this report.

6. Financial Implications

6.1 This report on the above national audit will provide important evidence and context for the development of the Partnership Board's Strategic Plan and medium-term financial planning.

7. Professional Implications

7.1 None associated with this report.

8. Locality Implications

8.1 None associated with this report.

9. Risk Analysis

9.1 This report stresses that the Scottish Government needs to increase the pace of change if it is to achieve its 2020 vision. This includes changes to the NHS estate.

9.2 This report will provide important evidence and context in assessing the strategic planning challenges and financial risks facing the Partnership Board over the medium term, including the Partnership Board's overall approach to risk management.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 This report on the above national audit will provide important evidence and context for the development of the next Strategic Plan.

Author: Jeanne Middleton – Chief Financial Officer
West Dunbartonshire Health & Social Care Partnership.

Date: 5th January 2016

Person to Contact: Jeanne Middleton – Chief Financial Officer
Garshake Road, Dumbarton, G82 3PU
Telephone: 01389 737311
e-mail: jeanne.middleton@ggc.scot.nhs.uk

Appendices: Audit Scotland: NHS in Scotland 2015

Background Papers: None

Wards Affected: All

NHS in Scotland 2015

AUDITOR GENERAL

Prepared by Audit Scotland
October 2015

Auditor General for Scotland

The Auditor General's role is to:

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

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

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

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

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

Contents

Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

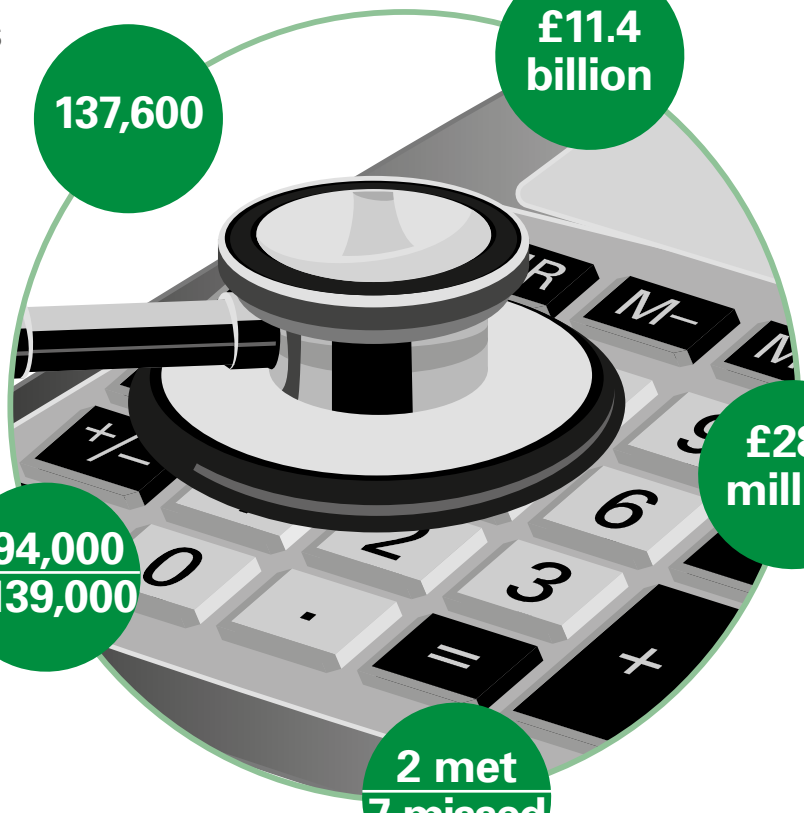
Key facts

Total spending by NHS boards in 2014/15

£11.4 billion

Number of staff employed by NHS boards at March 2015 (whole-time equivalent)

137,600



£285 million

Total savings reported by NHS boards in 2014/15

Number of inpatient cases at March 2015

394,000

Number of outpatient appointments at March 2015

1,139,000

2 met
7 missed

Number of key waiting time targets and standards met and missed at March 2015

Summary

Key messages

1 Significant pressures on the NHS are affecting its ability to make progress with long-term plans to change how services are delivered. Tightening budgets combined with rising costs, higher demand for services, increasingly demanding targets and standards, and growing staff vacancies mean the NHS will not be able to continue to provide services in the way it currently does. Together, these pressures signal that fundamental changes and new ways to deliver healthcare in Scotland are required now.

2 During 2014/15, NHS boards spent £11.4 billion, and ended the year with a very small underspend of £10 million (0.09 per cent) against the budget available. This is commendable given the financial challenges it faces. All territorial NHS boards are finding it increasingly difficult to meet national performance targets and standards while remaining within their annual budgets. The NHS in Scotland missed seven of its nine key waiting time targets and standards at March 2015, reflecting a general decline in performance in recent years. Many boards relied on one-off savings and two boards required extra financial support from the Scottish Government to break even. Greater flexibility in managing their finances as part of good long-term planning would help boards respond better to local needs and priorities.

3 The number of people working in the NHS is at its highest level, although recruiting and retaining staff remains a significant problem for many boards. Reasons for this include the rural location of some boards, competition between boards for specialist staff and a greater demand from staff for more flexible working patterns. NHS boards hire temporary staff to help keep services running and meet performance targets and standards but this approach is increasingly expensive and provides only a short-term solution. In 2014/15, NHS boards spent £284 million on temporary staff, an increase of 15 per cent from 2013/14. The ability to attract, recruit and retain medical professionals across Scotland, with the right skills to deliver the services required, is one of the biggest challenges facing the NHS today. A coordinated national approach to managing current and future workforce pressures is needed.

4 The Scottish Government has not made sufficient progress towards achieving its 2020 vision of changing the balance of care to more homely and community-based settings. There is some evidence of new approaches to delivering healthcare although it is unlikely that all

the necessary changes will be in place by 2020. To help increase the pace of progress, the Scottish Government launched a new national conversation in August 2015. The conversation is expected to inform plans to change how services will be provided in Scotland over the next ten to 15 years.

Recommendations

The Scottish Government needs to increase the pace of change if it is to achieve its 2020 vision. In doing so, it is important that the Scottish Government and NHS boards ensure changes are underpinned by good long-term financial and workforce planning. They also need to consider the implications for performance targets and standards and the NHS estate, as well as ongoing initiatives and reform programmes. By doing so, the Scottish Government and boards will gain a better understanding of the nature, scale and impact of changes required.

In developing its long-term approach, the Scottish Government and NHS boards should:

- ensure better longer-term financial planning which extends beyond the three-or five-year period currently used by boards. Boards should assess their spending needs and options over a longer period of five to ten years. To support this, the Scottish Government should consider options to offer greater financial flexibility to NHS boards. Flexibility that is managed well and planned in advance can help boards meet local needs and priorities over an extended period

- ensure that work towards meeting financial and performance targets also supports longer-term changes to delivering healthcare. This will help ensure that short-term actions do not conflict with longer-term plans. In doing so, the Scottish Government should continually review each national performance target and standard to assess its relevance, priority and sustainability as new changes are introduced

- develop a coordinated, national approach for workforce planning and outline what changes mean for all NHS staff. This should assess what levels and types of jobs are needed, including skills required, roles and responsibilities, to meet the requirements of how services will be delivered in the future. This should also include detailed plans on how and when changes will be made

- assess what changes are required to NHS assets, such as land, buildings and medical equipment, to help deliver effective healthcare services in the future. Transforming services and bringing care closer to people's homes and communities will involve significant changes to where assets are located and what type of equipment is needed. Greater links are necessary to demonstrate how capital investment activity will result in the changes required

- ensure ongoing initiatives and reform programmes such as health and social care integration, seven-day services, out-of-hours and maternity services fully align with, and contribute to, the longer-term changes in healthcare services.

The Scottish Government should:

- be clear about what improvements are expected at each stage of the process and how they intend to monitor and assess progress. In doing so, they should assess the financial impact of any changes to help inform boards' funding allocations and financial planning. The Scottish Government should also apply any lessons from the slow progress made towards achieving the 2020 vision to help improve the pace of change.

Background

1. The NHS continues to deliver a wide range of vital healthcare services to thousands of people across Scotland each day. Almost 140,000 NHS staff are involved in providing a variety of high-quality services, support and advice in different settings such as hospitals, GP and dental surgeries, community facilities and patients' homes. The level and quality of care provided have contributed to people living longer along with continued advances in diagnosis, treatment and care. Although Scotland's population is living longer, demand for healthcare is increasing as older people are more likely to have complex health and care needs. In recent years, the cost of delivering health services has increased significantly, coinciding with a period of constrained public finances.

About this audit

2. This is our annual report on how the NHS in Scotland is performing. It analyses the performance of the NHS during 2014/15 and comments on its future plans. The overall aim of the audit was to answer the question: How well is the NHS in Scotland performing and is it equipped to deal with the challenges ahead? The specific audit questions were:

- How well did the NHS manage its finances in 2014/15?
- Is the NHS in Scotland equipped to deal with the financial challenges in 2015/16 and beyond?
- How is the NHS performing against national targets and standards and is it making good progress towards achieving the 2020 vision?
- How effectively are NHS boards managing changes to their workforce?

3. The report has three parts:

- Part 1 Financial and service performance
- Part 2 Workforce
- Part 3 Looking ahead.

4. Our findings are based on evidence from sources that include:

- the audited annual accounts and auditors' reports on the 2014/15 audits of the 23 NHS boards
- NHS boards' Local Delivery Plans (LDPs), which set out indicative spending plans for the next three to five years
- monthly Financial Performance Returns (FPRs) that each NHS board submits to the Scottish Government throughout the year
- activity and performance data published by Information Services Division (ISD) Scotland
- information submitted by auditors on the use of temporary staff in the NHS
- interviews with senior staff in the Scottish Government and a sample of NHS boards.

5. We reviewed service performance information at both national level and board level. Our aim was to present the national picture as well as highlighting any significant variances between boards. It is important to note that performance can vary between boards and also within boards, for example between different hospitals within the same board area. We focused on a sample of nine key targets and standards, covering some of the most important activities of the NHS. Where we have used trend information, we have selected a time period where information is most comparable. There is limited data available on primary care services, such as the number of appointments with GPs, therefore we are unable to assess activity levels in this area. Details on the financial performance of NHS boards is in the Appendix

6. Alongside this report we have published a self-assessment checklist for NHS non-executive directors. The purpose of the checklist is to help non-executive directors with their scrutiny and challenge of their board's performance and to help them gain assurance on the board's approach in dealing with the issues raised in this report.

Part 1

Financial and service performance

Key messages

1 During 2014/15, NHS boards spent £11.4 billion, and ended the year with a very small underspend of £10 million (0.09 per cent) against the budget available. This is commendable given the size of the budget and the scale of the challenges faced. Many boards relied on one-off savings and two boards required extra financial support from the Scottish Government to break even. Greater flexibility in managing their finances as part of good long-term planning would help boards respond better to local needs and priorities.

2 All territorial NHS boards are finding it increasingly difficult to meet performance targets and standards while remaining within their annual budgets. The national performance against seven out of nine key targets and standards has deteriorated in recent years. Boards performed strongly against two standards: three-week referral for drug and alcohol treatment and cancer 31-day decision to treat to first treatment.

3 Improvements in public health, diagnosis and medical treatment have helped Scotland's population live longer. In the last ten years, the number of people aged over 75 increased by 17 per cent. Average life expectancy for both men and women also grew during this period. Although people are living longer, they are more likely to have complex health issues meaning increased activity and demand for health services. Ongoing financial pressures, combined with greater activity and demand, made achieving targets and standards more difficult.

NHS boards are finding it increasingly difficult to meet their financial and performance targets

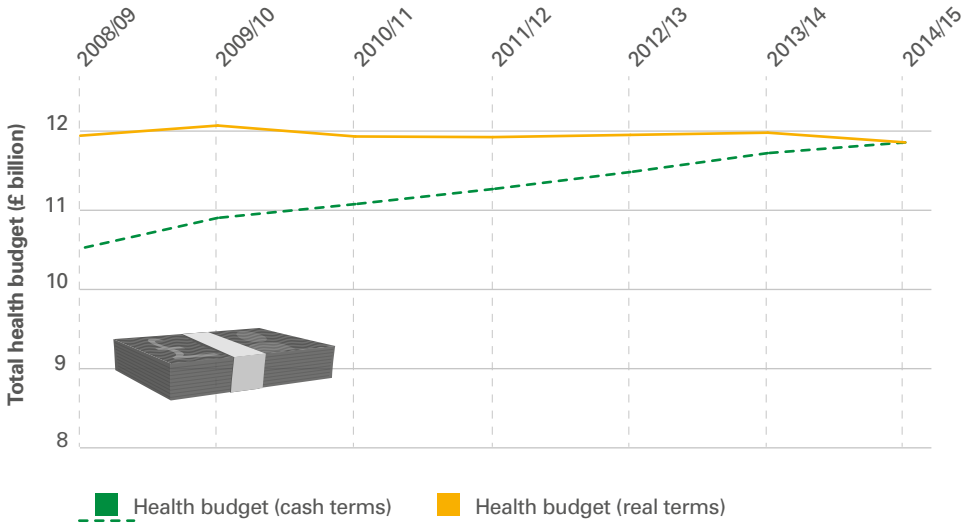
The health budget decreased by 0.7 per cent in real terms between 2008/09 and 2014/15

7. The Scottish Government is responsible for managing the overall health budget and allocating budgets to individual boards. Since 2008/09, budgets have only changed slightly each year in real terms (that is, adjusting to remove the effects of inflation) owing to the overall reduction in available public finances following the 2008 economic recession (Exhibit 1, page 10). In 2014/15, the health budget was £11.9 billion. The Scottish Government allocated £10.1 billion directly to the 14 territorial boards which cover each area of Scotland and provide frontline healthcare services. It also allocated £1.3 billion to the nine special health boards that provide specialist support and national services. The remaining £0.5 billion provided funding for national public health programmes such as tackling health inequalities, improving access to services, eHealth initiatives and medical research.

Exhibit 1

Health budgets (revenue and capital), 2008/09 to 2014/15

The health budget in Scotland decreased by 0.7 per cent in real terms between 2008/09 and 2014/15.



Note: Figures include both revenue and capital Departmental Expenditure Limit (DEL) budgets. Between 2008/09 and 2014/15, the revenue DEL budget increased by 2.2 per cent, while the capital DEL budget decreased by 57 per cent.

Source: Scottish Government

8. In 2014/15, the total amount of revenue funding allocated to boards, for day-to-day running costs such as staff pay and medical supplies, was just under one per cent more than in 2013/14 (in real terms). Territorial boards received an average increase of one per cent, and special boards an average increase of 0.7 per cent. The smaller increase for special boards reflects the Scottish Government's policy to transfer savings from boards that do not provide frontline services to those that do. In contrast, capital funding for boards, decreased by 35 per cent in 2014/15 from the previous year. Capital funding is used to develop NHS buildings and major IT programmes.

9. Looking ahead, the overall budget for 2015/16 will increase by 1.4 per cent, from £11.857 billion in 2014/15 to £12.022 billion. The revenue budget will increase by 1.9 per cent in real terms between 2014/15 and 2015/16. The capital budget will decrease by 21 per cent in 2015/16, from £254 million to £200 million. This reduction is largely due to the completion of the new Queen Elizabeth University Hospital in Glasgow, which was funded from the capital budget.

10. The amount of funding available beyond 2015/16 remains unknown. In November 2015, the UK Government will publish the results of its spending review. This will set out the UK's public spending plans for the next four years including much of the funding available to the Scottish Government. The Scottish Government will then decide how to allocate its budget to healthcare and to its other portfolio areas, such as education and justice.

All territorial boards are within at least two per cent of their target funding allocation

11. Since 2009/10, the Scottish Government has used a formula developed by the National Resource Allocation Committee (NRAC) to allocate around 70 per cent of the total NHS budget to the 14 territorial boards. This provides funding for hospital and community health services and GP prescribing. The formula is based on the number of people living in each board area and then adjusted for:

- the age and sex profile of the local population
- additional needs based on local circumstances such as geography, sickness and deprivation levels.

12. The final shares allocated to boards are different from the levels determined by the formula. The Scottish Government adjusts the formula to ensure all territorial boards receive an increase in funding each year until the target share determined by the formula is reached. The target share also changes each year in line with changes in population and local circumstances. This makes it more challenging to ensure all boards receive an increase in funding at the same time as progressing towards their target share.

13. The Scottish Government aims to be within one per cent of the target allocations by 2016/17. Initial funding allocations for 2015/16 show that eight boards are between one and two per cent from their target allocation, with the remaining six boards within one per cent or above parity. NHS Grampian is the furthest away, at two per cent (£16.9 million) behind its target share. This is an improvement on 2014/15, where the board was 3.7 per cent (£30.2 million) behind its target. In the last year, the board also saw an increase in its target share owing mainly to population changes.

NHS boards are finding it increasingly difficult to remain within their annual budgets

14. NHS boards are required to meet two key financial targets in each financial year: to at least break even against both their revenue and capital budget limits at the end of the financial year. This means that boards must not overspend against these two limits. Throughout the financial year, the Scottish Government changes boards' revenue and capital budget limits to help address short-term needs and to ensure the overall health budget is balanced. The limits change throughout the year, particularly in March which is the final month of the financial year, as boards work towards their year-end financial position. In one case, for NHS Tayside, an adjustment was made to their 2014/15 financial limit in June 2015, nine weeks after the financial year-end in order to avoid breaching their original limit.

15. In 2014/15, all boards were within their final revenue and capital limits at the year-end. Overall, boards spent £11,378 million and ended the year with a very small surplus of £10 million, 0.09 per cent of the £11,388 million limit. Only two per cent of the surplus related to capital spending as NHS boards remained within £0.2 million of their £431.9 million overall capital limit (Appendix).

16. This small year-end surplus, combined with changes to financial limits throughout the year, highlights the tight financial position facing boards. The requirement for boards to manage their finances within changing limits makes it more difficult for them to balance in-year funding of services and the need for investment to meet longer-term requirements.

NHS Ayrshire and Arran and NHS Tayside required loans from the Scottish Government to break even

17. The Scottish Government can agree to provide an NHS board with additional funding to help it manage unexpected changes to planned expenditure. This is agreed on the basis that the board provides assurance that it can repay the loan over an agreed period. This form of loan funding is known as brokerage. The amount of brokerage received by boards is generally very small compared to their overall budget.

18. In 2014/15, two boards received brokerage from the Scottish Government to help them cope with financial pressures during the year:

- NHS Ayrshire and Arran received £378,000 (0.05 per cent of its revenue budget) for demolition costs at its Heathfield site. It plans to repay this in 2015/16 using income raised from selling the site.
- NHS Tayside received £14.2 million (two per cent of its revenue budget):
  - £8 million to cover retrospective holiday pay enhancements and overspends in workforce costs and primary care prescribing
  - £6.2 million related to an accounting adjustment identified by the auditors in recognition of the sale of land (formerly Ashludie Hospital) in the draft 2014/15 accounts.

19. This is the third consecutive year NHS Tayside has received brokerage. The board repaid £4 million of previously agreed brokerage during 2014/15 and plans to repay all remaining sums (£15 million) during 2015/16. The Auditor General has prepared a separate report on the 2014/15 audit of NHS Tayside, which comments on the financial position and challenges of the board.[1]

20. Six boards have ongoing commitments to repay brokerage to the Scottish Government over the next five financial years to 2019/20. This will reduce the amount they have available to spend during these years. Two boards, NHS Forth Valley and NHS Lothian, made final repayments of previously borrowed sums in 2014/15. Three further boards, NHS Orkney, NHS Tayside and NHS 24, have requested brokerage in at least three of the last six financial years. This need for small amounts of brokerage highlights that NHS boards have limited flexibility to manage their budgets to deal with fluctuations in spending (Exhibit 2, page 13).

NHS Highland and NHS Orkney made improvements in managing their finances

21. In 2013/14, we reported weaknesses in NHS Highland's financial management arrangements. The board was unable to make all of the savings required and this, together with an overspend at Raigmore Hospital of almost £10 million, required brokerage of £2.5 million from the Scottish Government.[2] The need for brokerage was not formally reported to NHS Highland's Board until close to the end of the financial year. During 2014/15, auditors concluded that the board had strengthened its financial management arrangements, including an action plan to address savings shortfalls and a training programme for budget holders at Raigmore Hospital. Auditors also reported that the board's financial position is sustainable in the short term, but a robust longer-term financial plan is required to support this in the future. The Auditor General has prepared separate reports on the 2013/14 and 2014/15 audits of NHS Highland.[3]

Exhibit 2

Brokerage and planned repayments, 2009/10 to 2019/20

Six boards have commitments to repay brokerage over the next five years to 2019/20.

NHS board	(£ millions)	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	Total brokerage by board
Ayrshire and Arran	Brokerage						0.38						0.38
	Repayments							(0.38)					
Forth Valley[2]	Brokerage		2.10	11.00									13.10
	Repayments			(1.55)	(2.57)	(3.57)	(4.41)						
Highland[5]	Brokerage					2.50							2.50
	Repayments						(0.50)	(1.00)	(1.00)				
Lothian[3]	Brokerage				10.00								10.00
	Repayments				(2.00)	(4.00)	(4.00)						
Orkney[5]	Brokerage	1.11	1.01	2.26		1.00							5.38
	Repayments			(0.32)		(1.00)		(3.00)	(1.06)				
Tayside	Brokerage				2.25	2.85	14.20						19.30
	Repayments					(0.25)	(4.05)	(15.00)					
Western Isles[4]	Brokerage	3.10											3.10
	Repayments			(0.63)	(0.59)	(0.26)	(0.54)	(0.54)	(0.54)				
NHS 24[5]	Brokerage			0.32	16.58	3.86							20.76
	Repayments						(0.40)	(0.79)	(3.58)	(4.34)	(6.22)	(5.43)	
Total brokerage by year		4.21	3.11	13.58	28.83	10.21	14.58						

Notes:
1. Numbers in brackets represent brokerage repayments to the Scottish Government.
2. NHS Forth Valley received financial support of £2.1 million in 2010/11. The board received a further £11 million in 2011/12 towards the cost of implementing its healthcare strategy and to help it break even. The Scottish Government agreed that £1 million of this £11 million brokerage did not need repaid.
3. In 2012/13, NHS Lothian received £10 million to help improve its performance against waiting time targets.
4. In 2009/10, NHS Western Isles received £3.1 million following financial year 2008/09 to help pay for a historical deficit.
5. Reasons for NHS Highland, NHS Orkney and NHS 24 receiving brokerage are in paragraphs 21 to 23 and case study 1.

Source: Scottish Government

22. During 2014/15, auditors reported that NHS Orkney had also made improvements in financial management (Case study 1, page 14).

NHS 24 faces challenges in meeting future financial targets

23. NHS 24 has experienced financial difficulties owing to problems implementing a new IT system. The delay in implementing the new system has led to additional costs and risks to the board's ability to meet its financial targets in future years. These include cost pressures associated with the additional expenditure involved in delivering the new operational system, and the costs associated with the

Case study 1

Financial management at NHS Orkney

In October 2014, the Auditor General reported concerns about weaknesses in financial management in NHS Orkney during 2013/14. This was a factor in the board receiving brokerage of £1 million from the Scottish Government to break even, owing mainly to hiring locum doctors to cover vacant medical posts. This was the fourth time in five years that the board received brokerage. In addition, concerns were raised about the capacity of the finance team, given the financial pressures facing the board.[4]

The 2014/15 audit report highlights improvements in the board's financial management arrangements over the past year, particularly the quality of its financial forecasting. The board met its two main financial targets, remaining within £0.068 million of its £57.419 million revenue budget limit (0.1 per cent) and within £0.014 million of its £3.55 million capital budget limit (0.4 per cent). During the year, the Scottish Government provided the board with additional revenue (£0.6 million) and capital funding (£1.5 million) to help towards locum costs and the purchase of land for the new hospital in Kirkwall. NHS Orkney also reported delivering £1.567 million of savings, in line with those outlined in its local delivery plan. Savings achieved were 52 per cent higher than in 2013/14. The board is due to finish repaying all outstanding brokerage in 2016/17.

NHS Orkney still faces challenges in recruiting to vacant medical posts and continues to rely on locum doctors. In January 2015, an internal audit review concluded that the board could improve its use of temporary staff but there were no major weaknesses in its approach. The internal auditor found that the board explored alternative options before resorting to locums and that monitoring and reporting locum costs is part of financial reporting arrangements. The internal auditor also found that the approval process, succession planning and greater consistency with nationally agreed agency rates were areas for improvement. NHS Orkney reduced spending on temporary staff by 21 per cent, from £2.8 million in 2013/14 to £2.2 million in 2014/15.

Source: NHS Orkney, 2014/15 annual audit report

maintenance of the current system. The estimated cost of the new system is £117.4 million, £41.6 million (55 per cent) higher than the original estimate of £75.8 million. The Scottish Government has provided £20.8 million in brokerage between 2011/12 and 2013/14 to help fund the new system (Exhibit 2, page 13) The Auditor General has prepared separate reports on the 2013/14 and 2014/15 audits of NHS 24.[5, 6]

NHS boards made a total of £285 million of savings in 2014/15 to meet financial targets

24. At the end of March 2015, boards reported savings of £285 million to help them meet their financial targets. This was £3 million (one per cent) less than the overall target savings of £288 million in their financial plans for 2014/15.

Seven boards exceeded their savings targets by at least one per cent, with special boards delivering on average 17 per cent more savings than planned. Territorial boards achieved on average three per cent fewer savings than planned.

25. Many boards are relying more on non-recurring savings to achieve their targets. On average, 25 per cent of boards' savings in 2014/15 were non-recurring, four per cent higher than last year, and three per cent higher than 2012/13. These are one-off savings that only apply to one financial year, and do not result in ongoing (recurring) savings in future years. Non-recurring savings are typically short-term decisions rather than initiatives to change the way services are provided. It can be appropriate to have some non-recurring savings. But recurring savings are more important to ensure boards' ability to continue to meet financial commitments. We have highlighted this as a risk in each of our last three annual reports on the NHS.

26. In their LDPs for 2015/16, boards expect non-recurring savings to be on average 19 per cent. As in recent years, there is considerable variation in the type of savings boards are looking to achieve. NHS Borders, NHS Tayside and The State Hospital all plan to continue high levels of non-recurring savings in 2015/16, whereas NHS Greater Glasgow and Clyde continues to report all savings as recurring.

NHS boards are continuing to experience significant cost pressures

27. The health sector is experiencing significant cost pressures in a number of areas. For example:

- Latest available data shows that primary and secondary care drug costs increased by four per cent in cash terms from £1.37 billion in 2012/13 to £1.42 billion in 2013/14. Looking ahead costs are expected to increase significantly with boards planning for average cost increases in primary and secondary care drugs of five and 16 per cent respectively.

- Costs associated with using temporary staff increased in 2014/15 (see paragraph 68)

- Changes to superannuation rates will result in an increase in employer contributions. In 2015/16, the rate will increase to 14.9 per cent from 13.5 per cent in 2014/15. Changes in national insurance rules are expected to increase employer costs from 2016/17.

- Significant investment is required to ensure the NHS estate, such as land and buildings, is fit for purpose. The NHS reports that only 65 per cent of the estate is functionally suitable for its current use and around £797 million is required in backlog maintenance.[7]

- Revenue costs for signed private finance initiative (PFI) and non-profit distributing (NPD) projects were £223 million in 2014/15. Costs will increase by an estimated 38 per cent to £307 million in 2027/28. With around £560 million worth of major capital projects currently in progress using private finance, these payments will rise further.

There were 30 settlement agreements in the NHS in 2014/15

28. In 2014, the Scottish Government introduced new guidance on settlement agreements with the aim of providing more transparency, promoting consistency

and ensuring value for money.[8] A settlement agreement is any binding agreement between an employer and an employee to settle an employment dispute. Settlement agreements are used in circumstances where:

- the employment relationship has broken down or been significantly impaired
- the situation cannot be remedied through mediation or other personnel processes, and
- alternative routes to resolution would involve disproportionate cost at a tribunal or other legal process, and hinder the service from functioning effectively.

29. In 2014, confidentiality clauses were removed from standard NHS settlement agreements in Scotland. The clauses can still be used where there is explicit agreement between the employee and the employer. In June 2015, the Scottish Government reported to the Scottish Parliament's Public Audit Committee that there were 30 settlement agreements across 15 NHS boards.[9] Of these, 13 had confidentiality clauses. The total cost of settlement agreements was £895,000 including non-contractual payments of £533,000 made to employees.

Greater flexibility as part of good long-term financial planning would help boards respond better to local needs and priorities

30. Local delivery plans (LDPs) set out how boards plan to deliver national priorities for the NHS in Scotland. Within their LDP, each board produces spending plans for the next three or five years, highlighting expected funding, projected spending and where savings are required to balance the budget. Although these plans provide an insight into boards' activity, detailed financial planning continues to be limited to the first year of the LDP.

31. NHS boards need to do more longer-term financial planning. We have highlighted in past reports the need for NHS boards to undertake detailed long-term (five to ten years) financial planning to help demonstrate financial sustainability. Setting out a long-term financial strategy over an extended period can help identify problems with affordability at an early stage. The current short-term approach to financial planning means boards are focused on delivering services as business-as-usual. A lack of longer-term financial planning limits the potential for boards to plan and invest in opportunities that have a longer payback period, resulting in greater efficiencies in the long term. For example, the fundamental changes required in providing more care in people's homes and community settings needs investment now if the 2020 vision is to be successful. It is important that boards recognise the need to plan their finances effectively in both the short and long term. Being able to strike the right balance between the two will help boards manage their resources in a more sustainable manner over a longer period of time.

32. Depending on the timing of UK and Scottish Government spending reviews, boards may know indicative spending levels up to a period of around four years. At the time of our audit, boards did not know what their funding levels would be beyond the current financial year (see paragraph 10). However, this should not prevent boards assessing their spending needs and options over a longer period. This short-term approach to budgeting makes it more important that boards

undertake work to outline the best, worst and most likely scenarios of their financial position as part of good longer-term financial planning.

33. A short-term approach to budgeting and the setting of annual financial limits provides little opportunity for boards to manage their finances more flexibly over a number of financial years. The Scottish Government provides some flexibility for boards that wish to carry forward a planned underspend from one year to the next and boards need to agree this in advance. Similarly, brokerage provides some flexibility, but in recent years this has provided only small amounts and is mostly used to help boards break even. Some additional funding may also be made available through Scottish Government underspends (through the budget exchange mechanism) but amounts cannot be guaranteed or planned in advance. Although this provides some flexibility, it does not allow boards to plan for it with great certainty.

34. Over this year and next, the Scottish Government will receive greater fiscal autonomy through new financial powers created by the Scotland Act 2012. These changes will bring closer links between the Scottish Government's policy decisions and the income generated through taxation. With greater autonomy in the overall Scottish budget, there is an opportunity for the Scottish Government to explore how it can use this increased flexibility to support longer-term financial planning by NHS boards. We recognise that to introduce greater flexibility would require careful consideration of any practical challenges such as how the Scottish Government manages the overall health budget and distribution of funding to individual boards. However, increased flexibility can help:

- manage cost pressures over a longer period
- provide opportunities for spend-to-save investment
- provide greater autonomy and responsibility of finances at a local level
- allow greater certainty in service planning with greater certainty over longer-term funding.

35. Flexibility that is managed well and planned in advance can help boards with longer-term financial planning. The Scottish Government needs to manage the benefits of supporting greater financial flexibility alongside the risks of greater volatility (caused by any variations in its income levels) within its overall budget.

National performance against key targets and standards has declined in recent years

36. NHS boards are required to meet a number of performance targets and standards that the Scottish Government sets each year. These cover health improvement, efficiency, access and treatment, and are commonly known as HEAT targets and standards. They are designed to help achieve the Scottish Government's overall purpose and national outcomes as well as the quality standards that NHS Scotland seeks to meet. The introduction of performance targets and standards has improved how the NHS manages and delivers its services. Each year the Scottish Government issues boards with guidance on completing their LDPs. The guidance forms a performance contract between the Scottish Government and boards by setting out its expectations of boards' performance against targets and standards. NHS boards use the guidance to outline how they plan to achieve these targets in their LDPs.

37. The overall performance against key targets and standards worsened in recent years with performance declining in seven of the nine key targets and standards (Exhibit 3, page 19). Performance was strong against two standards:

- The three-weeks to referral for drugs and alcohol standard improved steadily as the number of patients referred within three weeks increased from 87.8 per cent in March 2012 to 95 per cent in March 2015. Demand for referrals during this time decreased by nine per cent from 12,242 to 11,114.

- There was a strong performance against the cancer 31-day decision to treat to first treatment standard. The national average of 98 per cent at March 2012 and 96.5 per cent in March 2015 both exceeded the 95 per cent threshold. This performance level was achieved at the same time as the number of referrals increased by two per cent from 5,481 in 2012 to 5,563 in 2015.

38. The performance against the other seven targets and standards has shown a pattern of steady decline over recent years. For example, the number of outpatients waiting over 12 weeks for their first appointment increased from three per cent in March 2013 to eight per cent in March 2015. Of those waiting, five per cent were waiting over 16 weeks.

An ageing population and higher activity levels made achieving targets more difficult

39. Improvements in public health, diagnosis and medical treatments have all contributed to people living longer in the last decade. Between 2004 and 2014, the population aged over 75 has increased by 17 per cent from 370,000 to 433,000. Average life expectancy also increased during this period. The average life expectancy of men increased by three years from 74 to 77; and by two years for women, from 79 to 81. Although the population is living longer, it is not necessarily doing so in good health. Our 2014 report, *Reshaping care for older people* [PDF] highlighted that the length of time people live in good health, known as healthy life expectancy, did not increase in line with life expectancy.[10] This means that some people will live longer with multiple and long-term health problems. The number of long-term health problems people have also increased significantly with age.

40. The increase in demand for health services is reflected in greater activity. For example, activity increased in the last five years at acute hospitals, such as general hospitals. Between March 2010 and March 2015, inpatient cases and outpatient appointments increased by 13 per cent and two per cent to 394,000 and 1,139,000 respectively.[11] Data recorded for the first time this year showed that there were over 990,000 GP out-of-hours consultations during 2014/15.[12]

41. These changes in population and health conditions and subsequent increased use of health services, combined with recent financial pressures, may explain why NHS boards have found it challenging to maintain or improve performance in recent years. These patterns are predicted to continue in the foreseeable future, placing further demands on future healthcare provision in Scotland. Forthcoming audit work will examine the implications of these patterns for health and social care over the longer term. We plan to publish the results in spring 2016.

Exhibit 3

National performance against key waiting time targets and standards, 2012 to 2015

The national performance has declined in seven of the nine key waiting time targets and standards in recent years.

		Year			
Target/standard		**2012**	**2013**	**2014**	**2015**
A&E, four-hours[3]	98% (95% interim from April 2013)	95.4	91.9	93.3	92.2
Referral to treatment (RTT), 18-weeks[3]	90%	91.3	90.5	89.6	88.5
Child and Adolescent Mental Health Services (CAMHS), 26-weeks, changed to 18 weeks in December 2014[3]	90%	90.1	98.5	92.5	81.1
Drug and alcohol treatment, three-weeks[2]	90%	87.8	94.4	96.0	95.0
Inpatient/day case appointment treatment time guarantee (TTG), 12-weeks[2]	100%	–	98.2	97.0	94.5
Referral to outpatient appointment, 12-weeks[3]	0% (5% interim from December 2014)	–	3.3	3.1	8.0
Cancer: 62-day referral to treatment[2]	95%	94.8	94.5	91.5	91.8
Cancer: 31-day decision to treat to first treatment[2]	95%	98.0	97.7	96.2	96.5
Delayed discharges (42 day target to January 2013, 28 day target to January 2015 and a 14 day target from April 2015)[2]	Zero patients delayed over target time	13	44	173	357

00: target missed. 00: target met. 00: within 5 per cent of target. 00: within 5 per cent of interim target.

Notes:
1. Blanks represent a time where earlier data is non-comparable owing to changes in data collection methodology.
2. Quarter ending.
3. Month ending.
4. Most data shows the position as at March. CAMHS 2012 data is at April 2012, and all delayed discharge data is for the quarter ending April.

Source: Audit Scotland using ISD Scotland data as at June 2015. Data is subject to any caveats described by ISD Scotland

All territorial boards found it difficult to meet key performance targets and standards in 2014/15

42. All territorial boards had difficulties in meeting their key performance targets and standards. Many NHS boards failed to meet most key waiting times targets and standards at the end of 2014/15 (Exhibit 4, page 20). All boards met the **cancer (31-day decision to treat to first treatment)** standard, while only two boards, NHS Lothian and NHS Dumfries and Galloway, failed to meet the **three-week drug and alcohol treatment** standard.

Exhibit 4

Performance against key waiting time targets and standards in territorial NHS boards at the end of 2013/14 and 2014/15

The performance against most key targets and standards has declined in the last year.

	A&E		Referral to treatment (RTT)		Child and Adolescent Mental Health Services (CAMHS)[3, 5]		Drug and alcohol treatment		Inpatient/ day case treatment time guarantee (TTG)		Referral to outpatient appointment		Cancer: urgent referral to first treatment		Cancer: decision to treat to first treatment		Delayed discharges: number of patients delayed over target time[5]	
Target/ standard	4 hours		18 weeks		26 weeks, reduced to 18 weeks in Dec 2014		3 weeks		12 weeks		12 weeks		62 days		31 days		28 days, reduced to 14 days in April 2015	
	98% (95% interim)		90%		90%		90%		100%		0% (5% interim)[7]		95%		95%		Zero patients	
	Mar 2014[2]	Mar 2015[2]	Mar 2014[2]	Mar 2015[2]	Mar 2014[2]	Mar 2015[2]	Mar 2014[1]	Mar 2015[1]	Mar 2014[1]	Mar 2015[1]	Mar 2014[2]	Mar 2015[2]	Mar 2014[1]	Mar 2015[1]	Mar 2014[1]	Mar 2015[1]	Apr 2014[1]	Apr 2015[1]
Ayrshire and Arran	93.7	87.8	90.5	78.4	72.2	92.7	96.7	98.1	99.7	96.3	3.7	10.7	95.6	91.6	98.9	99.5	0	7
Borders	98.0	91.8	90.1	90.1	100	89.6	96.1	99.3	94.9	92.9	2.6	7.6	96.7	94.4	100	97.8	1	0
Dumfries and Galloway	96.8	96.8	91.4	90.4	100	100	97.7	88.9	97.9	95.5	2.3	7.0	96.3	96.6	100	100	6	7
Fife	95.8	92.5	92.3	86.3	96.0	80.2	95.3	98.6	99.8	97.9	3.4	11.2	91.0	89.0	98.0	96.0	14	17
Forth Valley	97.2	93.6	80.8	89.8	90.4	48.6	97.2	98.9	99.9	99.5	6.4	5.8	87.5	91.2	98.6	98.0	16	1
Grampian	95.0	95.0	89.0	83.7	91.5	74.5	93.1	92.9	93.9	92.8	4.0	17.8	85.6	84.9	93.6	95.0	45	86
Greater Glasgow and Clyde	89.6	88.5	90.4	91.3	100	99.3	96.5	95.5	100	100	0.1	0.1	90.9	91.0	94.5	96.6	22	44
Highland[4]	96.7	97.4	–	–	–	94.2	91.3	91.4	97.8	74.1	7.6	25.5	90.0	96.0	91.6	96.0	11	56
Lanarkshire	92.4	91.8	94.1	92.3	98.6	94.6	99.9	99.2	100	96.3	1.4	4.8	96.2	95.3	95.8	96.5	12	39
Lothian	92.2	92.6	85.2	88.0	83.1	62.2	92.2	87.1	87.8	87.9	6.4	6.1	92.9	94.7	98.3	95.2	39	75
Orkney	98.8	99.7	97.3	96.6	100	100	100	100	99.3	95.7	2.5	7.4	100	100	100	100	0	0
Shetland	98.7	97.2	96.2	91.8	100	100	94.7	100	99.8	100	5.0	9.2	86.7	91.7	100	100	0	5
Tayside	99.3	99.3	91.4	86.9	79.7	35.9	94.9	91.8	99.4	94.5	1.7	11.4	90.2	92.3	96.5	95.3	4	14
Western Isles	98.1	99.0	82.0	92.4	100	100	97.5	94.9	100	100	9.3	13.3	91.7	80.0	100	100	3	6
Scotland	93.3	92.2	89.6	88.5	92.5	81.1	96.0	95.0	97.0	94.5	3.1	8.0	91.5	91.8	96.2	96.5	173	357

00: target missed. 00: target met. 00: within 5 per cent of target. 00: within 5 per cent of interim target.

Notes: 1. Quarter ending. 2. Month ending. 3. CAMHS data for island boards are grouped when reported by ISD Scotland. 4. NHS Highland did not provide CAMHS data in March 2014 or 18-week RTT in March 2014 or 2015. 5. Targets for CAMHS and delayed discharges changed during 2014/15, so the 2014 and 2015 values are not directly comparable. 6. National Waiting Times Board (Golden Jubilee National Hospital) is not included in this table. The board met all four of the targets and standards that apply to it: RTT, Outpatients, TTG, and Cancer: decision to treat to first treatment. 7. Five per cent interim target introduced from December 2014.

Source: Audit Scotland using ISD Scotland data as at June 2015. Data is subject to any caveats described by ISD Scotland

43. Many NHS boards found it difficult to meet the other seven key targets and standards, with the national average also below the target set:

- Only NHS Greater Glasgow and Clyde met the interim **12-week outpatient appointment** standard of five per cent consistently throughout the year. At March 2015, more than a quarter of patients in NHS Highland were waiting longer than 12 weeks for an outpatient appointment.

- The majority of boards did not meet the inpatient **12-week treatment time guarantee (TTG)** and the performance of ten boards deteriorated over the last year. Only NHS Greater Glasgow and Clyde, NHS Shetland and NHS Western Isles achieved 100 per cent at March 2015.

- In no quarter during 2014/15 did more than three boards meet the **delayed discharges** target. At April 2015, NHS Borders and NHS Orkney had no delayed discharges, while NHS Grampian, Lothian and Highland had the highest number of delayed discharges, together accounting for 61 per cent of the national total. In 2014/15, the number of bed days occupied by patients who were delayed was 498,545, an increase of 77,388 (18 per cent) from 2013/14.

- In March 2015, half of territorial boards met the **18-week referral to treatment** standard of 90 per cent although the national average misses this. NHS Orkney was the highest performing board with 97 per cent. NHS Ayrshire and Arran was the lowest performing board with 78 per cent.

- Only NHS Tayside, NHS Western Isles and NHS Orkney met the **four-hour accident and emergency (A&E)** waiting time standard of 98 per cent at the end of 2014/15. NHS Dumfries and Galloway, NHS Grampian, NHS Highland and NHS Shetland met the interim target of 95 per cent. NHS Greater Glasgow and Clyde and NHS Ayrshire and Arran were the only boards below 90 per cent.

- In any month, five or six boards were not meeting the **Child and Adolescent Mental Health Service (CAMHS) 18-week** target of 90 per cent since the target was introduced in December 2014. Five boards had not yet met the target. In March 2015, NHS Forth Valley and NHS Tayside met the target in fewer than half of their cases (49 per cent and 36 per cent respectively).

- NHS Lanarkshire was the only board to consistently meet the **cancer 62 days to treatment** standard with five boards not meeting the standard once during 2014/15. NHS Dumfries and Galloway, NHS Highland and NHS Orkney were the only other boards to meet the standard at the end of 2014/15.

44. Performance varied across Scotland with no boards consistently above or below all of the main targets. For example, NHS Greater Glasgow and Clyde consistently met targets for 18-week referrals to treatment and CAMHS but missed the A&E and the cancer 62 day to treatment targets throughout the year. Similarly, boards that found it challenging to meet financial targets in recent years also found it difficult to meet performance targets and standards. For example, NHS Highland and NHS Tayside were amongst the lowest performing boards against the outpatient standard and CAMHS target respectively.

45. Failure to meet certain targets and standards can increase the pressure in other parts of the service. For example, delays in discharging patients from hospital mean that beds are not available for other patients who need them, causing delays and blockages. This can significantly reduce boards' ability to manage the flow of patients effectively. Similarly, the failure to meet outpatient standards can have implications for patients receiving timely treatment.

46. Unexpected levels of activity can also affect boards' ability to deliver an effective service across the whole system. For example, the Scottish Government reported that during winter 2014/15 emergency admissions from respiratory illness and influenza were higher than in previous years and also continued over a longer period of time. Although NHS boards increased their staffing capacity during winter to help, boards reported that the additional emergency activity resulted in more cancellations of elective inpatient procedures during the period.[13]

Changes to targets and thresholds did not alter trends in performance

47. The Scottish Government is responsible for setting national performance targets. Within a target it may also raise or lower the thresholds that NHS boards must meet. Changes to performance thresholds and targets did not result in significant changes to the pattern of performance across Scotland. Recently, two targets have become more challenging for boards:

- Delayed discharges: since April 2013, no patient should wait in hospital for more than 28 days from when they are clinically ready for discharge. This is a reduction on the previous target of 42 days. From April 2015, this was reduced to 14 days. At this date, NHS Borders and NHS Orkney were within the 14-day target with a further two boards, NHS Ayrshire and Arran and NHS Forth Valley, meeting the previous 28-day target.

- CAMHS: in December 2014, a new target was introduced that 90 per cent of patients should wait no longer than 18 weeks from referral to treatment compared to the previous target of 26 weeks. At March 2015, an average of 88 per cent met the previous target of 26 weeks, compared to an average of 81 per cent meeting the new target of 18 weeks.

48. In April 2013, the Scottish Government established an interim reduced threshold for the four-hour A&E target. It lowered the threshold from 98 per cent of patients to be seen within four hours to 95 per cent. At the target due date in September 2014, five boards missed the interim target: NHS Forth Valley, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lothian, and NHS Lanarkshire. Overall, the national average performance declined with the target only being met twice in July and August 2013. The 95 per cent interim target remains in place and the Scottish Government expects boards that meet this target to then progress towards achieving the 98 per cent target.

Achieving waiting time targets remains a top priority for the Scottish Government and NHS boards

49. The Scottish Government and NHS boards place great importance on achieving waiting time targets and standards. Although responsibility to meet targets and standards remains with individual boards, the Scottish Government provides support where performance is particularly poor. For example, during 2014, the Scottish Government provided support teams to help boards missing

cancer waiting time targets. Similarly in 2015, the Scottish Government provided a support team to help improve A&E waiting times performance at the Royal Alexandra Hospital in Paisley and the new Queen Elizabeth University Hospital in Glasgow. The Scottish Government also provided funding to NHS boards of £26 million in 2014/15 to help them improve their performance against the 18-week referral to treatment standard and the 12-week treatment time guarantee. In January 2015, it committed to spend £100 million over three years to help reduce delayed discharges from hospitals.

50. NHS boards are increasingly using the private sector to help them meet performance targets and standards by increasing short-term capacity. Capacity refers to the resources available to do work, for example available equipment and staff time. Boards typically use the private sector to help meet waiting time targets and standards and also where specialist treatment is not available in the NHS. Since 2009/10, NHS spending on using the private sector has increased by 18 per cent in real terms, from £72.3 million to £85.2 million in 2014/15. This accounted for around 0.8 per cent of NHS revenue spending in 2014/15. NHS Lothian spends over 20 per cent (£17.8 million) of all private sector spending in Scotland, over 140 per cent more than it spent in 2009/10 (£7.3 million). In the last year, the largest increases were in four boards: NHS Grampian, NHS Highland, NHS Lanarkshire and NHS Shetland. Each increased their private sector spending by over a quarter.

51. The extensive effort and focus placed by the Scottish Government and NHS boards on meeting performance targets and standards may be detrimental to the longer-term ambitions of redesigning services, focusing more on prevention and moving more care into the community. Additional short-term funding, increased use of the private sector and deploying support teams may help meet targets in the short term but do not demonstrate value for money in achieving the longer-term aims and objectives of the NHS.

52. The Scottish Government and boards should consider setting targets that will help them achieve longer-term aims such as implementing the 2020 vision. This will help ensure that short-term actions do not conflict with longer-term plans. In doing so, the Scottish Government should continually review each performance target and standard to assess its relevance, priority and sustainability (see also paragraph 106).

Part 2

Workforce

Key messages

1 The number of people working in the NHS in Scotland is at its highest level, although recruiting and retaining staff on permanent contracts remains a significant problem for many boards. The ability to attract, recruit and retain medical professionals across Scotland, with the right skills to deliver the services required, is one of the biggest challenges facing the NHS today.

2 Vacancy rates, staff turnover rates and sickness absence levels have all increased during 2014/15. As a result, boards are now hiring more temporary staff to help keep services running and meet targets. This approach is increasingly expensive and only provides a short-term solution. In 2014/15, NHS boards spent £284 million on temporary staff, an increase of 15 per cent in real terms from 2013/14.

3 A national coordinated approach is needed to help resolve current and future workforce issues in the NHS in Scotland. The approach should assess longer-term changes to skills, job roles and responsibilities within the sector as well as aligning predictions of demand and supply with recruitment and training plans. This is necessary to help ensure the NHS workforce adapts to changes in the population's needs and how services are delivered in the future.

recruiting and retaining permanent staff is a significant problem for many NHS boards

The number of people working in the NHS is at its highest level

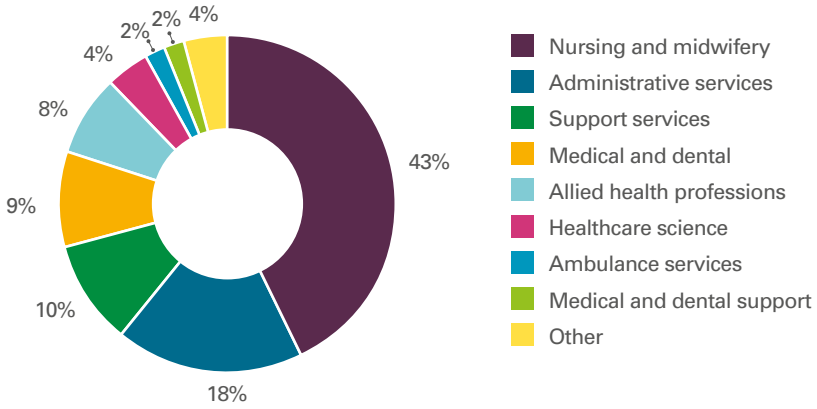
53. NHS staff provide a wide range of healthcare services and are essential to ensuring high-quality, safe and effective care. The number of people working in the NHS is at its highest level ever with 137,600 whole-time equivalent (WTE) staff employed as at March 2015.[14] This is an increase of 1.5 per cent in the last year. Of the special boards, Healthcare Improvement Scotland had the largest increase of 7.4 per cent (22 WTE) and NHS Lothian had the largest increase for a territorial board of 3.1 per cent (601 WTE). Four boards saw their overall WTE decrease: NHS Western Isles, NHS Borders, Health Scotland and The State Hospital.

54. Nursing and midwifery are the largest staff group in the NHS, making up 43 per cent of the workforce (59,175 WTE). Administrative staff are the second largest staff group with 18 per cent (25,144 WTE) while medical and dental staff account for nine per cent (12,538 WTE) (Exhibit 5, page 25).

Exhibit 5

NHS workforce, by main staff groups, at March 2015

Nursing and midwifery are the largest staff group in the NHS in Scotland.



Source: ISD Scotland

55. Staff costs are the largest spending area in the NHS. In 2014/15, staff costs were almost £6 billion, accounting for around 55 per cent of total revenue spending. The majority of staff costs are for salaries and wages (£4.8 billion; 81 per cent) with a further £977 million (16 per cent) spent on national insurance and pension costs.

56. In recent years, the age profile of the NHS workforce has changed. There has been limited change in the gender balance of staff and the proportion working part-time, but the workforce has continued to age. At March 2015, almost 20 per cent of staff were aged 55 and over, compared to 16 per cent in March 2011.[15] This means that nearly a fifth of staff will be retiring, or close to retiring, in the next ten years. Good succession planning helps to ensure that enough new staff are being trained to replace the people who retire. For example, the percentage of GPs over 50 years old increased from 28 per cent in 2004 to 34 per cent in 2014.[16] It takes around ten years for a GP to become fully qualified, so replacing these skills requires good long-term planning.

Recruiting and retaining staff on permanent contracts is a significant problem for many boards

57. The NHS in Scotland is under pressure from rising staff vacancies owing to difficulties in recruiting and retaining staff on permanent contracts. Retaining staff has become an increasing problem for boards with turnover rates increasing in recent years. In 2014/15, net staff turnover was 6.8 per cent on average, an increase of 0.5 per cent from 2013/14.[17] Net turnover measures the rate at which staff are leaving the NHS. Changes in staff are more common amongst medical and dental staff than other staff groups with a turnover rate of 9.2 per cent in 2014/15. This compares to 6.5 per cent in nursing and midwifery. The four territorial boards with the highest turnover were all generally rural boards: NHS Shetland (13.3 per cent), NHS Grampian (11.1 per cent), NHS Western Isles (10.4 per cent) and NHS Orkney (10.2 per cent).

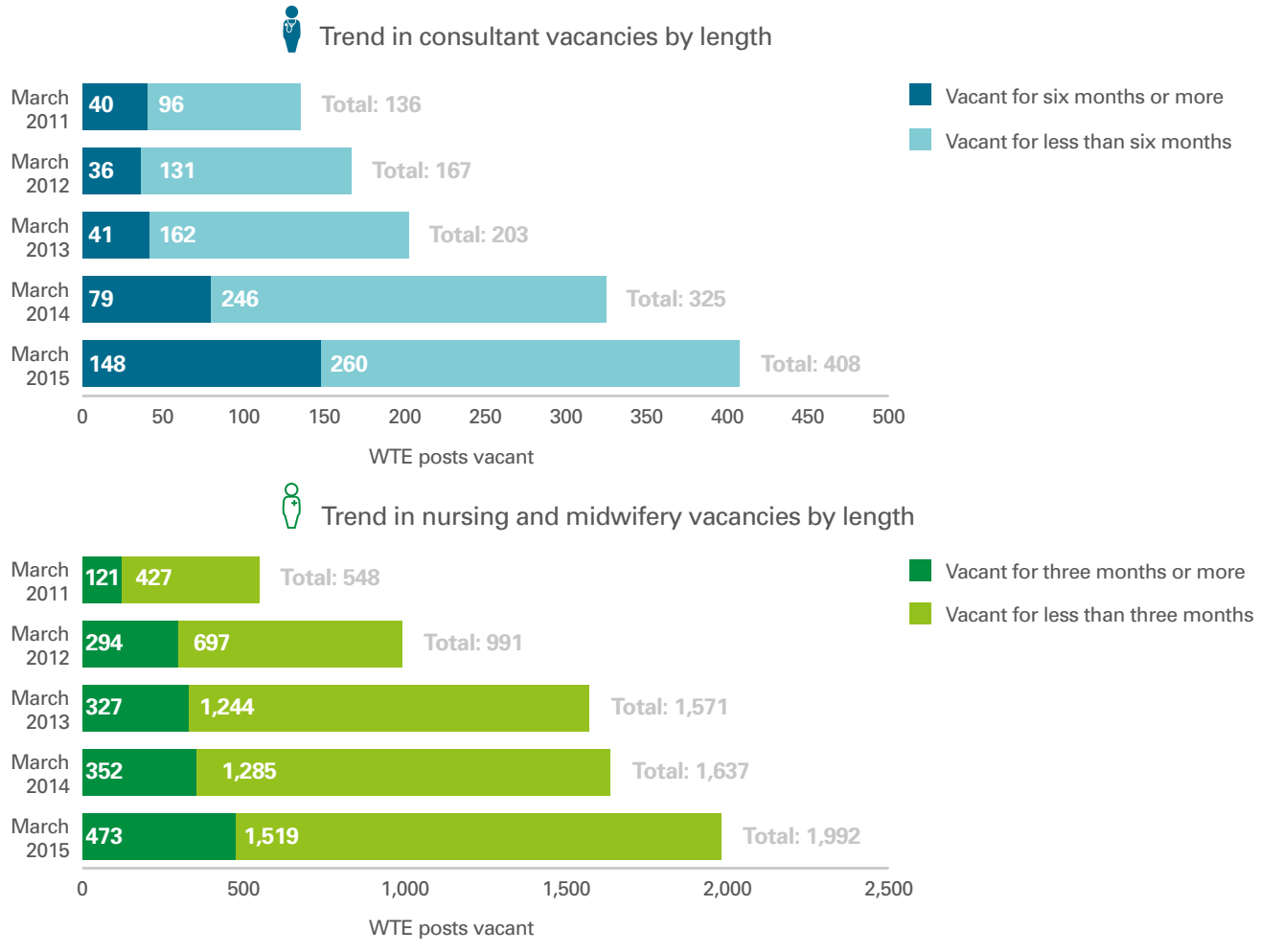
58. The number of vacant posts across all boards increased during 2014/15. Vacancies for consultant posts increased by about a quarter between March 2014 and March 2015 from 325 WTE to 408 WTE. Island boards have the highest consultant vacancy rates with NHS Western Isles and NHS Orkney having rates of 28 per cent and 19 per cent respectively. Posts vacant for more than six months increased by 87 per cent over the last year to 148 WTE (Exhibit 6). Specialties with the highest number of vacancies were:

- Clinical radiology: 40 WTE (12 per cent of posts)
- Anaesthetics: 37 WTE (five per cent)
- General acute medicine: 26 WTE (17 per cent)
- Emergency medicine: 24 WTE (11 per cent)
- Paediatrics: 24 WTE (eight per cent).

Exhibit 6

Consultant and nursing and midwifery vacancies

The number of long-term vacant consultant and nursing and midwifery posts increased in the last year.



Note: Figures subject to rounding.

Source: ISD Scotland

59. In emergency medicine, 71 per cent of vacancies were vacant for more than six months. Similarly, clinical radiology, anaesthetics, general acute medicine and paediatrics all had around 40 per cent of vacancies vacant for more than six months.

60. Nursing and midwifery vacancies have a similar trend to consultant vacancies. In March 2015, 1,992 WTE posts were vacant, with 473 WTE (24 per cent) of these vacant for more than three months. This is almost four times the number of vacancies vacant for more than three months at March 2011. NHS Shetland had the highest percentage of nursing and midwifery vacancies at over nine per cent (19 vacancies) whereas NHS Greater Glasgow and Clyde had the highest number of nursing and midwifery vacancies at 584 vacancies (four per cent of their establishment). Specialties with the highest number of vacancies across Scotland were:

- Adult nursing: 1,101 WTE (three per cent of posts)
- Mental health: 256 WTE (three per cent)
- Paediatrics: 122 WTE (five per cent).

Learning disabilities had the highest percentage of vacancies open for more than three months at 37 per cent.

61. Vacancies of allied health professions (AHP), such as dieticians and occupational therapists, fell by 11 per cent from 453 WTE in March 2014 to 403 WTE in March 2015.

62. The vacancy data shows advertised vacancies only. It does not include vacant posts that are not advertised and being covered by other staff such as temporary agency or bank staff. Advertised vacancies where the incumbent is still in post are included in the data. The length of vacancy does not include the time in which the post has been offered to other staff through redeployment.

63. Vacancy rates vary among boards, and within boards, with vacancies in some specialties and locations taking longer to fill. There are several reasons why boards are finding it challenging to recruit and retain staff on a permanent basis. These include:

- the rural location of some posts
- the increasing number of specialist posts within the NHS
- strong competition between boards for staff with specialist skills
- greater demand from staff for flexible working patterns such as part-time working
- staff seeking posts that allow greater opportunities for further training and development.

64. Where posts remain unfilled, boards are able to identify associated savings, on either a recurring or non-recurring basis. For example, NHS Highland reported that its policy is to hold corporate services vacancies open for at least six months, unless there are exceptional circumstances, to allow it to generate non-recurring savings.

65. Some NHS boards have launched marketing campaigns abroad to try and fill vacancies. Filling vacancies is not only about the role being advertised but also about the lifestyle it offers, such as housing, education and career progression opportunities for the candidate. More rural boards, such as NHS Highland and NHS Grampian, are enhancing their recruitment campaigns by showing the advantages of working in rural areas to try to recruit staff from outside the UK for difficult-to-fill posts. For example, NHS Highland launched a website showing the advantages of being a rural GP to help recruit GPs from countries such as the Netherlands and Spain. Similarly, NHS Grampian has advertised posts in countries such as New Zealand and South Africa.

66. Unsuccessful recruitment can lead to difficulties for boards in maintaining service levels. It can require boards to re-evaluate how they deliver services to ensure there is no risk to patient safety or care. For example, reducing opening hours to maintain safe staffing levels or altering the skills mix within a service are options that boards have recently considered (Case study 2).

Case study 2

Dealing with staff shortages in NHS Lothian and NHS 24

In July 2015, **NHS Lothian** decided to stop admitting child inpatients at St John's Hospital in Livingston for six weeks over the summer to maintain patient safety. It made this decision owing to unsuccessful national and international campaigns to fill key medical and specialist nursing posts. As a result, the service relies heavily on locum doctors and staff from the Royal Hospital for Sick Children in Edinburgh. Staff shortages meant during this period the service would assess patients between 8am and 8pm but children needing inpatient care were transferred to the Royal Hospital for Sick Children in Edinburgh. This is the second time in three years that the board has made this decision. During the temporary closure, the board consulted with clinical staff and the Scottish Government. At its October 2015 Board meeting, the board reported that no significant issues had been identified. Everyone agreed that the current staffing model is not sustainable in the longer term. The board is reviewing acute paediatric services to explore the options for providing sustainable and safe children inpatient services across NHS Lothian.

NHS 24 provides a national telephone and online-based health service. Telephone demand has increased year-on-year to over 1.57 million calls. The board implemented a multi-disciplinary team approach using different skill sets and grades with clinical supervision from band seven nurses and allied health professions. Under the new model, the board exceeded its HEAT target to provide at least 30 per cent of patients with self-care advice. The board also reported its staff had high levels of satisfaction from this new approach.

Source: Audit Scotland using information from NHS Lothian and NHS 24

Increasing rates of sickness absence adds pressure to maintaining staff levels

67. Monitoring levels of sickness absence is important as it is an indicator of the health and wellbeing of staff. Managing sickness absence is also important as absenteeism can lead to cancelled appointments and procedures for patients. Recruitment problems reduce the ability of services to cope flexibly with staff sickness. This can lead to additional costs as boards have to hire temporary staff to cover posts. In 2014/15, sickness absence in NHS Scotland was five per cent, one per cent higher than the national standard of four per cent and 0.3 per cent higher than 2013/14.[18] During the year, the highest rate was in The Scottish Ambulance Service at over seven per cent. The service reported this was mainly due to high levels of musculoskeletal complaints linked to the unique working environment for ambulance staff. NHS Education for Scotland had the lowest rate (2.4 per cent) and NHS Orkney was the only territorial board to meet the four per cent standard.

NHS boards are spending more on temporary staff to ensure they maintain levels of service and meet targets

68. Difficulties in recruiting and retaining staff have meant boards have increased their use of temporary staff. NHS boards use bank or agency staff to fill gaps in staffing when posts are either vacant or cover is needed for staff sickness or leave. This helps maintain safe staffing levels, allows services to continue and fills short-term skills gaps. Boards also use temporary staff to help them meet waiting time targets and standards. However, relying too much on temporary staff may pose risks to patient safety. These risks can arise from poor continuity of staff, temporary staff being unaware of local systems and processes, or from limited staff management to detect poor performance.

69. In 2014/15, NHS boards spent £284 million on temporary staff, an increase of 15 per cent in real terms from £247 million in 2013/14. This is the equivalent of five per cent of total NHS staff costs. This included additional work for those already employed in a substantive NHS role as well as those employed through external agencies. Some external agencies are part of a national contract where rates, and other terms, are agreed in advance following an open procurement process. Temporary staff covered both clinical and non-clinical roles including nurses, midwives, doctors and administration staff.

The number of agency nursing and midwifery staff increased by 53 per cent in 2014/15

70. In 2014/15, the NHS spent £146 million on nursing and midwifery bank and agency staff. This was a real terms increase of 12 per cent from 2013/14. It spent most of this on NHS bank staff (£130 million, 89 per cent). This bank is made up of NHS staff carrying out additional shifts above their core working pattern. The remaining £16 million (11 per cent) was spent on using agency staff. This was a real terms increase of 68 per cent from £9.5 million in 2013/14.[19]

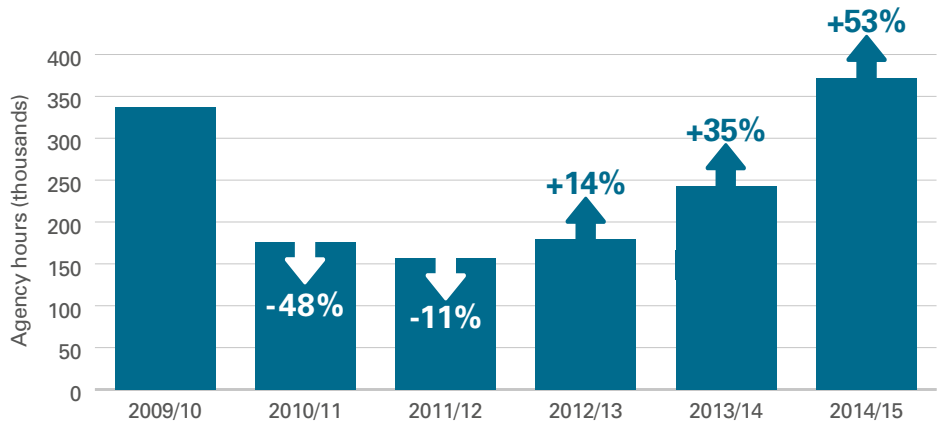
71. The number of agency nursing and midwifery staff increased 53 per cent from 124.5 WTE to 191 WTE over the last year, delivering 372,356 hours of work. NHS Lothian and NHS Tayside accumulated half of the 191 WTE agency staff cover, with 60 WTE and 36 WTE respectively (Exhibit 7, page 30).

72. Using agency nursing and midwifery staff costs the NHS almost three times more than using NHS bank staff. In 2014/15, the average hourly cost of using agency nursing and midwifery staff increased by nine per cent to £42.97 from

Exhibit 7

Agency nursing and midwifery staff, 2009/10 to 2014/15

The number of hours worked by agency nursing and midwifery staff increased by 53 per cent between 2013/14 and 2014/15.



Note: Percentage shows change in hours used by NHS in Scotland compared to previous year.

Source: Audit Scotland using ISD Scotland data

£39.26 in 2013/14. In comparison, in 2014/15, NHS bank staff for nursing and midwifery was £15.62 an hour, a decrease of just under one per cent. The cost of agency staff is particularly difficult for more rural boards where the average agency hourly rate exceeds the Scotland average. NHS Shetland (£84.05), NHS Orkney (£58.98) and NHS Dumfries and Galloway (£57.44) paid the highest rate per hour for agency staff (Exhibit 8, page 31).

Spending on locum doctors increased by 22 per cent in 2014/15

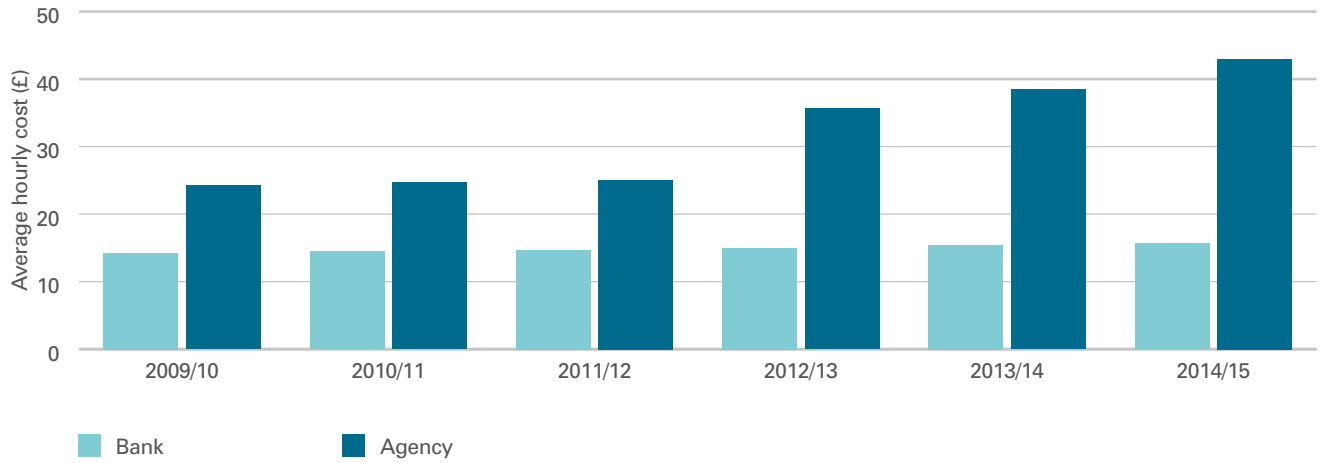
73. To help keep services running and meet targets, NHS boards are increasingly using locum doctors to cover shifts and fill vacant posts on a temporary basis. In 2014/15, NHS boards spent almost £107.5 million on using locum doctors. This was a real terms increase of 22 per cent from £88.2 million in 2013/14 (Exhibit 9, page 31). Spending increased on both internal and agency locums, with agency locums accounting for around 70 per cent (£76 million) of total locum spending. Internal locums are employees of the board while agency locums are recruited from external agencies. Approximately two-thirds was spent on consultants with a third on doctors of other grades.

74. The National Waiting Times Centre had the highest increase in locum spending of all boards in the last year. It increased by 78 per cent in real terms to just over £311,000 owing mainly to difficulties in recruiting junior doctors. This was followed by NHS Dumfries and Galloway and NHS Fife. Both boards spent between 40 and 50 per cent more on locums compared to 2013/14, spending £10 million and £8.2 million respectively. Only two boards reduced spending on locum doctors during 2014/15. NHS Orkney and NHS Forth Valley reduced their spending by 25 per cent (£0.6 million) and five per cent (£0.3 million) respectively.

Exhibit 8

Average hourly cost of bank and agency nursing and midwifery staff, 2009/10 to 2014/15

The average hourly cost of using agency staff was almost three times higher than using NHS bank staff in 2014/15.



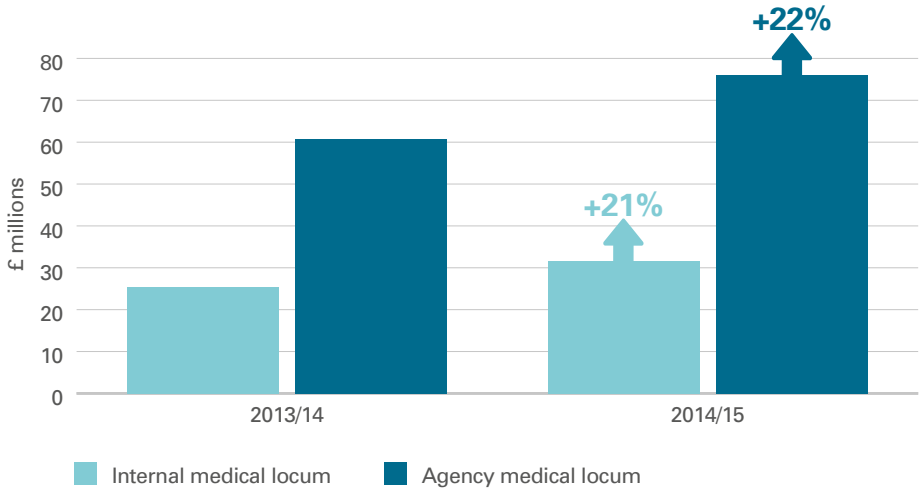
Note: The average hourly cost is the total cost divided by total number of hours paid for. The hourly cost is expressed in real terms at 2014/15 prices.

Source: Audit Scotland using ISD Scotland data

Exhibit 9

NHS boards' spending on locum doctors, 2013/14 and 2014/15

Total spending on locum doctors increased by 22 per cent between 2013/14 and 2014/15.



Note: Total spending is expressed in real terms at 2014/15 prices.

Source: Audit Scotland using information from NHS boards

NHS boards often experience problems in recruiting temporary staff

75. NHS boards often face difficulties after taking the decision to recruit temporary staff. Boards reported a variety of reasons for struggling to fill nursing and midwifery and doctors posts using both internal and agency staff. These included:

- staff unable to work additional hours owing to European Working Time Regulations
- staff unwilling to work in areas where staffing levels and support are poor
- excessive costs of using agencies not on the national contract
- agency doctors unwilling to work for the national contract rate
- short supply of staff in certain specialities and grades
- unwillingness of staff to work in more rural locations
- agencies unable to provide the required numbers of staff
- short notice demand increasing the likelihood of using off-contract agencies
- competition between boards for the same skills and specialties.

76. Using temporary staff provides short-term flexibility to workforce plans but it does not address the underlying problems of recruitment and retention, skill shortages and sickness absence. Together, the Scottish Government and NHS boards should address the comparatively high costs of using agency staff and encourage greater use of internal or bank staff, or national contracts where temporary staffing is required. Reducing the cost of temporary staff is the collective responsibility of medical, clinical, human resources and finance professionals. Sharing information between these groups will support better and more cost-effective decision making. Our 2010 report *Using locum doctors in hospitals* [PDF] made a number of recommendations to help boards better manage the costs and demand of using locums.[20] Boards should revisit these recommendations to ensure their approach to using locums meets good practice and also to help them manage other types of temporary staff.

A national approach to managing current and future workforce pressures is needed

77. All NHS boards currently produce local workforce plans covering one year, although there are plans to move towards producing three-year plans. Local workforce plans have the advantage of allowing planning to fit the needs of individual boards. But they do not give an overview of national workforce issues or trends and do not provide solutions across boards, or nationally, to problems such as difficulties in recruiting and retaining staff.

Scottish Government initiatives aim to improve workforce planning and wellbeing but are limited in scope

78. In 2014, the Scottish Government published a review of workforce planning across the NHS in Scotland, *Pan Scotland Workforce Planning Assessment and Recommendations*.[21] The review concluded that boards needed a more joined-up

approach to gathering and sharing information to support better workforce planning. Six priority actions for 2015/16 were agreed, including:

- reviewing workforce planning guidance
- improving the way in which boards record and report vacancies
- improving consistency in data coding for medical staff
- establishing a pan-Scotland perspective on use of job planning and eRostering systems
- clarifying workforce planning expectations for Integration Authorities (these are part of the new arrangements for integrating health and social care)
- establishing a workforce observatory for the NHS to make better linkages and use of intelligence for workforce planning in the long term.

79. In June 2013, the Scottish Government published *Everyone Matters: 2020 Workforce Vision*.[22] This followed a consultation with over 10,000 staff and stakeholders. The purpose was to identify staff concerns and where things could be done better, as well as setting out a commitment on how boards value and treat staff. It requested each board to bring their local values in line with the national core values of the NHS in Scotland:

- care and compassion
- dignity and respect
- openness, honesty and responsibility
- quality and teamwork.

80. The Scottish Government publishes annual implementation plans identifying actions to deliver these values against five priority areas. The latest implementation plan, published in November 2014, outlines priorities for action against each area in 2015/16.[23] While the actions are strategic, they do not outline what indicators or measures are in place to monitor boards' progress or achievements.

A coordinated national approach can help identify future workforce requirements

81. Workforce pressures in the NHS are unlikely to be solved by boards working in isolation. A more strategic and collaborative approach is needed for workforce planning, bringing together knowledge and experience from across the Scottish Government and individual boards.

82. A sustainable workforce should meet the needs of both patients and staff, while at the same time delivering services that meet, and deliver on, local and national priorities and outcomes for the NHS. To enable this to happen, the Scottish Government and NHS boards should build on recent initiatives such as *Pan-Scotland Workforce Planning* and the *Everyone Matters: 2020 Workforce Vision* to develop a national, coordinated approach to workforce planning.

83. Adopting a national coordinated approach would give the Scottish Government and NHS boards the opportunity to generate greater efficiencies through better sharing of staff resources, better information and aligning recruitment plans. It could also provide a basis for boards to adapt to changes in the workforce, for example as demands for services change and new technologies emerge. A coordinated approach would help address the workforce implications of transferring more care into people's homes and communities. Future changes are likely in relation to staff roles and responsibilities, job design, skills and training requirements and individual career progression. Such an approach would help the Scottish Government and NHS boards to work towards creating a sustainable workforce. The approach should:

- assess what types of jobs are needed, including roles and responsibilities, to meet the requirements of how services will be delivered in the future
- bring predictions of population health in line with the types of jobs and number of posts boards need
- align workforce demand and supply with recruitment and training plans to ensure there is a good supply of staff across different groups and specialties
- develop and use consistent information and data about vacancies, absences and staff availability to help local and national decision-making
- develop a coordinated approach to recruiting and retaining staff that will help boards fill vacancies successfully.

Part 3

Looking ahead

Key messages

1 The Scottish Government has not made sufficient progress towards achieving its 2020 vision of changing the balance of care to more homely and community-based settings. There is some evidence of new approaches to delivering healthcare although it is unlikely that all the necessary changes will be in place by 2020. The Scottish Government plans to continue working towards the vision as part of an overall, longer-term plan for healthcare in Scotland. To help increase the pace of progress, the Scottish Government launched a new national conversation in August 2015. The conversation is expected to inform plans to change how services will be provided in Scotland over the next ten to 15 years.

2 Providing more options for care in patients' homes, care homes and communities has significant implications for how the NHS estate, such as land and buildings, operates in the future. In the last three years, around £1.4 billion was invested in major capital projects to improve the NHS estate. Major projects worth a further £849 million are currently in progress. It is not clear how recent and planned changes to the NHS estate are contributing to the 2020 vision.

3 Several initiatives and major reform programmes aimed at improving longer-term healthcare in Scotland are under way. It is important that the Scottish Government is able to demonstrate how various policies and reform programmes align and contribute to the longer-term vision for health and social care. Without alignment, there is a risk that reforms will operate in isolation. This could result in duplication, competition for limited resources such as staff or money, or conflicting priorities.

the Scottish Government needs to increase the pace of change if it is to achieve its 2020 vision

The Scottish Government has not made sufficient progress towards achieving the 2020 vision

84. In September 2011, the Scottish Government set out an ambitious vision for health and social care to enable everyone to live longer, healthier lives at home or in a homely setting by 2020.[24] This 2020 vision aims to help shape the future of healthcare in Scotland in the face of changing demographics and increasing demand for health services. In May 2013, the Scottish Government set out 12 priority areas for action in the form of a route map to the 2020 vision.[25] The Scottish Government sees achievement of the vision providing:

- integrated health and social care services
- a focus on prevention, anticipation and supported self-management
- day case treatment for hospital treatment where possible
- highest standards of quality and safety, with the person at the centre of all decisions, whether at home or in hospital
- a focus on ensuring that people get back home as soon as appropriate, with minimal risk of re-admission.

85. There is limited evidence of progress towards achieving the 2020 vision. For example, a progress report on the *Everyone Matters* 2014/15 workforce implementation plan found that boards had improved at embedding the values of the 2020 vision.[26] However, we found that progress was slow in getting consistent workforce data and more evidence is needed that boards are meeting the other aspects of the vision. Similarly, Scottish Government plans to develop a route map for capital investment to support the 2020 vision have not yet materialised.

86. Achieving the 2020 vision requires major changes in the way healthcare services are provided. This includes a significant shift of resources such as money and staff into more preventative and community-based services. It also requires use of new and innovative ways of delivering services, including using new technology to generate greater efficiencies. Following on from our 2014 report recommendation, the Scottish Government has yet to introduce milestones and indicators to measure progress of moving towards more preventative and community-based care. This makes it more difficult to assess developments and progress towards the vision.

The Scottish Government is planning to revise its long-term plan for health and social care

87. In June 2015, the Cabinet Secretary for Health, Wellbeing and Sport confirmed that the Scottish Government and NHS boards had not made sufficient progress quickly enough towards delivering the 2020 vision.[27] At the same time, the Scottish Government announced plans to launch a new national conversation on the future of healthcare in Scotland. The Scottish Government decided to consider a longer-term plan, beyond 2020, because it wanted:

- more progress and pace towards achieving the vision
- to expand the current focus of the vision.

88. The conversation focuses on 'creating a healthier Scotland' and the future of health and social care over the next 15 years to 2030. The Scottish Government considers this an extension to the 2020 vision by including a greater emphasis on prevention and addressing health inequalities. The Scottish Government plans to hold events across Scotland up to April 2016 with staff, service users and other interested groups to get feedback about the aspirations of the 2020 vision. The Scottish Government wants to emphasise the need for cultural and behavioural changes in the approach to improving health outcomes.

89. In developing a revised long-term plan, the Scottish Government will need to engage widely with clinical representatives, councils, new integration authorities, community planning partnerships, patients and the wider public. The Scottish Government will also need to outline milestones and indicators of planned progress and how it plans to measure this between now and 2020, and beyond to 2030. In doing so, it should learn from the slow progress made so far in achieving the 2020 vision and ensure the new approach includes any lessons learned.

Several major initiatives and programmes aim to improve longer-term healthcare in Scotland

90. The 2020 vision provides the strategic context for ongoing Scottish Government-led health initiatives and programmes. The most significant of these is the *Healthcare Quality Strategy*, published in May 2010.[28] This strategy aims to make Scotland among the best countries in the world for providing healthcare and is centred on three ambitions:

- Safe: There will be no avoidable injury or harm to people from healthcare, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times
- Person-centred: Mutually beneficial partnerships between patients, their families and those delivering healthcare services, that respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making
- Effective: The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

91. A number of initiatives are under way to help implement the strategy, including the following:

- **Scottish patient safety programme:** This aims to improve the safety and reliability of healthcare and reduce harm, where care is delivered.
- **Whole system patient flow programme:** This aims to reduce delays and help ensure that patients receive the right care at the right time, improving the quality of care received.
- **eHealth:** This aims to use information and technology in a coordinated way to help achieve the three quality ambitions.
- **National review of primary care out-of-hours services:** This is considering how best to deliver primary care out-of-hours services in light of the challenges of Scotland's ageing population, and as health and social care services are integrated.
- **Taskforce on sustainability and seven-day services:** This is considering the implications of delivering a sustainable seven-day clinical service across the NHS.

92. Similarly, the Scottish Government has established several programmes to help specific groups or healthcare conditions. These include 'reshaping care for older people', 'getting it right for every child' and separate heart and stroke improvement plans.[29, 30, 31] It will be important for the Scottish Government to demonstrate how its revised, longer-term approach links with ongoing national initiatives and programmes and what fundamental changes will arise from them and how these will be embedded in mainstream services. The speed at which substantial changes are needed within the NHS means that good progress with supporting programmes and initiatives is vital if the Scottish Government is to achieve the overall ambitions of the 2020 vision and beyond. There is a risk that underpinning programmes may lack coordination, compete for limited resources, lose focus or become subject to delay as changes are made to the overall strategic direction. The Scottish Government is aware of this risk and has recently established a transformational programme board including senior representatives from NHS boards to try and address this.

Changes to the NHS estate are vital for achieving the vision

93. Investing in hospital and community buildings and other assets such as IT and transport is vital to delivering high-quality patient care and making services more efficient. Providing more options for care in patients' homes, care homes and communities has significant implications for ensuring assets are in the right place at the right time, suitable for their purpose and well maintained. For example, some patients will need specialist technology and equipment installed in their homes where this is the location of their care. It is important that the NHS estate and other assets evolve to reflect the longer-term vision of transferring care to more local settings to help ensure services are fit for purpose and sustainable.

Significant changes to the NHS estate are needed to improve its suitability and the way it is used

94. The NHS in Scotland has physical assets worth about £5.4 billion (net book value), of which land and buildings are worth £5 billion with medical and IT equipment and vehicles accounting for the rest. The NHS uses a further £1.5 billion worth of privately owned assets. These assets include some GP surgeries and dental surgeries and those delivered under PFI contracts (such as the Royal Infirmary of Edinburgh). The overall size of the estate is around 4.5 million square metres, with 74 per cent of this (3.34 million square metres) covering 228 hospitals.

95. In February 2015, the Scottish Government published its annual NHS assets and facilities report (covering 2014) which showed:

- Twenty-five per cent of the NHS estate is over 50 years old. Fifty-nine per cent of the estate is in good condition, 37 per cent requires investment and four per cent requires major refurbishment or replacement. The percentage of the estate in good condition is eight per cent lower than in 2013, but this is largely attributed to changes in surveying methods.

- NHS boards reported that approximately 77 per cent of the estate is fully used, with a further 14 per cent underused or empty. Nine per cent is overcrowded. Although over three-quarters of the estate is fully used, boards considered around 65 per cent as functionally suitable. This is a three per cent decrease from 2013.

- The level of backlog maintenance and repair was reduced during 2013/14. The backlog maintenance requirement as at the end of March 2014 was £797 million, equivalent to 15 per cent of NHS estate value. This is a decrease of £61 million (seven per cent) from £858 million in 2013 and includes £95 million of newly identified backlog from additional survey work carried out during the year. Overall, 12 per cent (£96 million) of the backlog is considered high risk with 35 per cent (£279 million) considered as significant risk. Of the backlog, £80 million relates to properties expected to be disposed within five years and £65 million relates to replacements planned in the next five years. Together, various projects planned are expected to address £275 million (35 per cent) of backlog.[32]

It is unclear how capital investment plans link to achieving the 2020 vision

96. The NHS in Scotland completed 22 major capital projects (projects with a capital value of at least £5 million) in the last three years costing £1.4 billion (Exhibit 10, pages 40-41). The three largest projects were:

- Queen Elizabeth University Hospital (NHS Greater Glasgow and Clyde): £842 million.
- Emergency Care Centre (NHS Grampian): £110 million.
- Mental health developments (NHS Tayside): £100 million.

97. A further 13 major capital projects are currently in progress with an estimated capital value of £849 million. Projects vary in size from large-scale developments such as new hospitals in NHS Dumfries and Galloway and NHS Orkney to smaller projects such as community health centres.

98. Recent and planned investment aims to improve the quality of patient care and experience, and efficiency, by improving facilities and using assets and technology in a better way. Similarly, such improvements can enhance the wellbeing of staff who are able to work in an environment more suited to the needs of their role.

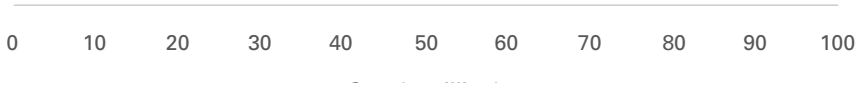
99. The Scottish Government has yet to finalise its planned route map for how capital investment activity and changes to the NHS estate will help achieve the 2020 vision. The route map is intended to support the implementation of the vision and form the basis of guidance material for boards. The scale and cost of planned capital investment means there will be significant changes to how the NHS estate contributes to effective service delivery. The 2020 vision of changing the balance of care from hospitals to more homely settings is likely to change the scale, type and quantity of NHS assets needed to deliver services in the future. The Scottish Government needs to demonstrate how planned investment and changes to the NHS estate aim to achieve this.

Exhibit 10a

Major capital investment activity in the NHS

Major capital projects completed between 1 April 2012 and 31 March 2015.

Board	Cost £m	Project
NHS Dumfries and Galloway	£6.1	North West Dumfries Primary Care Centre
NHS Fife	£5.7	Glenwood Health Centre
NHS Grampian	£110.0	Health campus programme. Emergency care centre project
	£6.7	Aberdeen Royal Infirmary. Phase 2 linear accelerator project
	£22.8	Aberdeen Community Health and Care Village
	£15.7	Forres, Woodside and Tain Health Centres bundle
NHS Greater Glasgow and Clyde	£18.1	Glasgow Royal Infirmary University Tower refurbishment
	£20.8	Alexandria Health Centre Oakview Medical Practice
	£7.7	Older people's mental health inpatient redesign
	£10.4	Possilpark Health and Care Centre
	£9.5	Psychiatry and mother & baby unit relocation to Leverndale Hospital
	£5.4	Glasgow Dental Hospital phased upgrade
	£841.7	Queen Elizabeth University Hospital and the Royal Hospital For Children
NHS Lanarkshire	£24.1	Airdrie Community Health Centre
	£50.6	Primary health care centres
NHS Lothian	£17.5	Musselburgh Primary Care Centre
	£43.6	Royal Victoria Building, Western General Hospital
	£10.8	Wester Hailes Healthy Living Centre
NHS Tayside	£100.3	Mental health developments
	£10.5	Nuclear medicine redevelopment, Ninewells Hospital
	£7.9	Adolescent mental health inpatient service
The State Hospital	£92.0	Redevelopment of The State Hospital
	Total: £1,437.9	



Note: Break in bar graph is where project is over £100 million.

Source: Scottish Government, NHS boards and the Scottish Futures Trust

Exhibit 10b

Major capital investment activity in the NHS

Major capital projects in progress as at 1 April 2015.

Board	Estimated cost £m	Project
National Services Scotland	£38.3	Scottish National Blood Transfusion Centre
NHS Ayrshire and Arran	£27.6	Building for Better Care
	£54.8	Acute mental health facility & North Ayrshire Community Hospital
NHS Dumfries and Galloway	£274.3	Acute services re-development project
NHS Fife	£15.1	General hospitals and maternity services project[1]
	£28.0	General hospitals and maternity services project[2]
NHS Greater Glasgow and Clyde	£13.7	Maryhill Health Centre
	£10.8	Eastwood Health and Care Centre
NHS Lanarkshire	£17.9	Reprovision of Monklands theatres and intensive care unit
	£21.9	Lanarkshire Beatson
NHS Lothian	£230.1	Royal Hospital for Sick Children and Dept. of Clinical Neurosciences
	£49.4	Royal Edinburgh Hospital campus redevelopment (phase 1)
NHS Orkney	£67.0	New hospital and healthcare facility
Total: £848.9		

Notes:
1. Reconfiguration works.
2. Enabling works to retained estate.
3. Break in bar graph is where project is over £100 million.

Source: Scottish Government, NHS boards and the Scottish Futures Trust

Better understanding of demand, capacity and patient flow is needed to support future plans

100. Our 2014 report highlighted the complexities of the health and social care system in which patient flows need to be understood and managed to ensure the right resources meet demand.[33] We reported that the NHS needs a better understanding of:

- current capacity, for example having the right number of hospital beds, outpatient clinics, community services and trained staff available when and where they are needed
- current and future demands for services.

This information will help the NHS make the major changes needed to ensure it can deliver services and meet the longer-term needs of the population.

101. There is limited evidence of boards or the Scottish Government evaluating: whether health and care services can adapt to changes in demand; if they have sufficient capacity to implement the 2020 vision for health and social care; and the financial implications of NHS boards and councils implementing the vision. We plan to analyse projections for activity and conditions and use some case studies to examine the implications for health and social care resources over the longer term. We plan to publish the results of this work in spring 2016.

Responsibility for delivering health and social care services in the future extends beyond the NHS

102. Responsibility for delivering health and social care in Scotland has extended beyond the boundaries of the NHS. The Scottish Government has launched many policies and reform programmes aimed at improving health and social care in Scotland. These have resulted in local government and the private and voluntary sectors getting more involved. Examples of these policies and reform programmes include:

- Community Care Act 2002
- NHS Reform Act 2004
- Better Health Better Care Strategy 2007
- NHS Quality Strategy 2010
- Social Care (Self-directed support) Act 2013
- Public Bodies Joint Working Act 2014.

103. Major reform is under way to integrate health and social care services in Scotland. This is an important part of the Scottish Government's 2020 vision. It requires NHS boards and councils to redirect resources towards more community-based and preventative care. Under these arrangements, NHS boards and councils will be required to delegate services and resources to a new body, known as an integration authority. As a minimum, integration authorities will be responsible for adult social care services, adult community health services and

some adult acute health services. The integration authority will be responsible for planning these services and directing NHS boards and councils to deliver services in line with their plans. The reforms are intended to ensure that partners work better together, develop different models of care and make better use of their resources to improve outcomes for people. The 31 new integration authorities will be operational by the deadline of 1 April 2016. We plan to publish a report on progress with health and social care integration in December 2015. This will identify the key risks and challenges that are likely to face the new bodies.

Better performance monitoring is needed to assess progress in delivering long-term ambitions for health and social care

104. In January 2015, the Scottish Government issued revised guidance to NHS boards on completing LDPs. The guidance reaffirmed the Scottish Government's commitment to assessing NHS performance against HEAT targets and standards as well as six new improvement priorities covering:

- health inequalities and prevention
- antenatal and early years
- person-centred care
- safe care
- primary care
- integration.

105. The Scottish Government plans to assess overall NHS performance using HEAT targets and standards, improvement priorities and, from April 2016, new health and social care performance indicators for integration authorities.

106. In our 2014 report, we recommended that the Scottish Government should review current performance targets and standards and the planned indicators for integration authorities to ensure consistency with, and support for, the 2020 vision.[34] It remains unclear how these targets and indicators will align. The Scottish Government, NHS boards and integration authorities need to work together to ensure the targets and indicators provide comprehensive coverage of all activity across health and social care in Scotland.

Endnotes

1 *The 2014/15 audit of NHS Tayside: financial management* [PDF], Audit Scotland, October 2015.

2 *The 2013/14 audit of NHS Highland: financial management* [PDF], Audit Scotland, October 2014.

3 *The 2014/15 audit of NHS Highland: update on financial management* [PDF], Audit Scotland, October 2015.

4 *The 2013/14 audit of NHS Orkney: financial management* [PDF], Audit Scotland, October 2014.

5 *The 2013/14 audit of NHS 24: management of an IT contract* [PDF], Audit Scotland, October 2014.

6 *The 2014/15 audit of NHS 24: update on management of an IT contract* [PDF], Audit Scotland, October 2015.

7 *Annual State of NHSScotland Asset and Facilities Report for 2014*, Scottish Government, February 2015.

8 *Finance guidance note to Scottish Public Finance Manual*, Scottish Government, June 2014.

9 *Scottish Government Annual Report on the Use of Settlement Agreements 2014-2015*, Scottish Government, June 2015.

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

11 *Quarterly inpatient, day case and outpatient activity*, ISD Scotland, June and September 2015.

12 *GP Out of Hours Services in Scotland 2014/15*, ISD Scotland, August 2015.

13 *Health & Social Care: Winter in Scotland in 2014/15*, Scottish Government, August 2015.

14 *NHS workforce data tables*, ISD Scotland, June 2015.

15 Ibid.

16 *GP workforce and practice population statistics to 2014*, ISD Scotland, December 2014.

17 *NHS workforce data tables*, ISD Scotland, June 2015.

18 Ibid.

19 Ibid.

20 *Using locum doctors in hospitals* [PDF], Audit Scotland, June 2010.

21 *Pan Scotland Workforce Planning Assessment and Recommendations*, Scottish Government, March 2014.

22 *Everyone Matters: 2020 Workforce Vision*, Scottish Government, June 2013.

23 *Everyone Matters: 2020 Workforce Vision Implementation Plan* 2015/16, Scottish Government, November 2014.

24 *2020 Vision: Strategic Narrative*, Scottish Government, September 2011.

25 *Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013.

26 *Everyone Matters: 2020 Workforce Vision, review of progress in 2014-15*, Scottish Government, September 2015.

27 Cabinet Secretary for Health, Wellbeing and Sport, NHSScotland Event 2015, 23 June 2015.

28 *The Healthcare Quality Strategy for NHSScotland*, Scottish Government, May 2010.

29 *The Reshaping Care for Older People: A Programme for Change 2011-2021*, Scottish Government, 2011.

30 *Getting it right for every child*, Scottish Government, 2008.

31 *Heart disease and stroke improvement plans*, Scottish Government, 2014.

32 *Annual State of NHS Scotland Assets and Facilities Report for 2014*, Scottish Government, December 2014.

33 *NHS in Scotland 2013/14,* [PDF], Audit Scotland, October 2014.

34 Ibid.

Appendix

NHS financial performance 2014/15

	£(000)			£(000)		
Health board	**Revenue Resource Limit**	**Outturn**	**Variance**	**Capital Resource Limit**	**Outturn**	**Variance**
Ayrshire and Arran	697,885	697,539	346	35,321	35,319	2
Borders	208,675	208,599	76	1,581	1,573	8
Dumfries and Galloway	311,974	309,945	2,029	31,917	31,917	0
Fife	643,738	643,504	234	13,458	13,458	0
Forth Valley	510,847	509,821	1,026	4,144	4,144	0
Grampian	912,346	912,209	137	22,191	22,191	0
Greater Glasgow and Clyde	2,258,960	2,257,727	1,233	159,357	159,337	20
Highland	624,294	624,158	136	16,243	16,243	0
Lanarkshire	1,127,908	1,127,508	400	53,410	53,410	0
Lothian	1,393,050	1,392,811	239	46,613	46,613	0
Orkney	57,419	57,351	68	3,550	3,536	14
Shetland	53,315	53,271	44	759	756	3
Tayside	790,447	790,389	58	13,871	13,868	3
Western Isles	78,472	78,470	2	1,756	1,756	0
Territorials Total	9,669,330	9,663,302	6,028	404,171	404,121	50
National Services Scotland	389,165	388,929	236	10,257	10,220	37
The Scottish Ambulance Service	246,853	246,792	61	11,730	11,729	1
NHS Education for Scotland	434,299	433,657	642	2,002	2,002	0
NHS 24	69,742	67,943	1,799	300	283	17
National Waiting Times Centre	65,165	64,664	501	3,824	3,821	3
The State Hospital	35,485	35,395	90	198	198	0
NHS Health Scotland	20,630	20,426	204	-816	-864	48
Healthcare Improvement Scotland	20,395	20,002	393	50	42	8
Mental Welfare Commission	4,626	4,626	0	212	212	0
Specials Total	1,286,360	1,282,434	3,926	27,757	27,643	114
Total	**10,955,690**	**10,945,736**	**9,954**	**431,928**	**431,764**	**164**

Source: Scottish Government

NHS in Scotland 2015

This report is available in PDF and RTF formats, along with a podcast summary at:
www.audit-scotland.gov.uk

If you require this publication in an alternative format and/or language, please contact us to discuss your needs: 0131 625 1500 or **info@audit-scotland.gov.uk**

For the latest news, reports and updates, follow us on Twitter or subscribe to our email delivery service:

@AuditScotland

Subscribe to updates

pinterest.com/AuditScotland

AUDIT SCOTLAND

Audit Scotland, 110 George Street, Edinburgh EH2 4LH
T: 0131 625 1500 E: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

ISBN 978 1 909705 74 6 AGS/2015/9

This publication is printed on 100% recycled, uncoated paper

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13th January 2016

Subject: Forthcoming Audit Scotland Report - Social Work in Scotland

1. Purpose

1.1 To bring to the Audit Committee's attention a national audit on Social Work in Scotland that has been initiated by Audit Scotland and that is of direct relevance to the work of the Health & Social Care Partnership.

2. Recommendation

2.1 The Partnership Board is recommended to:

1) Note the Audit Scotland work being undertaken.

2) Direct the Chief Officer to bring a report to the Audit Committee on the above once the final report is published.

3. Background

3.1 Audit Scotland undertakes a number of audits for the Auditor General for Scotland and the Accounts Commission as part of a wider public audit model. This includes reports on significant issues of public interest; and overview reports on specific sectors.

3.2 Audit Scotland has recently announced that it is initiating a national audit of Social Work in Scotland – the Position Statement for which is attached.

4. Main Issues

4.1 The audit will look at:

- The scale of the financial and demand pressures facing social work.
- What strategies councils and their partners are adopting to address these challenges.
- Whether councils have effective governance arrangements, including elected member leadership and oversight of social work services.
- The impact of financial and demand pressures on service users and carers and how councils involve users and carers in service design.

4.2 Audit Scotland have specified that this audit will explicitly not look at health and social care integration, but we will consider its impact on social work governance arrangements.

5. People Implications

5.1 None associated with this report.

6. Financial Implications

6.1 None associated with this report.

7. Professional Implications

7.1 None associated with this report.

8. Locality Implications

8.1 None associated with this report.

9. Risk Analysis

9.1 WD HSCP officers have been in contact with Audit Scotland to seek clarity on the focus and purpose of this work as currently framed, with particular reference to that its arguably reductive use of the term “social work services”; and the apparent lack of consideration of the governance and strategic planning accountabilities of integration authorities.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The report on the above national audit will provide important evidence and context for the development of future Strategic Plans.

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement West Dunbartonshire Health & Social Care Partnership.

Date: 5th January 2016

Person to Contact: Soumen Sengupta – Head of Strategy, Planning & Health Improvement, Garshake Road, Dumbarton. G82 3PU.
Telephone: 01389 737321
e-mail: soumen.sengupta@ggc.scot.nhs.uk

Appendices:	Audit Scotland Position Statement: Social Work in Scotland
Background Papers:	None
Wards Affected:	All

Social work in Scotland

ACCOUNTS COMMISSION

Prepared by Audit Scotland

Councils' social work departments provide essential services to some of the most vulnerable people in society. The services they provide to children, adults and families, and other specific groups, aim to transform people's lives.

Councils spent over £3 billion on social work services in 2013/14, 29 per cent of their total budget. In 2014, councils provided social work services to over 150,000 people, around 80 per cent of whom are 65 and over. They include 36,751 adults in care homes and a further 1,470 children in various types of residential care.

Demand for social work services has been increasing, particularly among older people. At the same time, budgets have been reducing, creating significant challenges for social work services.

Councils and health boards are implementing new integrated health and social care arrangements, which are to be in place by April 2016. The combination of increasing demand for services, reducing budgets and significant organisational change may result in increased risks for social work services.

Why is this audit important?

An audit of social work services in 2015/16 is timely as there is a complex and challenging agenda for change in social work services at a time of significant financial pressures:

- There has been little change in the percentage of NHS and council budgets spent on community-based services over the past decade.
- The implementation of self-directed support gives people control over an individual budget but requires councils to transform many of their processes and procedures.
- There are significant staffing challenges in the social services sector, including recruiting and retaining experienced staff and concerns about terms and conditions.
- Spending on free personal and nursing care (FPNC) has increased significantly.
- Councils are tightening the criteria people must meet to be eligible for help and are focusing resources on people with acute needs, creating challenges in making the shift towards prevention.
- The Children and Young People (Scotland) Act 2014 is leading to significant changes in social work practice.

What will the scope of the audit be?

The audit will look at:

- the scale of the financial and demand pressures facing social work
- what strategies councils and their partners are adopting to address these challenges
- whether councils have effective governance arrangements, including elected member leadership and oversight of social work services
- the impact of financial and demand pressures on service users and carers and how councils involve users and carers in service design.

We will not be specifically looking at health and social care integration, but we will consider its impact on social work governance arrangements. We will be liaising closely with Audit Scotland colleagues currently undertaking audit work in this area.

How will we carry out this audit?

We will build on the work of previous audits including, *Commissioning social care* (March 2012), *Reshaping care for older people* (February 2014) and *Self-directed support* (June 2014) and link to current audits on *Changing models of health and social care* and the position statement on *Health and social care integration*.

We will gather evidence using a range of methods including analysing data, reviewing documents, interviews with staff and elected members in councils, and focus groups with service users and carers. We will carry out fieldwork and case studies in a small number of councils to better understand the specific challenges in meeting care needs, key developments, examples of good practice and strategies and plans for the future.

What impact will the audit have?

The report will provide an independent assessment of the scale of the challenges facing social work services and how councils are addressing these challenges. This will be timely as councils move into new integrated health and social care arrangements. The report will identify areas for improvement and examples of good practice.

Audit timetable and contact

We plan to publish a report in Summer 2016. Audit Scotland is carrying out this work on behalf of the Accounts Commission. If you have any questions, please get in touch with John Lincoln, Audit Manager, on 0131 625 1864 or at jlincoln@audit-scotland.gov.uk

AUDIT SCOTLAND

Audit Scotland, 110 George Street, Edinburgh EH2 4LH
T: 0131 625 1500 E: info@audit-scotland.gov.uk
www.audit-scotland.gov.uk

This leaflet was produced in October 2015

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 13th January 2016

Subject: Audit Scotland Report on Health & Social Care Integration

1. Purpose

1.1 To bring to the Audit Committee's attention the recently published Audit Scotland report on Health & Social Care Integration.

2. Recommendation

2.1 The Partnership Board is recommended to:

1) Note the findings of the Audit Scotland report.

2) Ask that the Chief Internal Auditor use the relevant recommendations made by Audit Scotland within this national report to inform and shape their internal audit of the local implementation of the Public Bodies (Joint Working) Act during 2016/17 following the first year of the HSCP Board's establishment.

3. Background

3.1 Audit Scotland undertakes a number of audits for the Auditor General for Scotland and the Accounts Commission as part of a wider public audit model. This includes reports on significant issues of public interest; and overview reports on specific sectors.

3.2 At is September 2015 meeting, the Audit Committee were informed that Audit Scotland had been undertaking national work looking at initial progress across Scotland with respect to the implementation of the Public Bodies (Joint Working) Act. Audit Scotland has now published the first of three planned audits of this major reform programme (appended). Subsequent audits will look at the progress of integration authorities after their first year of being established, and their longer-term impact in shifting resources to preventative services and community-based care and in improving outcomes for the people who use these services.

3.3 This first audit provides a progress report during what is viewed as a transitional period, with progress reviewed at this relatively early stage to provide a picture of the emerging arrangements for setting up, managing and scrutinising integration authorities as they become formally established.

4. Main Issues

4.1 The implementation of the Public Bodies (Joint Working) Act is already relatively well advanced in and for West Dunbartonshire.

4.2 West Dunbartonshire Health & Social Care Partnership Board is one of six (out of 32) integration authorities confirmed in the report has having been established and taken on operational responsibility for budgets and services by October 2015.

4.3 West Dunbartonshire Health & Social Care Partnership Board is one of six (out of 32) integration authorities confirmed in the report to have published a strategic plan.

4.4 West Dunbartonshire Health & Social Care Partnership is one of the few partnerships to have developed and have in place an approved workforce (and organisational development) strategy and risk management strategy (and policy).

5. People Implications

5.1 None associated with this report.

6. Financial Implications

6.1 None associated with this report.

7. Professional Implications

7.1 None associated with this report.

8. Locality Implications

8.1 None associated with this report.

9. Risk Analysis

9.1 As members will recall, there is already a commitment in place for an internal audit of the implementation of the Public Bodies (Joint Working) Act following the first year of the establishment of the Partnership Board to be undertaken by the Chief Internal Auditor during 2016/17 for the HSCP Board Audit Committee; the Health Board's Audit Committee; and the Council's Audit and Performance Review Committee. Given that Audit Scotland will ask all three bodies to report on how they have applied any learning from this national report, it would be logical for the Chief Internal Auditor to be supported to use the relevant recommendations made by Audit Scotland within this national report to inform and shape that planned internal audit.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 This report on the above national audit will provide important evidence and context for the development of the next Strategic Plan.

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement West Dunbartonshire Health & Social Care Partnership.

Date: 5th January 2016

Person to Contact: Soumen Sengupta – Head of Strategy, Planning & Health Improvement, Garshake Road, Dumbarton. G82 3PU.
Telephone: 01389 737321
e-mail: soumen.sengupta@ggc.scot.nhs.uk

Appendices: Audit Scotland: Health and Social Care Integration (December 2015)

Background Papers: Audit Committee Report: Forthcoming Audit Scotland Reports (September 2015)

Wards Affected: All

Health and social care series

Health and social care integration

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
December 2015

The Accounts Commission

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

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

Our work includes:

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

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

Auditor General for Scotland

The Auditor General's role is to:

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

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

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

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

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

Contents

Key facts

Over **£8 billion**

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

18-29 per cent

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

31

Integration authorities are required to be operating by April 2016

£138-£157m

Scottish Government estimates of annual savings from integration

9

National outcomes that integration authorities are required to contribute towards

Summary

Key messages

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

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

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

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

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

Recommendations

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

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

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

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

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

Background

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

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

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

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

About this audit

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

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

7. We gathered audit evidence by:

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

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

Appendix 1 provides further information on our audit approach.

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

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

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

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

Part 1

Expectations for integrated services

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

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

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

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

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

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

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

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

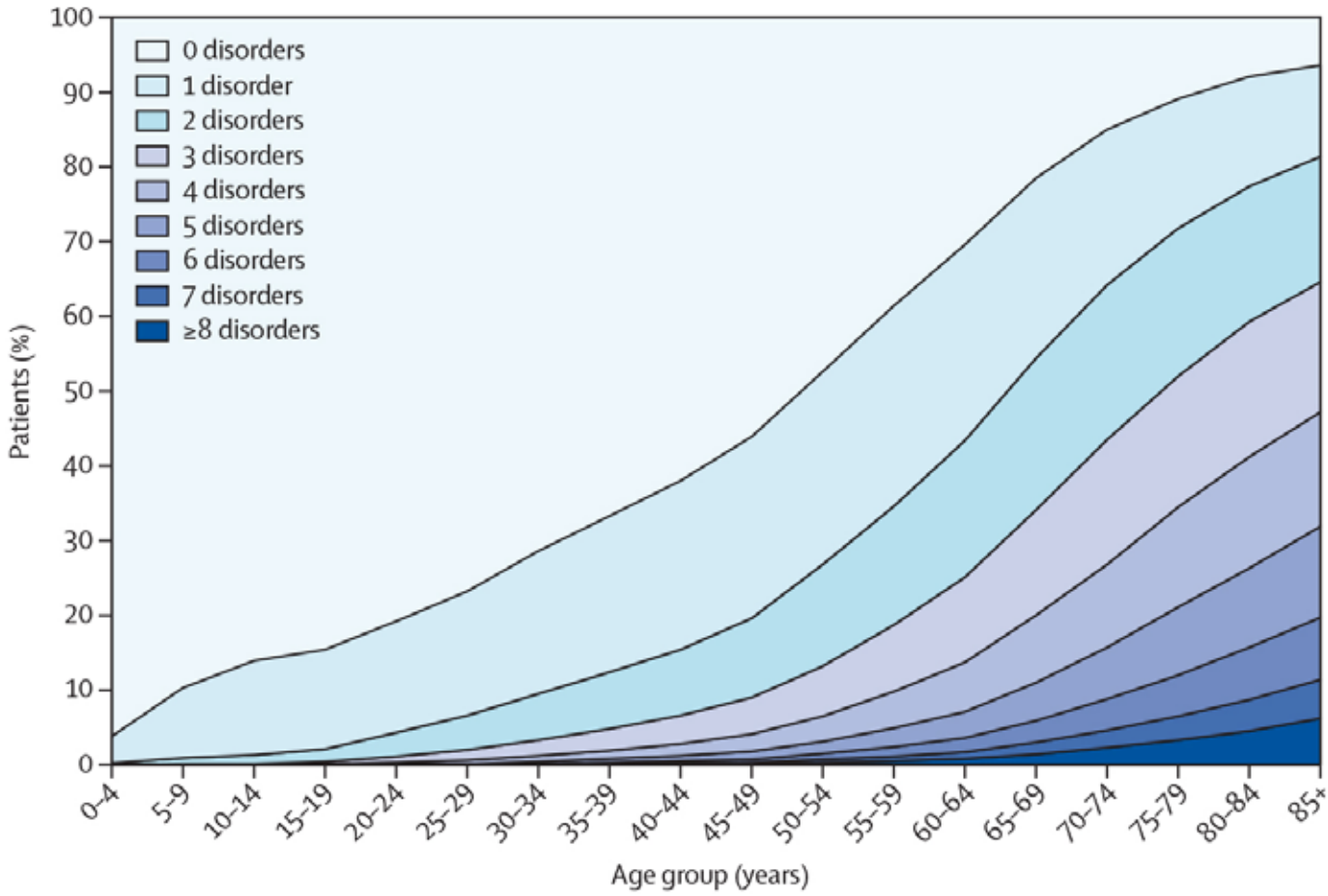
- A patient's discharge from hospital may be delayed when they are judged to be clinically ready to leave hospital but unable to leave because arrangements for care, support or accommodation have not been put in place. In 2014/15, this led to the NHS in Scotland using almost 625,000 hospital bed days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

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

Exhibit 1

Long-term conditions by age

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



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

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

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

Exhibit 2

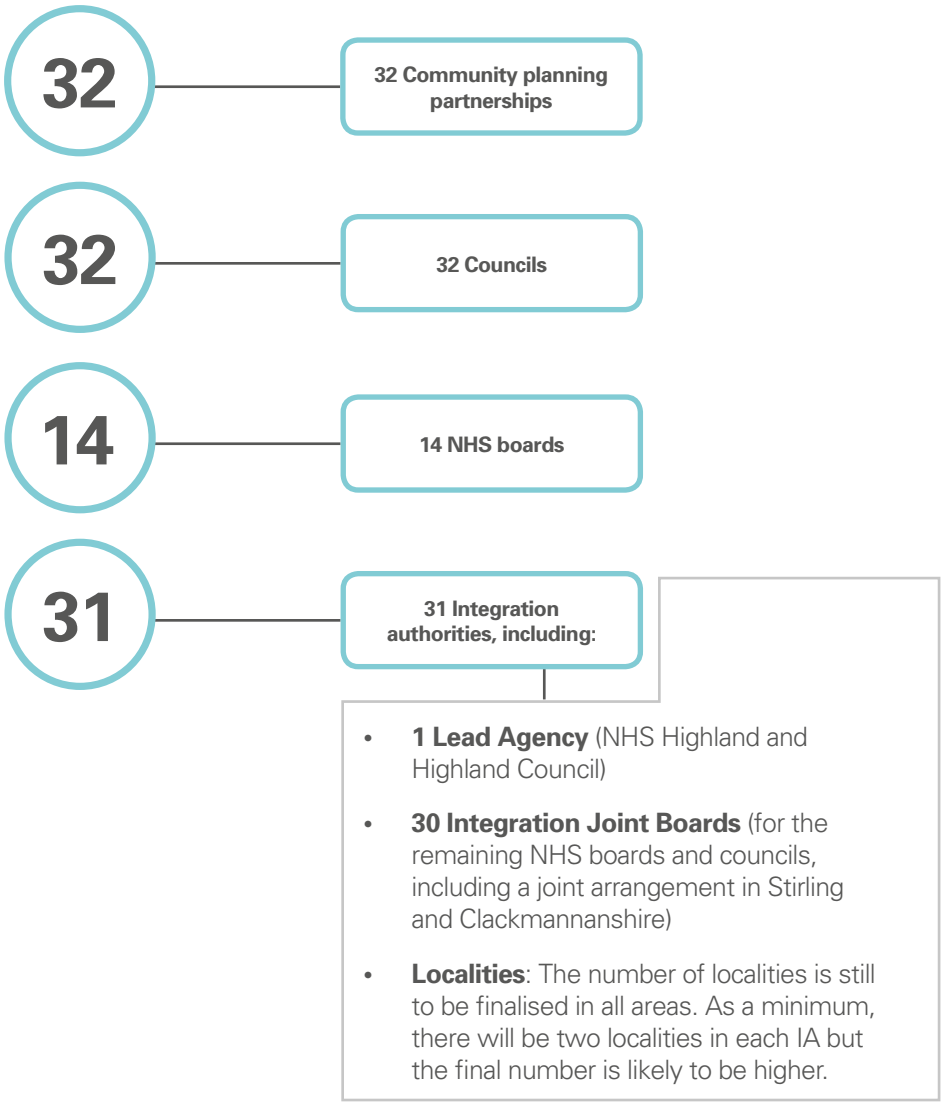
A brief history of integration in Scotland

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

Source: Audit Scotland

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

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



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

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

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

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

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

Scope of services to be integrated

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

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

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

How IAs are structured

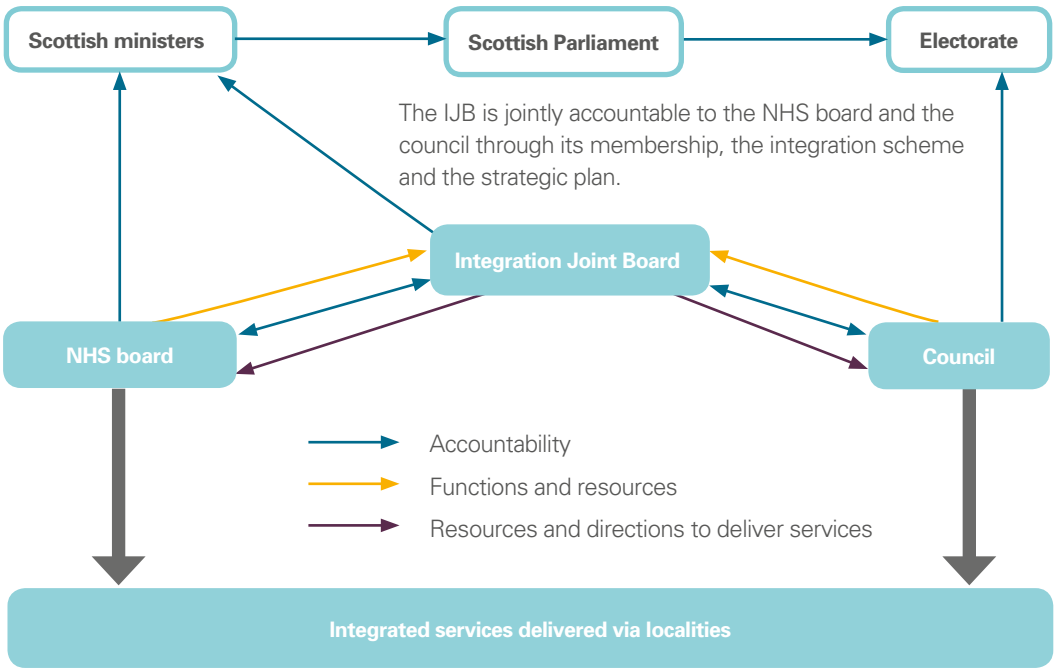
21. IAs will be responsible for overseeing certain functions that are delegated from the local NHS board and council(s). IAs can follow one of two main structural models (Exhibit 4, page 14).

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

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

Exhibit 4
Integration authorities will follow one of two main models

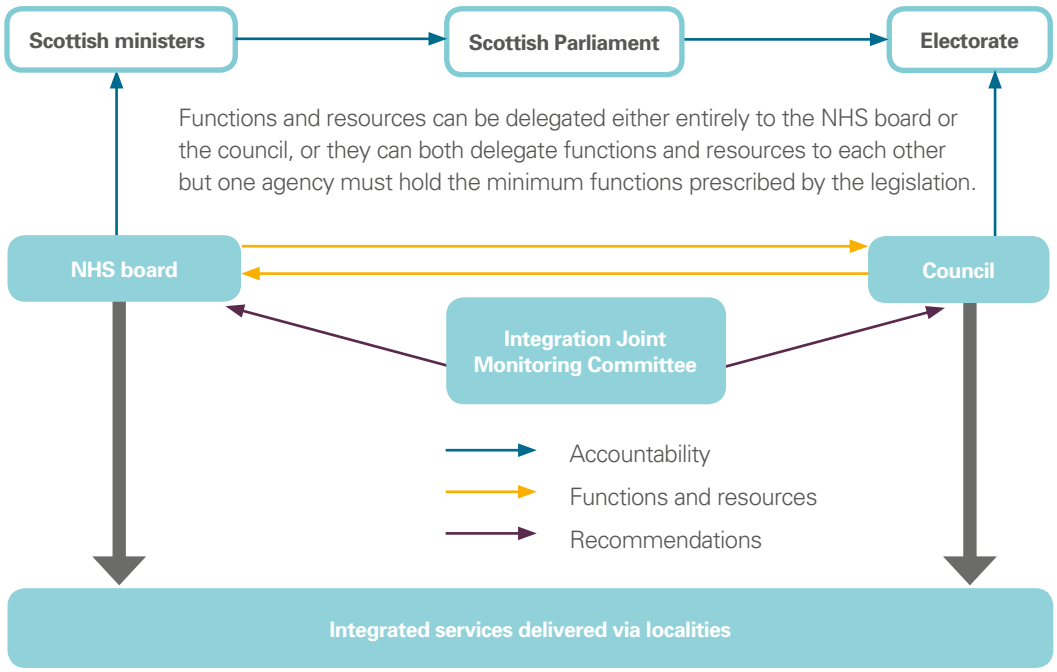
Body corporate or Integration Joint Board model



Body corporate

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

Lead agency model



Lead agency

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

Source: Audit Scotland

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

- A statutory duty of Best Value applies to IJBs.

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

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

Membership of Integration Joint Boards (IJBs)

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

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

Scrutinising integrated health and social care

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

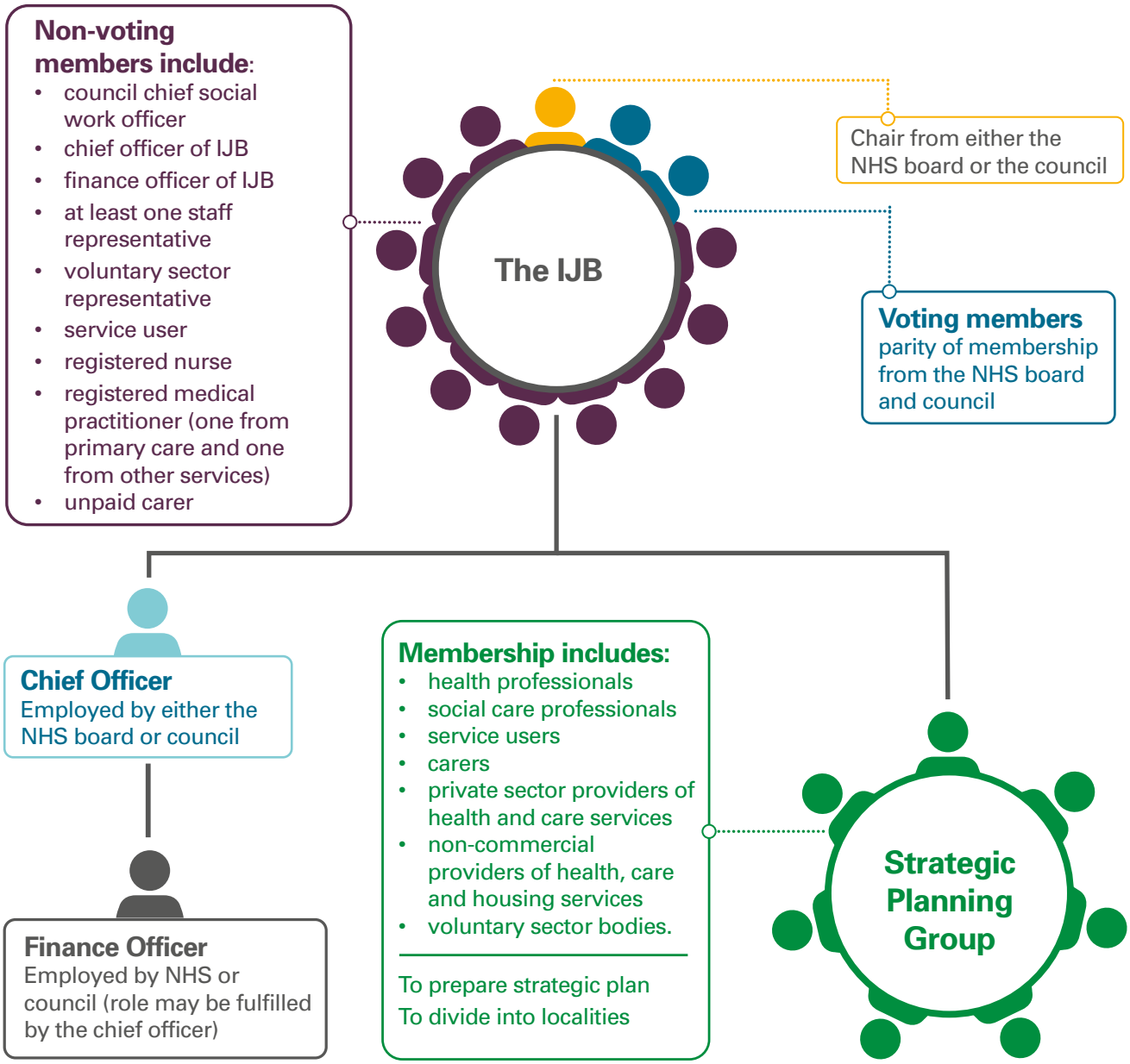
- The Accounts Commission is responsible for appointing auditors to IJBs and so has an interest in financial management and governance arrangements. As local government bodies, IJBs are also covered by the duty of Best Value as set out in the Local Government in Scotland Act 2003. The Accounts Commission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

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

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

Exhibit 5

Organisation chart for a typical IJB



Source: Audit Scotland

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

Implications for the public, voluntary and private sectors

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

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

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

Localities

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

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

Outcomes and performance measures

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

The Scottish Government is providing resources to help support integration

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

Exhibit 6

National health and wellbeing outcomes

IAs are required to contribute to achieving nine national outcomes.

1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5	Health and social care services contribute to reducing health inequalities.
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
7	People who use health and social care services are safe from harm.
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9	Resources are used effectively and efficiently in the provision of health and social care services.

Source: National Health and Wellbeing Outcomes, Scottish Government

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

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

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

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

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

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

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

Part 2

Current progress

Integration authorities are being established during 2015/16

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

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

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

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

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

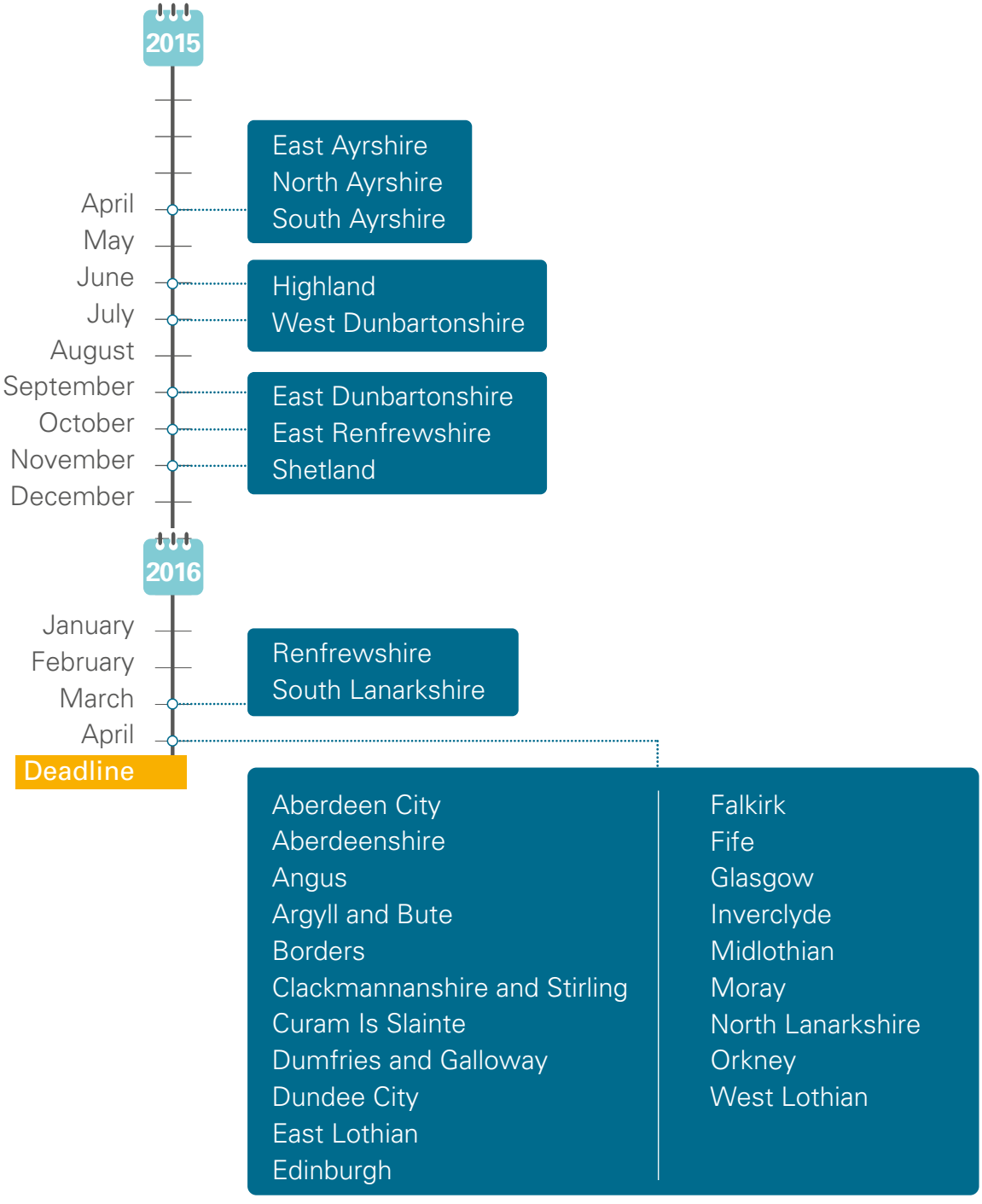
the scope of the services being integrated varies widely across Scotland

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

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

Exhibit 7

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



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

Source: Audit Scotland

Exhibit 8

Additional integrated services

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

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

Key

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

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

Source: Scottish Government, 2015 and Audit Scotland, 2015

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

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

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

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

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

Chief officer accountability

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

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

Accountability to the IJB

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

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

Accountability to the NHS board and council

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

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

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

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

Part 3

Current issues

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

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

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

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

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

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

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

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

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

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

Sound governance arrangements need to be quickly established

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

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

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

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

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

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

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

IJB members will have to manage conflicts of interest

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Most IAs have still to produce supporting strategies

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

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

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

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

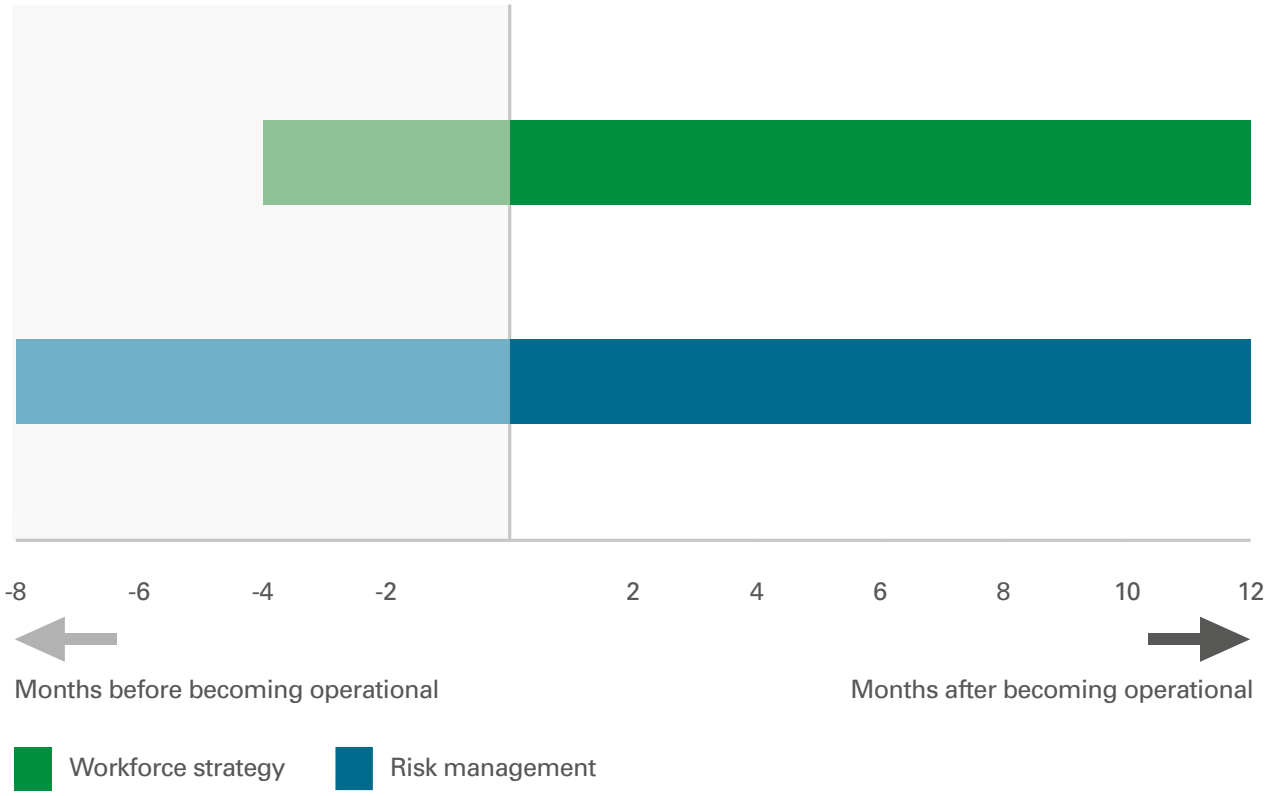
Equally, there are risks where the IA will not have plans in place until they have been operational for many months. It is important that IAs have clear strategic priorities and use these in developing:

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

Exhibit 9

Range of timescales for supporting strategies

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



Source: Audit Scotland analysis of available integration schemes

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

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

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

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

85. The following will add to these difficulties:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

  – They will use different measures from each other. This has the benefit of allowing IAs to focus on their local priorities. However, it will make it difficult for the Scottish Government to compare performance across IAs to identify what approaches are working best (Exhibit 10, page 37).

  – In various places, both IAs have associated a different mix of indicators to an outcome from that set out in Scottish Government guidance. This occurs more frequently in North Ayrshire which developed its plans before the Scottish Government published its approach. But North Lanarkshire also has taken a different view on which indicators it will use to measure progress on some of the national outcomes, making it difficult for the Scottish Government to measure progress at a national level.

  – We have provided a more detailed comparison of the approaches used by North Lanarkshire and North Ayrshire IAs in a supplement to assist other IJBs when developing their plans (Exhibit 10, page 37).

Exhibit 10

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

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

NL = North Lanarkshire map this to outcome

NA = North Ayrshire map this to outcome

AL = Neither map this to outcome

Source: Audit Scotland analysis of performance frameworks

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

The role of localities still needs to be fully developed

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

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

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

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

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

Part 4

Recommendations

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

The Scottish Government should:

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

Integration authorities should:

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

This includes:

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

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

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

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

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

Integration authorities should work with councils and NHS boards to:

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

Endnotes

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

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

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

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

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

6 *Scotland Performs*, Scottish Government, 2015.

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

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

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

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

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

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

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

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

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

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

17 East Dunbartonshire, Shetland and West Dunbartonshire.

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

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

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

21 Ibid.

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

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

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

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

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

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

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

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

30 Ibid.

Appendix 1

Audit methodology

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

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

We interviewed stakeholders in the following IA areas:

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

We drew on the work already carried out by:

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

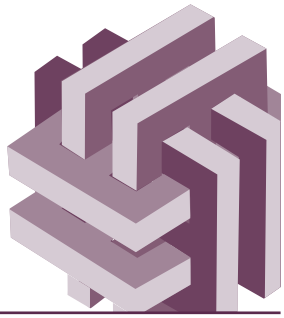
We also interviewed staff from:

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

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

Appendix 2

Scottish Government core integration indicators



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

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

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

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

* Indicates indicator is under development.

Health and social care integration

This report is available in PDF and RTF formats, along with a podcast summary at:
www.audit-scotland.gov.uk

If you require this publication in an alternative format and/or language, please contact us to discuss your needs: 0131 625 1500 or **info@audit-scotland.gov.uk**

For the latest news, reports and updates, follow us on:

AUDIT SCOTLAND

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
T: 0131 625 1500 E: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

ISBN 978 1 909705 76 0 AGS/2015/10

This publication is printed on 100% recycled, uncoated paper